[redacted]

LATHAM & WATKINS LLP

555 Eleventh Street, N.W., Suite 1000
Washington, D.C. 20004-1304
Tel: +1.202.637.2200 Fax: +1.202.637.2201
www.lw.com

December 20, 2023

HIGHLY CONFIDENTIAL
VIA ELECTRONIC TRANSMISSION

The Honorable Sheldon Whitehouse
The Honorable Charles E. Grassley
Committee on the Budget
United States Senate
Washington, D.C. 20510-6100

Re: December 6, 2023 Letter to Apollo Global Management, Inc.

Dear Chairman Whitehouse and Ranking Member Grassley,

On behalf of our client, Apollo Global Management, Inc. ("Apollo" or the "Company"), we write in response to your December 6, 2023 letter regarding the tragic events at the Ottumwa Regional Health Center ("ORHC") and your inquiry into the role of private equity in healthcare. Of course, Apollo shares your interest in ensuring rural communities have access to high-quality, cost-effective care—a goal that Apollo has pursued through the investment in Lifepoint Health ("Lifepoint") by certain investment funds managed by affiliates of Apollo (the "Apollo Funds"). As discussed on our December 14, 2023 call with the Committee's staff, Apollo looks forward to cooperating with the Committee's inquiry and appreciates your leadership and advocacy for rural hospitals and their patients.

We provide these preliminary responses to certain of your questions below. Apollo is continuing to gather the requested information responsive to the Committee's requests, and we anticipate providing additional information and documents on a rolling basis. We propose to submit another installment of documents and responses to the Committee by Friday, January 19, and to have a call with the Committee's counsels the following week to discuss further productions.

* * *

Responses

1. **Describe the historical (both current and former) financial and operational relationship between Apollo and Lifepoint, including the exact dollar amount of its own capital that Apollo has invested in Lifepoint and in Ottumwa Regional, whether made directly in the**

hospital or indirectly through Lifepoint. Produce all documents demonstrating this relationship—including, but not limited to, contracts or written agreements, memoranda of understanding, proofs of investment, investment thesis documents describing or setting out evidence-based rationales for Apollo's investment in Lifepoint, any memoranda setting out the reason for Apollo's acquisition of or investment in Lifepoint, and operational or administrative procedure manuals.

The Apollo Funds' original investment thesis in Lifepoint and its predecessor companies centered on investing in healthcare companies that provide care for underserved communities. Rural hospitals across the United States have faced challenges for decades, in part driven by underinvestment. The Apollo Funds sought to do the opposite by investing in and supporting companies, such as Lifepoint, that invest in these underserved communities to recruit physicians, expand service line offerings, and upgrade equipment in order to care for these communities. On an ongoing basis, the Apollo Funds' involvement with Lifepoint is through the Apollo employees that serve on the Board (further detailed below) who, in their roles as directors, support Lifepoint in this mission.

The Apollo Funds first invested in parent entities of ORHC in 2015. The Apollo Funds' initial investment occurred in December 2015 through the acquisition of RegionalCare, an eight-hospital system, from funds affiliated with Warburg Pincus. *See* AP-SBC-000001. Following the acquisition of RegionalCare, the Apollo Funds continued to support rural healthcare through further investments the following year with the acquisition of Capella. *See* AP-SBC-000004. In 2018, the Apollo Funds invested additional capital to facilitate the combination of RegionalCare, Capella, and Lifepoint; with that combination, ORHC became part of the Lifepoint health system. *See* AP-SBC-000006.

Since 2016, RegionalCare and its successor entities (including Lifepoint) have invested approximately $23 million in ORHC, with more than $3.5 million invested in capital projects in 2022 alone. Moreover, RegionalCare and its successor entities have invested an additional approximately $29 million in attracting and retaining physicians.

2. **While invested in Ottumwa Regional or any related entity that has or had an interest in Ottumwa Regional, please describe and produce all documents that support your answer with respect to Apollo's role, including that of Apollo employees, in determining or otherwise affecting the ability or authority of Ottumwa Regional or Lifepoint to:**

    a. Manage its care delivery;

    b. Manage its billing practices;

    c. Determine its charge-per-patient goals;

    d. Determine its staff-to-patient ratios;

    e. Determine its charge-to-cost ratios;

f. Enter into contracts for staffing;

g. Enter into any contracts on behalf of Ottumwa Regional; and

h. Determine its net annual income goals.

Apollo does not have management or decision-making authority with respect to the matters set forth above. In general, Apollo's approach to investing is to back and support strong management teams at portfolio companies that manage day-to-day operations and decision-making. Consistent with this approach, Lifepoint's management team is fully responsible for administering Lifepoint's business and making key decisions for Lifepoint's communities. The Apollo Funds support Lifepoint's mission through representation on Lifepoint's Board of Directors.

A core tenet of the Apollo Funds' investment approach is empowering management teams and portfolio companies. Lifepoint's hospitals, including ORHC, each have a local management team responsible for general clinical operations, human resources and administration, and other day to day matters. The local management team is supported by the local Board of Directors (comprising industry experts such as local community members, physicians, and a member of the hospital management team) and the Lifepoint management team.

The operations of ORHC are carried out by RCHP-Ottumwa, LLC, a Delaware limited liability company. RCHP-Ottumwa, LLC is an indirect, wholly owned subsidiary of Lifepoint. ORHC is operated through a shared governance model, in which the local management team is responsible for day-to-day general and clinical operations, human resources, and administration of ORHC, with oversight by the hospital's Board of Trustees and RCHP-Ottumwa, LLC.

Please see below for a list of the Apollo employees who currently serve on Lifepoint's Board and those who previously served on the Board. The Apollo Funds acquired RegionalCare in 2015 and facilitated the combination of RegionalCare, Capella, and Lifepoint in 2018; the below includes Apollo employees' Board service beginning with the RegionalCare Board.

Director Name	Title	Board Tenure	Committee Assignments
Heather Berger	Partner and Head of Global Product	9/27/2023 to present	None
Bill Lewis	Partner	6/15/2023 to present	None
Christine Cahill	Principal	3/23/2022 to present	None
Maxwell David	Partner	12/13/2018 to present	Executive Quality
Holly McMullan	Partner and Global Head of Consultant Relations	12/13/2018 to 7/13/2023	Quality
Olivia Wassenaar	Partner and Head of Sustainable Investing and Natural Resources	12/13/2018 to 3/22/2022	None

Director Name	Title	Board Tenure	Committee Assignments
Matthew Nord	Partner and Co-Head of Private Equity	12/13/2015 to present	Executive (9/22/2016) Compensation (9/22/2016)
Eric L. Press	Partner	12/3/2015 to 5/22/2023	Executive (12/13/2018) Compensation (9/22/2016) Nominating & Governance (9/22/2016)
Chris Edson	Partner and Co-Head of Global FIG	12/3/2015 to 12/4/2018	Executive

4. Does Apollo have any current plans to divest its financial or operational interest in Lifepoint or Ottumwa Regional? If so, please describe those plans. Produce all documents that support your answer, including any information concerning Apollo's investment decisions in those entities.

The Apollo Funds do not have any plans to divest its financial interest in Lifepoint. As noted above, Apollo fully supports Lifepoint's efforts to continue to invest in ORHC and the Ottumwa community, and to support the critical provision of healthcare to rural communities in the United States.

5. Describe in detail Apollo's role in facilitating, approving, or in any way affecting the 2019 sale-leaseback transaction. Produce all documents that support your answer.

The Lifepoint Board, which includes Apollo employees, approved Lifepoint management's decision to conduct this transaction. We understand that the sale-leaseback was approved by the Lifepoint Board on October 30, 2019. This sale-leaseback transaction was part of a broader capital structure initiative to lower Lifepoint's interest and rental expense to optimize and enhance Lifepoint's capacity to invest in community healthcare by, among other things, improving the physical facility, acquiring medical devices, and recruiting talented caregivers. A copy of the sale-leaseback agreement is attached at AP-SBC-000533.

6. Explain in detail Apollo's justification for the 2019 sale-leaseback of Ottumwa Regional. Produce all documents that support your answer, including, but not limited to, all correspondence between and among Apollo, Medical Properties Trust, Lifepoint, and Lifepoint's Board.

As noted above, the Lifepoint Board approved Lifepoint management's decision to conduct this transaction. ORHC's sale-leaseback was part of this transaction.

A sale-leaseback transaction allows an owner of real estate to raise cash through the sale of real estate to a third party, while simultaneously leasing the real estate back. This allows the seller to receive a lump sum of cash for the real estate sale, while still being able to use the property moving forward in exchange for a long-term lease. Sale-leaseback transactions result in an improved balance sheet by converting an illiquid asset into working capital that can be invested

into the seller's core operations. At Lifepoint, the sale-leaseback transaction generated gross proceeds of approximately $700 million. Importantly, all of these proceeds went to pay down Lifepoint debt or invest in Lifepoint communities, and none of these proceeds went to Apollo. The transaction did not add to the total debt of Lifepoint, but rather resulted in lower fixed charges (interest expense) after Lifepoint used some of the proceeds to repay portions of Lifepoint's indebtedness. As described above, the sale-leaseback, along with other capital structure activity that was facilitated by the sale-leaseback, resulted in estimated annual net savings to Lifepoint of approximately $46 million. Additionally, through these activities, Lifepoint added approximately $350 million of cash to its balance sheet—ultimately enabling Lifepoint to invest more in its hospitals, including ORHC.

While there may be instances of financing transactions, including sale-leaseback transactions, that can burden the borrower with greater interest expense and result in a depletion of company resources, this is and was not the case for Lifepoint. The rent expense associated with the sale-leaseback transaction represents a very small portion of Lifepoint's EBITDA—less than five percent. And since completing the sale-leaseback transaction in 2019, Lifepoint has invested more than $17 million in the Ottumwa community and added more than 135 caregivers.

7. Explain in detail how Apollo used the 2019 sale-leaseback transaction to facilitate changes to its balance sheet, including paying down debt and issuing dividends. Produce all documents that support your answer, including, but not limited to, all correspondence between and among Apollo, Medical Properties Trust, Lifepoint, and Lifepoint's Board.

While the 2019 sale-leaseback transaction resulted in estimated annual net savings to Lifepoint of approximately $46 million and other balance sheet improvements as described above, it had no direct effect on Apollo's balance sheet.

* * *

Apollo remains proud to support Lifepoint and its management team in their mission to serve some of the most underserved communities in our country, and will continue to support and invest in the Ottumwa community through its commitment to Lifepoint.

On December 18, 2023, you asked whether Apollo has a "joint defense or common interest agreement with Lifepoint," and on December 19 requested a description of the scope of that agreement, its effective date, and "whether the agreement(s) defines which party is responsible for responding to the questions and producing the documents that are the subject of this investigation." Apollo entered into an oral common interest agreement with Lifepoint in March 2023. That agreement does not include any formal arrangement regarding the production of documents. Because, as detailed above, ORHC and Lifepoint are directly responsible for the day-to-day management and operations at ORHC, Lifepoint will naturally tend to have documents responsive to operations-related requests. However, based on our discussions with Committee staff, we understand that the Committee would prefer to receive documents in Apollo's possession, even where duplicative of documents already produced, and Apollo will accommodate this request consistent with its broader commitment to cooperate with the Committee's inquiry.

Apollo is voluntarily providing this information and we respectfully request that it be treated as confidential and not disclosed publicly or to any third party. To the extent you intend to disclose this information, Apollo requests that your staff notify Apollo in advance to allow us to discuss the matter and to take appropriate steps to safeguard Apollo's confidential business information.

Sincerely,

[redacted]

[redacted]
of LATHAM & WATKINS LLP

cc: [redacted], Latham & Watkins LLP
[redacted], Latham & Watkins LLP

[redacted]

LATHAM & WATKINS LLP

555 Eleventh Street, N.W., Suite 1000
Washington, D.C. 20004-1304
Tel: +1.202.637.2200 Fax: +1.202.637.2201
www.lw.com

April 5, 2023

HIGHLY CONFIDENTIAL
VIA ELECTRONIC TRANSMISSION

The Honorable Charles E. Grassley
United States Senate
Washington, DC 20510

Re: Letter of March 17, 2023

Dear Senator Grassley:

I write in response to your letter of March 17 on behalf of Apollo Global Management, Inc. ("Apollo") relating to the tragic events that occurred at the Ottumwa Regional Health Center ("ORHC"). We were appalled and dismayed to learn of the reprehensible and criminal acts that a lone actor committed against the Ottumwa and ORHC communities. We are fully supportive of the work that the Lifepoint Health, Inc. ("Lifepoint") leadership team has already undertaken in earnest to immediately investigate the situation, to cooperate with law enforcement and state and federal regulators, and to learn from this tragic experience.

As described in more detail below, certain investment funds managed by affiliates of Apollo (the "Apollo Funds") first invested in parent entities of ORHC in 2015, and ORHC joined the Lifepoint system when the Apollo Funds acquired Lifepoint in 2018. Apollo recognizes the critical role that rural hospitals play in their communities and supports that mission.

As we explain in more detail below, Lifepoint's March 31 response will be the best primary source of information regarding ORHC's operations and provide the most informed responses to your questions because Apollo is not involved in the day-to-day management of either Lifepoint or its hospitals. Nonetheless, we want to address and to respond directly to the questions raised in your letter to which Apollo is the more appropriate party to respond.

We appreciate your consistent leadership and fierce advocacy for rural hospitals and their patients. We also appreciate the communications we have had with your staff on this matter over the past two weeks. We provide our responses to your questions below.

* * *

Responses

1. **Describe your company's financial or operational relationship with Ottumwa Regional Health Center and provide the exact dollar amount your company has invested in Ottumwa Regional. Please answer in timeline form and include any agreements or contracts between your company and Ottumwa Regional.**

The Apollo Funds have been invested in parent entities of ORHC since 2015. The Apollo Funds' initial investment occurred in December 2015 through the acquisition of RegionalCare, an eight-hospital system, from funds affiliated with Warburg Pincus.[1]

Following the acquisition of RegionalCare, the Apollo Funds continued to seek to support rural healthcare through further investments the following year with the acquisition of Capella.[2] In 2018, the Apollo Funds invested additional capital to facilitate the combination of RegionalCare, Capella, and Lifepoint; with that combination, ORHC became part of the Lifepoint health system.[3]

Since 2016, RegionalCare and its successor entities (including Lifepoint) have invested approximately $23 million in ORHC, with more than $3.5 million invested in capital projects in 2022 alone. Moreover, RegionalCare and its successor entities have invested an additional approximately $29 million in attracting and retaining physicians.

2. **If your company no longer has a financial or operational relationship with Ottumwa Regional, explain the reasons for which your company withdrew its investment, including the date you exited and your return on investment.**

Not applicable.

3. **While invested in Ottumwa Regional Center or any related entity that has an interest in Ottumwa Regional, please describe your company's authority to:**

    a. **Manage its care delivery;**

---

[1] *See, e.g.*, *RegionalCare Hospital Partners to Be Acquired by Funds Affiliated with Apollo Global Management*, BUS. WIRE (Nov. 12, 2015), https://www.businesswire.com/news/home/20151112005441/en/RegionalCare-Hospital-Partners-to-Be-Acquired-by-Funds-Affiliated-with-Apollo-Global-Management.

[2] *See, e.g.*, *Medical Properties Trust Agrees to Merge Capella Health Holdings with RegionalCare, an Affiliate of Certain Funds Managed by Affiliates of Apollo Global Management, LLC*, BUS. WIRE (Mar. 22, 2016), https://www.businesswire.com/news/home/20160322005906/en/Medical-Properties-Trust-Agrees-to-Merge-Capella-Health-Holdings-with-RegionalCare-an-Affiliate-of-Certain-Funds-Managed-by-Affiliates-of-Apollo-Global-Management-LLC.

[3] *See, e.g.*, Press Release, Apollo, LifePoint Health to Merge with RCCH HealthCare Partners (Jul. 23, 2018), https://www.apollo.com/media/press-releases/2018/07-23-2018-115937195.

b. Manage its billing practices;
c. Determine its annual net income goals;
d. Determine its charge per patient goals;
e. Determine its staff-to-patient ratios;
f. Determine its charge-to-cost ratios;
g. Enter into contracts for staffing; and
h. Enter into any contracts on behalf of Ottumwa Regional.

A key tenet of the Apollo Funds' investment approach is empowering management teams and portfolio companies. Lifepoint's management team is fully responsible for administering Lifepoint's business and making key decisions for Lifepoint's communities. The Apollo Funds support Lifepoint's mission through its representation on Lifepoint's Board of Directors. Lifepoint's hospitals, including ORHC, each have a local management team responsible for general clinical operations, human resources and administration, and other day to day matters. The local management team is supported by a local Board of Directors (comprising industry experts such as local community members, physicians, and a member of the hospital management team) and the Lifepoint management team.

Given this structure, Apollo does not have the management or decision-making authority with respect to the matters set forth above. Lifepoint is the best source of information regarding ORHC's operations; please see Lifepoint's March 31 response to your letter for additional information.

4. Does your company have plans to invest capital in Ottumwa Regional? If so, please describe them. If not, why not?

Apollo remains fully supportive of Lifepoint's plans to continue to invest substantial capital in ORHC and the Ottumwa community. Please see Lifepoint's March 31 response to your letter for additional information.

5. How was your company involved in the 2019 sale-leaseback?

Lifepoint, and not Apollo, made the decision to undertake the 2019 sale-leaseback. The Lifepoint Board, which includes Apollo employees, approved Lifepoint management's decision to conduct this transaction. Please see Lifepoint's March 31 response to your letter for additional information.

6. Explain in detail the reasons for the 2019 sale-leaseback of Ottumwa Regional. What were the terms of the 2019 sale-leaseback transaction? How did you sell this to the local communities and hospitals? Please provide all records.

As noted above, the Lifepoint Board approved Lifepoint management's decision to conduct this transaction. ORHC's sale-leaseback was part of this transaction. Please see Lifepoint's March 31 response to your letter for additional information.

7. To what extent does your company contractually shield itself from liability for activities that occur at the hospitals you invest in, operate, or manage?

As noted above, the Apollo Funds are investors in Lifepoint and do not operate or manage any of its hospitals. As investors, the Apollo Funds are not liable for activities that occur at Lifepoint hospitals in the same way that investors in other American companies are not liable for the activities of the companies in which they invest beyond their investments themselves. The Apollo Funds do not have any separate contractual "shield" for liability than any other investor in an American company.

8. What happens if one of the medical facilities that are subject to a sale-leaseback is unable to pay rent?

Please see Lifepoint's March 31 response to your letter for additional information.

9. Describe in detail your company's expertise regarding rural or non-urban hospitals. Please include the full name and curriculum vitae of every person your company relies on for rural or non-urban hospital advice.

As noted above, a key tenet of the Apollo Funds' investment approach is empowering management teams and portfolio companies. We have invested the Apollo Funds' capital behind what we believe to be a best-in-class management team, who are seasoned healthcare administration experts of the highest quality. Lifepoint's hospitals, including ORHC, each have a local management team responsible for general clinical operations, human resources and administration, and other day to day matters. The local management team is supported by a local Board of Directors (comprised of local community members, physicians, and a member of the hospital management team) and the Lifepoint management team. Please see Lifepoint's March 31 response to your letter for additional information.

10. How much money did your company receive in COVID-19 stimulus aid, including CARES Act dollars and grants? Provide an explanation as to why your company needed federal stimulus aid. Describe in detail how these funds were allocated.

Neither Apollo nor the Apollo Funds received COVID-19 stimulus aid. Please see Lifepoint's March 31 response to your letter for information regarding any COVID-19 aid it or its hospitals received.

11. Explain your company's role in the decision to hire William Kiefer as CEO of Ottumwa Regional.

Lifepoint management and the ORHC Board made the decision to hire Mr. Kiefer. Neither Apollo nor the Apollo Funds were involved in that decision. Please see Lifepoint's March 31 response to your letter for information regarding Mr. Kiefer.

12. Explain your company's relationship with William Kiefer, including any prior positions he held with your company or a related company.

Neither Apollo nor the Apollo Funds have any relationship with Mr. Kiefer beyond each's relationship to Lifepoint.

* * *

While we remain deeply saddened by the events that have transpired at Ottumwa as a result of a lone actor, we are incredibly proud to be able to support Lifepoint and its management team in everything they have accomplished in serving some of the most underserved communities across the United States. We commend you for your oversight and your advocacy for rural hospitals in Iowa and across the country. We will continue to support and invest in the Ottumwa community through our commitment to Lifepoint.

I trust this information answers your questions. Apollo is voluntarily providing this information and we respectfully request that the information be treated as confidential, and not be disclosed publicly or to any third party. To the extent you intend to disclose this information, Apollo requests that your staff notify Apollo in advance to allow us to discuss the matter and to take appropriate steps to safeguard Apollo's business confidential information. If you have any additional questions, please feel free to contact me at [redacted]

Sincerely yours,

[redacted]

[redacted]
of LATHAM & WATKINS LLP

cc: [redacted], Latham & Watkins
[redacted], Latham & Watkins

[redacted]

LATHAM & WATKINS LLP

555 Eleventh Street, N.W., Suite 1000
Washington, D.C. 20004-1304
Tel: +1.202.637.2200 Fax: +1.202.637.2201
www.lw.com

May 11, 2023

CONFIDENTIAL
VIA ELECTRONIC TRANSMISSION

The Honorable Charles E. Grassley
United States Senate
Washington, DC 20510

Re: Letter of March 17, 2023

Dear Senator Grassley:

We write on behalf of Apollo Global Management, Inc. ("Apollo") in further response to your letter of March 17 and our e-mail correspondence with your Budget Committee staff of May 5, 2023. This letter supplements our April 5, 2023 response (the "April 5 Letter"), consistent with our subsequent discussions. We appreciate your and your staff's continued engagement and cooperation on this important matter, and the opportunity for us to provide additional information we trust will be helpful. We provide our further responses to your questions below.

* * *

Responses

3. While invested in Ottumwa Regional Center or any related entity that has an interest in Ottumwa Regional, please describe your company's authority to:

a. Manage its care delivery;
b. Manage its billing practices;
c. Determine its annual net income goals;
d. Determine its charge per patient goals;
e. Determine its staff-to-patient ratios;
f. Determine its charge-to-cost ratios;
g. Enter into contracts for staffing; and
h. Enter into any contracts on behalf of Ottumwa Regional.

As noted in our April 5 Letter, Apollo does not have management or decision-making authority with respect to the matters set forth above. Lifepoint's management team is fully responsible for administering Lifepoint's business and making key decisions for Lifepoint's

communities. Certain investment funds managed by affiliates of Apollo (the "Apollo Funds") support Lifepoint's mission through representation on Lifepoint's Board of Directors.

Moreover, as noted in Lifepoint's March 31, 2023 response, the operations of Ottumwa Regional are carried out by RCHP-Ottumwa, LLC, a Delaware limited liability company. RCHP-Ottumwa, LLC is an indirect, wholly owned subsidiary of Lifepoint. Ottumwa Regional is operated through a shared governance model, in which the local management team is responsible for day-to-day general and clinical operations, human resources, and administration of Ottumwa Regional, with oversight by the hospital's Board of Trustees and RCHP-Ottumwa, LLC.

In our e-mail correspondence with your Budget Committee staff on May 5, your staff asked for "detailed information about the Apollo employees who serve on Lifepoint's Board, including the name, title, role on Lifepoint's Board (what committee they serve on)" and "current and past Apollo representation on Lifepoint's Board." Please see below. Please note that, as discussed in our April 5 Letter, the Apollo Funds acquired RegionalCare in 2015 and facilitated the combination of RegionalCare, Capella, and Lifepoint in 2018. The below includes Apollo employees' Board service beginning with the RegionalCare Board.

Director Name	Title	Board Tenure	Committee Assignments
Christine Cahill	Principal	3/23/2022 to present	None
Maxwell David	Principal	12/13/2018 to present	Executive Quality
Chris Edson	Partner and Co-Head of Global FIG	12/3/2015 to 12/4/2018	Executive
Holly McMullan	Partner and Global Head of Consultant Relations	12/13/2018 to present	Quality
Matthew Nord	Partner and Co-Head of Private Equity	12/13/2015 to present	Executive (9/22/2016) Compensation (9/22/2016)
Eric L. Press	Partner	12/3/2015 to present	Executive (12/13/2018) Compensation (9/22/2016) Nominating & Governance (9/22/2016)
Olivia Wassenaar	Partner and Head of Sustainable Investing and Natural Resources	12/13/2018 to 3/22/2022	None

5. How was your company involved in the 2019 sale-leaseback?

As explained in our April 5 Letter, the Lifepoint Board, which includes Apollo employees, approved Lifepoint management's decision to conduct this transaction. We understand that the sale-leaseback was approved by the Lifepoint Board on October 30, 2019.

This sale-leaseback transaction, as explained in Lifepoint's March 31 letter, was part of a broader capital structure initiative to lower Lifepoint's interest and rental expense to optimize and enhance Lifepoint's capacity to invest in community healthcare by, among other things, improving the physical facility, acquiring medical devices, and recruiting talented caregivers.

6. Explain in detail the reasons for the 2019 sale-leaseback of Ottumwa Regional. What were the terms of the 2019 sale-leaseback transaction? How did you sell this to the local communities and hospitals? Please provide all records.

Companies frequently use asset-level (mortgage, sale leaseback financing, working capital financing) and corporate (syndicated or private term loans and bonds) financings to fund operations and / or investments. Corporate financings, such as those done in connection with a bank credit facility, frequently include asset pledges and mortgages of individual pieces of real estate as part of the collateral package under the loan. All of these structures represent some of the many ways companies use the value of their real estate assets to finance their business operations. Thus, sale-leaseback transactions are one of a variety of ways for companies with real estate assets to obtain financing. They are commonly used across a broad range of industries, including healthcare, manufacturing and industrial, and leisure and hospitality, among others, and in connection with a variety of asset types. There were over $31 billion in sale-leaseback transactions completed in 2022 alone.

A sale-leaseback transaction allows an owner of real estate to raise cash through the sale of real estate to a third party, while simultaneously leasing the real estate back. This allows the seller to receive a lump sum of cash for the real estate sale, while still being able to use the property moving forward in exchange for a long-term lease. Sale-leaseback transactions result in an improved balance sheet by converting an illiquid asset into working capital that can be invested into the seller's core operations. At Lifepoint, the sale-leaseback transaction generated gross proceeds of approximately $700 million. Importantly, all of these proceeds went to pay down Lifepoint debt or invest in Lifepoint communities, and none of these proceeds went to Apollo. The transaction did not add to the total debt of Lifepoint, but rather resulted in lower fixed charges (interest expense) after Lifepoint used some of the proceeds to repay portions of Lifepoint's indebtedness. The sale-leaseback, along with other capital structure activity that was facilitated by the sale-leaseback, resulted in estimated annual net savings to Lifepoint of approximately $46 million. Additionally, through these activities, Lifepoint added approximately $350 million of cash to its balance sheet—ultimately enabling Lifepoint to invest more in its hospitals, including Ottumwa Regional.

While there may be instances of financing transactions, including sale-leaseback transactions, that can burden the borrower with greater interest expense and result in a depletion of company resources, this is and was not the case for Lifepoint. The rent expense associated with the sale-leaseback transaction represents a very small portion of Lifepoint's EBITDA—less than five percent. And since completing the sale leaseback transaction in 2019, Lifepoint has invested more than $17 million in the Ottumwa community and added more than 135 caregivers.

It is our understanding that Lifepoint will be providing the underlying sale-leaseback agreement in this transaction to your offices. Given the sensitive and business confidential terms in such agreement, including competitively sensitive information, we respectfully request that you grant Lifepoint's request to keep this document confidential and not release it publicly or to any third party.

* * *

LATHAM & WATKINS LLP

Again, we appreciate your consistent leadership and fierce advocacy for rural hospitals and their patients. We also appreciate the communications we have had with your staff on this matter over the past several weeks. Apollo respectfully requests that the information be treated as confidential, and not be disclosed publicly or to any third party. To the extent you intend to disclose this information, Apollo requests that your staff notify Apollo in advance to allow us to discuss the matter and to take appropriate steps to safeguard Apollo's business confidential information. If you have any additional questions, please feel free to contact me at [redacted]

Sincerely yours,

[redacted]

[redacted]
of LATHAM & WATKINS LLP

cc: [redacted], Latham & Watkins
[redacted], Latham & Watkins

[redacted]

LATHAM & WATKINS LLP

555 Eleventh Street, N.W., Suite 1000
Washington, D.C. 20004-1304
Tel: +1.202.637.2200 Fax: +1.202.637.2201
www.lw.com

January 19, 2024

HIGHLY CONFIDENTIAL
VIA ELECTRONIC TRANSMISSION

The Honorable Sheldon Whitehouse
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on the Budget
United States Senate
Washington, D.C. 20510-6100

Re: December 6, 2023 Letter to Apollo Global Management, Inc.

Dear Chairman Whitehouse and Ranking Member Grassley,

On behalf of our client, Apollo Global Management, Inc. ("Apollo" or the "Company"), we write to continue our responses to your December 6, 2023 letter regarding the tragic events at the Ottumwa Regional Health Center ("ORHC") and your inquiry into the role of private equity in healthcare. Apollo continues to share your interest in ensuring rural communities have access to high-quality care—a goal that Apollo has pursued through its investment in Lifepoint Health ("Lifepoint") by certain investment funds managed by affiliates of Apollo (the "Apollo Funds"). As discussed on our December 14, 2023 call with the Committee's staff, Apollo looks forward to cooperating with the Committee's inquiry and appreciates your leadership and advocacy for rural hospitals and their patients.

This letter supplements our initial responses and production on December 21, 2023. Apollo is continuing to gather the requested information responsive to the Committee's requests, and we anticipate providing additional information and documents on a rolling basis.

* * *

Responses

1. **Describe the historical (both current and former) financial and operational relationship between Apollo and Lifepoint, including the exact dollar amount of its own capital that Apollo has invested in Lifepoint and in Ottumwa Regional, whether made directly in the**

hospital or indirectly through Lifepoint. Produce all documents demonstrating this relationship—including, but not limited to, contracts or written agreements, memoranda of understanding, proofs of investment, investment thesis documents describing or setting out evidence-based rationales for Apollo's investment in Lifepoint, any memoranda setting out the reason for Apollo's acquisition of or investment in Lifepoint, and operational or administrative procedure manuals.

The Apollo Funds' original investment thesis in Lifepoint and its predecessor companies centered on investing in healthcare companies that provide care for underserved communities. Rural hospitals across the United States have faced challenges for decades, in part driven by underinvestment. The Apollo Funds sought to do the opposite by investing in and supporting companies, such as Lifepoint, that invest in these underserved communities to recruit physicians, expand service line offerings, and upgrade equipment in order to care for these communities. Apollo Fund IX invested ~$2.0 billion of equity in 2021 to support Lifepoint, alongside ~$1.5 billion from affiliated co-investors and management. Enclosed please find a copy of the June 2, 2021 Capital Demand Notice for Apollo Fund IX, the Fund IX investment amount as well as the thesis for the investment in Lifepoint. *See* AP-SBC-000832. On an ongoing basis, the Apollo Funds' involvement with Lifepoint is through the Apollo employees that serve on the Board (please see further details below) who, in their roles as directors, support Lifepoint in this mission.

2. **While invested in Ottumwa Regional or any related entity that has or had an interest in Ottumwa Regional, please describe and produce all documents that support your answer with respect to Apollo's role, including that of Apollo employees, in determining or otherwise affecting the ability or authority of Ottumwa Regional or Lifepoint to:**

    a. Manage its care delivery;

    b. Manage its billing practices;

    c. Determine its charge-per-patient goals;

    d. Determine its staff-to-patient ratios;

    e. Determine its charge-to-cost ratios;

    f. Enter into contracts for staffing;

    g. Enter into any contracts on behalf of Ottumwa Regional; and

    h. Determine its net annual income goals.

Apollo does not have management or decision-making authority with respect to the matters set forth above. In general, Apollo's approach to investing is to back and support strong management teams at portfolio companies that manage day-to-day operations and decision-making. The Apollo Funds support Lifepoint's mission through representation on the Board of Directors as well as Board committees. Enclosed please find copies of:

- RegionalCare corporate resolution and Lifepoint Board resolutions, each reflecting the appointment of the Apollo representatives on Lifepoint's Board of Directors, at AP-SBC-000837 through AP-SBC-000869; and

- Lifepoint Board Committee Charters, at AP-SBC-000870 through AP-SBC-000895.

The Board of Directors delegates day-to-day decision-making authority to management and reserves certain major matters for Board approval. The profile of matters that require Board approval are enterprise-wide strategic decisions, including the enterprise-wide process (which sets quality and financial goals for the full company), acquisitions and divestitures, settling material litigation, and the hiring of and compensation for the senior management team.

5. Describe in detail Apollo's role in facilitating, approving, or in any way affecting the 2019 sale-leaseback transaction. Produce all documents that support your answer.

The Lifepoint Board, which includes Apollo employees, approved Lifepoint management's decision to conduct this transaction. Apollo's role in the 2014 transaction was through its employees who served as part of the board. The sale-leaseback was approved by the Lifepoint Board on October 30, 2019. Please see attached a copy of the minutes for the October 30, 2019 meeting, at AP-SBC-000896, which includes the unanimous approval of the resolution for the sale-leaseback transaction. The Lifepoint Board also received materials related to the sale-leaseback transaction, and the presentation provided information on the financial impact of the sale leaseback and other details about the transaction. *See* AP-SBC-000905. This sale-leaseback transaction was part of a broader capital structure initiative to lower Lifepoint's interest and rental expense to optimize and enhance Lifepoint's capacity to invest in community healthcare by, among other things, improving the physical facility, acquiring medical devices, and recruiting talented caregivers.

6. Explain in detail Apollo's justification for the 2019 sale-leaseback of Ottumwa Regional. Produce all documents that support your answer, including, but not limited to, all correspondence between and among Apollo, Medical Properties Trust, Lifepoint, and Lifepoint's Board.

As noted above, the Lifepoint Board approved Lifepoint management's decision to conduct this transaction. ORHC's sale-leaseback was part of this transaction.

A sale-leaseback transaction allows an owner of real estate to raise cash through the sale of real estate to a third party, while simultaneously leasing the real estate back. This allows the seller to receive a lump sum of cash for the real estate sale, while still being able to use the property moving forward in exchange for a long-term lease. Sale-leaseback transactions result in an improved balance sheet by converting an illiquid asset into working capital that can be invested into the seller's core operations. At Lifepoint, the sale-leaseback transaction generated gross proceeds of approximately $700 million. Importantly, all of these proceeds went to pay down Lifepoint debt or invest in Lifepoint communities, and none of these proceeds were distributed to Apollo. The transaction did not add to the total debt of Lifepoint, but rather resulted in lower fixed

charges (interest expense) after Lifepoint used some of the proceeds to repay portions of Lifepoint's indebtedness. As described above, the sale-leaseback, along with other capital structure activity that was facilitated by the sale-leaseback, resulted in estimated annual net savings to Lifepoint of approximately $46 million. Additionally, through these activities, Lifepoint added approximately $350 million of cash to its balance sheet—ultimately enabling Lifepoint to invest more in its hospitals, including ORHC.

7. **Explain in detail how Apollo used the 2019 sale-leaseback transaction to facilitate changes to its balance sheet, including paying down debt and issuing dividends. Produce all documents that support your answer, including, but not limited to, all correspondence between and among Apollo, Medical Properties Trust, Lifepoint, and Lifepoint's Board.**

While the 2019 sale-leaseback transaction resulted in estimated annual net savings to Lifepoint of approximately $46 million and other balance sheet improvements as described above, it had no direct effect on Apollo's balance sheet and no money was distributed to Apollo.

* * *

Apollo remains proud to support Lifepoint and its management team in their mission to serve some of the most underserved communities in our country, and will continue to support and invest in the Ottumwa community through its commitment to Lifepoint.

Apollo is voluntarily providing this information and we respectfully request that it be treated as confidential and not disclosed publicly or to any third party. To the extent you intend to disclose this information, Apollo requests that your staff notify Apollo in advance to allow us to discuss the matter and to take appropriate steps to safeguard Apollo's confidential business information.

Sincerely,

[redacted]

[redacted]
of LATHAM & WATKINS LLP

cc: [redacted], Latham & Watkins LLP
[redacted], Latham & Watkins LLP

[redacted]

LATHAM & WATKINS LLP

555 Eleventh Street, N.W., Suite 1000
Washington, D.C. 20004-1304
Tel: +1.202.637.2200 Fax: +1.202.637.2201
www.lw.com

FIRM / AFFILIATE OFFICES

Austin	Milan
Beijing	Munich
Boston	New York
Brussels	Orange County
Century City	Paris
Chicago	Riyadh
Dubai	San Diego
Düsseldorf	San Francisco
Frankfurt	Seoul
Hamburg	Silicon Valley
Hong Kong	Singapore
Houston	Tel Aviv
London	Tokyo
Los Angeles	Washington, D.C.
Madrid	

March 18, 2024

HIGHLY CONFIDENTIAL
VIA ELECTRONIC TRANSMISSION

The Honorable Sheldon Whitehouse
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on the Budget
United States Senate
Washington, D.C. 20510-6100

Re: December 6, 2023 Letter to Apollo Global Management, Inc.

Dear Chairman Whitehouse and Ranking Member Grassley,

On behalf of our client, Apollo Global Management, Inc. ("Apollo" or the "Company"), we write to continue our responses to your December 6, 2023 letter regarding the tragic events at the Ottumwa Regional Health Center ("ORHC") and your inquiry into the role of private equity in healthcare. Apollo continues to share your interest in ensuring that rural communities have access to high-quality care—a goal that Apollo has pursued through the investment in Lifepoint Health ("Lifepoint") by certain investment funds managed by affiliates of Apollo (the "Apollo Funds" or "Funds"). Apollo looks forward to cooperating with the Committee's inquiry and appreciates your leadership and advocacy for rural hospitals and their patients.

This letter supplements our prior responses and document productions on December 20, 2023 and January 19, 2024. Apollo welcomes the opportunity to continue to engage with the Committee regarding Apollo's continued commitment to supporting Lifepoint in its mission to provide access to high-quality healthcare in rural communities.

* * *

Responses

3. Does Apollo have current or future plans to invest capital in Lifepoint Health or Ottumwa Regional? If so, please describe them. If not, why not? Produce all documents that support your answer, including any information concerning Apollo's investment decisions in those entities.

As investors in Lifepoint, the Apollo Funds support Lifepoint's investments in all of its hospitals, including ORHC. To provide a brief overview of our relevant investments to date, the Apollo Funds first invested in parent entities of ORHC in 2015. The Apollo Funds' initial equity investment occurred in December 2015 through an investment in RCCH Healthcare Partners ("RegionalCare"). Following the investment in RegionalCare, the Apollo Funds continued to invest in rural healthcare through further investments the following year via additional equity capital to support RegionalCare's combination with Capella Healthcare ("Capella"). In 2018, the Apollo Funds invested additional equity capital to facilitate the combination of RegionalCare, Capella, and Lifepoint; with that combination, ORHC became part of the Lifepoint health system.

Apollo has demonstrated its commitment to supporting Lifepoint in its investment in rural healthcare through the Apollo Funds' repeated investments in RegionalCare, Capella, and Lifepoint, and through Fund IX's subsequent investment in Lifepoint in 2021. While Apollo does not have any current or future plans to invest additional fund capital in Lifepoint, Apollo remains open to the possibility and is supportive of Lifepoint's investments in the hospitals it operates, including ORHC.

Since 2016, RegionalCare and its successor entities (including Lifepoint) have invested approximately $23 million in ORHC, with more than $3.5 million invested in capital projects in 2022 alone and nearly $5 million invested in 2023. Moreover, RegionalCare and its successor entities have invested an additional approximately $29 million in attracting and retaining physicians.

8. Explain in detail any financial benefits that Apollo received as a result of the 2019 sale-leaseback transaction. Produce all documents that support your answer.

Apollo did not receive any direct financial benefits as a result of the 2019 sale-leaseback transaction, and no funds were transferred from Lifepoint to Apollo or any Apollo Fund in connection with that transaction. The sale leaseback reduced Lifepoint's interest and rental expenses, which further enhanced Lifepoint's ability to invest in its communities.

9. Provide, broken down by fiscal year, the exact dollar amount of profits that Apollo has collected as a result of its ownership interest in Lifepoint. Produce all documents that support your answer.

Lifepoint is owned by the Apollo Funds. The Apollo Funds are, in turn, primarily owned by fund investors (also known as limited partners, or "LPs"), including public

pension funds. As a general matter, Apollo Funds do not receive "profits" from the operation of portfolio companies such as Lifepoint unless and until there is a realization event, such as a sale of the company. In the case of Lifepoint, the only profit that the Apollo Funds have collected to date was the result of the sale of Lifepoint from Apollo Fund VIII to Fund IX in 2021. These profits primarily went to Apollo's fund investors—including pension funds on behalf of which Apollo invests.

10. Provide, broken down by fiscal year, the exact dollar amount of any investments that Apollo has made in RCCH Healthcare Partners and any profits that Apollo has collected as a result of its ownership interest in RCCH Healthcare Partners. Produce all documents that support your answer.

As investors in Lifepoint, the Apollo Funds support Lifepoint's investments in all of its hospitals. To provide a brief overview of our relevant investments to date, the Apollo Funds first invested in parent entities of ORHC in 2015. The Apollo Funds' initial equity investment occurred in December 2015 through an investment in RegionalCare. Following the investment in RegionalCare, the Apollo Funds continued to invest in rural healthcare through further investments the following year via additional equity capital to support RegionalCare's combination with Capella. In 2018, the Apollo Funds invested additional equity capital to facilitate the combination of RegionalCare, Capella, and Lifepoint; with that combination, ORHC became part of the Lifepoint health system.

Apollo has demonstrated its commitment to supporting Lifepoint in its investment in rural healthcare through the Apollo Funds' repeated investments in RegionalCare, Capella, and Lifepoint, and through Fund IX's subsequent investment in Lifepoint in 2021. While Apollo does not have any current or future plans to invest additional fund capital in Lifepoint, Apollo remains open to the possibility and is supportive of Lifepoint's investments in the hospitals it operates.

Since 2016, RegionalCare and its successor entities (including Lifepoint) have invested approximately $23 million in ORHC, with more than $3.5 million invested in capital projects in 2022 alone and nearly $5 million invested in 2023. Moreover, RegionalCare and its successor entities have invested an additional approximately $29 million into attracting and retaining physicians.

11. Provide, broken down by fiscal year, the exact dollar amount of any investments that Apollo has made in Capella Healthcare and any profits that Apollo has collected as a result of its ownership interest in Capella Healthcare. Produce all documents that support your answer.

As investors in Lifepoint, the Apollo Funds support Lifepoint's investments in all of its hospitals. To provide a brief overview of our relevant investments to date, the Apollo Funds first invested in parent entities of ORHC in 2015. The Apollo Funds' initial equity investment occurred in December 2015 through an investment in RegionalCare. Following the investment in RegionalCare, the Apollo Funds continued to invest in rural healthcare through further investments the following year via additional equity capital to support

RegionalCare's combination with Capella. In 2018, the Apollo Funds invested additional equity capital to facilitate the combination of RegionalCare, Capella, and Lifepoint; with that combination, ORHC became part of the Lifepoint health system.

Apollo has demonstrated its commitment to supporting Lifepoint in its investment in rural healthcare through the Apollo Funds' repeated investments in RegionalCare, Capella, and Lifepoint, and through Fund IX's subsequent investment in Lifepoint in 2021. While Apollo does not have any current or future plans to invest additional fund capital in Lifepoint, Apollo remains open to the possibility and is supportive of Lifepoint's investments in the hospitals it operates.

Since 2016, RegionalCare and its successor entities (including Lifepoint) have invested approximately $23 million in ORHC, with more than $3.5 million invested in capital projects in 2022 alone and nearly $5 million invested in 2023. Moreover, RegionalCare and its successor entities have invested an additional approximately $29 million into attracting and retaining physicians.

12. Provide, broken down by fiscal year, the exact dollar amount of any dividends that Apollo paid out to shareholders as a result of its ownership interest in Lifepoint. Produce all documents that support your answer.

It would be difficult to draw even an indirect line between (a) the Apollo Funds' ownership interests in Lifepoint and (b) dividends paid on Apollo's common stock. Investors in Apollo's common stock do not have any ownership interest in Lifepoint. Apollo is a public company owned by its shareholders, whereas Lifepoint is a private company owned by Apollo Funds (which are in turn owned by fund investors – not Apollo shareholders). As a general matter, Apollo's shareholders benefit when Apollo Fund investments are successful. But tracing a line from a single portfolio company investment in a single Apollo Fund to the overall amount of dividends paid on Apollo's common stock on a quarterly basis is virtually impossible and is not a figure that can be precisely determined by fiscal year.

13. Provide, broken down by fiscal year, the exact dollar amount of any dividends that Apollo paid out to shareholders as a result of its ownership interest in Capella. Produce all documents that support your answer.

It would be difficult to draw even an indirect line between (a) the Apollo Funds' ownership interests in Lifepoint and (b) dividends paid on Apollo's common stock. Investors in Apollo's common stock do not have any ownership interest in Lifepoint. Apollo is a public company owned by its shareholders, whereas Lifepoint is a private company owned by Apollo Funds (which are in turn owned by fund investors – not Apollo shareholders). As a general matter, Apollo's shareholders benefit when Apollo Fund investments are successful. But tracing a line from a single portfolio company investment (i.e., Capella) in a single Apollo Fund to the overall amount of dividends paid on Apollo's common stock on a quarterly basis is virtually impossible and is not a figure that can be precisely determined by fiscal year.

14. Provide, broken down by fiscal year, the exact dollar amount of any dividends that Apollo paid out to shareholders as a result of its ownership interest in RCCH Healthcare Partners. Produce all documents that support your answer.

It would be difficult to draw even an indirect line between (a) the Apollo Funds' ownership interests in Lifepoint and (b) dividends paid on Apollo's common stock. Investors in Apollo's common stock do not have any ownership interest in Lifepoint. Apollo is a public company owned by its shareholders, whereas Lifepoint is a private company owned by Apollo Funds (which are in turn owned by fund investors – not Apollo shareholders). As a general matter, Apollo's shareholders benefit when Apollo Fund investments are successful. But tracing a line from a single portfolio company investment (i.e., RegionalCare) in a single Apollo Fund to the overall amount of dividends paid on Apollo's common stock on a quarterly basis is virtually impossible and is not a figure that can be precisely determined by fiscal year.

15. In 2021, Apollo sold Lifepoint back to itself, from Apollo Fund VIII to Fund IX, for a $1.6 billion gain. Explain in detail the reasons for this transaction, including but not limited to, any financial gains related to distributions or management fees and any financial or operational impacts on Ottumwa. Produce all documents that support your answer.

a. Explain in detail how Lifepoint and the hospitals owned or operated by Lifepoint benefited from this transaction. Produce all documents that support your answer.

It is not accurate to say that "Apollo sold Lifepoint back to itself." Lifepoint is owned by Apollo Funds, which are in turn owned by fund investors, including pension funds. Most Apollo Funds have a finite investment horizon – i.e., they cannot hold their investments forever. Apollo Fund VIII, a 2013 vintage fund, made the initial investment in Lifepoint. Typically, as a private equity fund such as Fund VIII approaches the end of its life, the investments in the fund are sold and the proceeds are distributed to the fund's

investors (i.e., its LPs). Rather than selling Lifepoint to a third party, Apollo Fund VIII instead elected to continue its commitment to the Lifepoint mission and sell that investment to Fund IX, which was a 2019 vintage fund with a longer investment horizon. This kind of "cross-fund" transaction is common among private equity funds.

The sale of Lifepoint from Apollo Fund VIII to Fund IX reflects Apollo's ongoing commitment to investments in community healthcare and underserved markets. The sale enabled the Apollo Funds to continue to support Lifepoint in this mission for a longer time horizon. The sale had no financial or operational impact on Lifepoint, but Lifepoint was aware and supportive of the sale as it ensured continued stability for Lifepoint and its hospitals.

Pursuant to the explanation provided above (see Responses 12-14), the vast majority of the $1.6 billion of profits associated with the 2021 Lifepoint sale from Fund VIII to Fund IX were distributed to the various LPs that invested in Fund VIII. Those LPs included, for example, state pension and retirement funds, whose beneficiaries include teachers, law enforcement personnel, state civil servants, and other government employees who benefitted from the appreciation of their investment in Lifepoint.

* * *

Apollo remains proud to support Lifepoint and its management team in their mission to serve some of the most underserved communities in our country, and will continue to support and invest in the Ottumwa community through its commitment to Lifepoint.

Apollo is voluntarily providing this information and we respectfully request that it be treated as confidential and not disclosed publicly or to any third party. To the extent you intend to disclose this information, Apollo requests that your staff notify Apollo in advance to allow us to discuss the matter and to take appropriate steps to safeguard Apollo's confidential business information.

Sincerely,

[redacted]

[redacted]
of LATHAM & WATKINS LLP

cc: [redacted], Latham & Watkins LLP
[redacted], Latham & Watkins LLP

[redacted]

LATHAM & WATKINS LLP

555 Eleventh Street, N.W., Suite 1000
Washington, D.C. 20004-1304
Tel: +1.202.637.2200 Fax: +1.202.637.2201
www.lw.com

September 6, 2024

HIGHLY CONFIDENTIAL
VIA ELECTRONIC TRANSMISSION

The Honorable Sheldon Whitehouse
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on the Budget
United States Senate
Washington, D.C. 20510-6100

Re: August 8, 2024 Email to Apollo Global Management, Inc.

Dear Chairman Whitehouse and Ranking Member Grassley,

On behalf of our client, Apollo Global Management, Inc. ("Apollo" or the "Company"), we write in response to the Committee Staff's supplemental requests outlined in the Committee Staff's August 8, 2024 email (the "August 8 Requests").

Consistent with our discussions with Committee Staff, including on August 28, 2024, this letter supplements our previous responses and productions from April 5, 2023, May 11, 2023, December 20, 2023, and January 19, 2024. Apollo is continuing to gather the requested information responsive to the Committee's requests, and we anticipate providing additional information and documents on a rolling basis.

* * *

Responses

1. **What measures of quality of care, patient safety, patient experience (such as HCAHPS), patient volume, staffing, hospital employee/provider turnover, and employee/provider satisfaction do Apollo representatives review in regards to Lifepoint and its facilities? Through what mechanisms do Apollo representatives review these measures, including but not limited to Apollo representatives to the Quality Committee of the Lifepoint Board of Directors? Do Apollo representatives review these measures at a system-level, hospital-level, or at another level of aggregation (e.g. division)? Have Apollo representatives ever voiced concerns and/or taken any actions in response to the performance of Lifepoint or any Lifepoint**

facility/division on these measures, specifically at Ottumwa Regional Health Center (ORHC)? If yes, please describe the concerns and/or actions. Please describe any steps Lifepoint took to address Apollo's concerns and their sufficiency. Please provide all ORHC scorecards reviewed by Apollo representatives and all other relevant documents, including meeting minutes and communication, that support your response to all above questions.

The Apollo Funds do not have management or decision-making authority with respect to the hospital-level operational and clinical matters set forth in the question above. In general, Apollo Funds' approach to investing is to back and support strong management teams at portfolio companies that manage day-to-day operations and decision-making. Consistent with this approach, Lifepoint's management team is fully responsible for administering Lifepoint's business. Lifepoint's hospitals, including Ottumwa Regional Hospital Center ("ORHC"), each have a local management team responsible for general clinical operations, human resources and administration, and other day to day matters.

Consistent with the general approach, the operations of ORHC are carried out by RCHP-Ottumwa, LLC, a Delaware limited liability company. RCHP Ottumwa, LLC is an indirect, wholly owned subsidiary of Lifepoint. ORHC is operated through a shared governance model, in which the local management team is responsible for day-to-day general and clinical operations, human resources, and administration of ORHC, with oversight by the hospital's Board of Trustees and Lifepoint.

The Apollo Funds support Lifepoint's mission through representation on the Board of Directors and certain Board Committees, including the Quality Committee.[1] As described in Apollo's December 20, 2023 correspondence, Maxwell David has served on the Quality Committee from December 13, 2018 to present; in addition, Holly McMullan served on the Quality Committee from December 13, 2018 to July 13, 2023. The Quality Committee assists the Lifepoint Board in its efforts to monitor and provide leadership with respect to the quality of care, patient safety and the appropriate environment for care at the Lifepoint system level; the members of the Quality Committee meet with Lifepoint management and review quality and patient experience data quarterly. In these meetings, members of the Quality Committee and Lifepoint management discuss areas of success as well as action plans to address the areas of opportunity, all with a goal of continuous improvement in the quality of care and patient experience that Lifepoint provides.

2. **Were any Apollo representatives aware of any issues related to quality of care; patient safety; drug diversion; and the behavior, competence, and sufficiency of staff at ORHC prior to the death of Mr. Devin Caraccio in October 2022? If yes, what actions did Apollo representatives take in response? Please provide all documents that support your response.**

[1] *See* Lifepoint Charter of the Quality Committee of the Board of Directors, previously produced at AP-SBC-000873.

As an investor in Lifepoint, the Apollo Funds recognize that operating rural hospitals, like ORHC, come with certain challenges. Consequently, Apollo representatives on the Lifepoint Board have supported Lifepoint management's emphasis on continuous improvements in quality of care, patient safety, drug diversion, and staffing at its hospitals, including at ORHC. Lifepoint has invested significantly in these areas since acquiring ORHC in November 2018.

3. **Please produce the March 7, 2023, power point document prepared by WilmerHale at the request of the Special Committee convened by Lifepoint's Board to assess the facts and circumstances, including any deficiencies and need for improvements, that may have contributed to the serial sexual assaults at ORHC. Please produce the minutes from this meeting as well. What actions did Apollo representatives recommend that Lifepoint/ORHC take? Have these actions occurred? Please provide all documents that support your response.**

The Lifepoint Board convened the Special Committee to assess the facts and circumstances referenced above. Apollo refers the Committee Staff to Lifepoint to request a copy of this presentation, as Apollo understands that the requested presentation is protected by Lifepoint's attorney-client privilege.

4. **Do Apollo representatives review the contracts that Lifepoint/its facilities enter with contractors or review the performance of contractors, including but not limited to ORHC's contract with TEAMHealth/Southeastern Emergency Physicians, LLC for emergency medicine providers and Apogee Medical Management for hospitalists? If yes, have Apollo representatives ever expressed concerns regarding the sufficiency of the services negotiated under these contracts or the performance of the contractors? If yes, what actions did Apollo representatives take in response? Please provide all documents supporting your response.**

No. As noted above, Lifepoint's hospitals, including ORHC, each have a local management team responsible for general clinical operations, human resources and administration, and other day-to-day matters. Lifepoint's management team is fully responsible for administering Lifepoint's business and making key decisions for Lifepoint's hospitals. Lifepoint's Board does not have management or decision-making authority with respect to the day-to-day operations of Lifepoint's hospitals, including staffing and clinical decisions at ORHC.

6. **What role do Apollo representatives play in decisions to cut or limit services at Lifepoint facilities? Specifically, what role did Apollo representatives play in regards to ORHC's discontinuation of its home healthcare services in 2018, discontinuation of its e-ICU program in 2022, significant reduction in ICU volume in 2023 (from 783 in 2022 to 107 in 2023), and limitation of its operating room call to cesarean sections only in 2023 due to financial and/or staffing limitations? Did Apollo consider providing Lifepoint/ORHC with financial support such that it could continue to provide these services? Please provide all documents that support your response.**

The Apollo Funds are investors in Lifepoint and do not operate or manage any of its hospitals, including ORHC. As a result, Apollo representatives did not play a role in the matters described above.

7. **What role do Apollo representatives play in reviewing the impact on access to health care in rural communities that results or could result from the discontinuation/ limitation of services or lack of nurses, providers, or other health care professionals at Lifepoint facilities? Please provide all documents that support your response.**

As noted above, the Apollo Funds are investors in Lifepoint and do not operate or manage any of its hospitals. The Apollo Funds' original investment thesis in Lifepoint and its predecessor companies centered on investing in healthcare companies that provide care for underserved communities. Rural hospitals across the United States have faced challenges for decades, in part driven by underinvestment. The Apollo Funds sought to do the opposite by investing in and supporting companies, such as Lifepoint, that invest in these underserved communities to recruit physicians, expand service line offerings, and upgrade equipment in order to care for these communities.

Apollo has demonstrated its commitment to supporting Lifepoint in its investment in rural healthcare through the Apollo Funds' repeated investments in RegionalCare, Capella, and Lifepoint, and through Fund IX's subsequent investment in Lifepoint in 2021. Since 2016, RegionalCare and its successor entities (including Lifepoint) have invested approximately $23 million in ORHC, with more than $3.5 million invested in capital projects in 2022 alone and nearly $5 million invested in 2023. Moreover, RegionalCare and its successor entities have invested an additional approximately $29 million in attracting and retaining physicians.

9. **Have Apollo representatives noted any concerns related to the transparency of Lifepoint senior management's communications to the Lifepoint board regarding the quality of care, safety, patient experience, staffing, billing practices, financial health, and compliance at the facilities that Lifepoint operates, including but not limited to ORHC?**

As noted previously, a key tenet of the Apollo Funds' investment approach is empowering management teams and portfolio companies. We have invested the Apollo Funds' capital behind what we believe to be a best-in-class management team. The Lifepoint Board of Directors delegates day-to-day decision-making authority to management and reserves certain major matters for Board approval, including enterprise-wide strategic decisions, acquisitions and divestitures, settling material litigation, and the hiring of and compensation for the senior management team. Apollo representatives have not noted any of the above concerns as members of the Lifepoint Board or otherwise.

10. **What goals and objectives does the Compensation Committee of the Lifepoint board use to evaluate the Lifepoint CEO's performance and thereby determine the CEO's compensation level? Since 2015, please describe how the Lifepoint CEO performed on these goals and objectives and thereby the CEO's associated compensation,**

including bonuses and any benefits excess of base salary. Please also provide all golden parachutes and retirement bonuses. Please provide all documents that support your response.

From 2015 to 2018, when Lifepoint was a public company, all detail on CEO compensation is available here in Lifepoint's public filings. Today, the Lifepoint CEO is evaluated based on a combination of financial and quality metrics, including the Company's performance. Please see our January 19 production for the Lifepoint Compensation Committee Charter. *See* AP-SBC-000876-AP-SBC-000879.

11. **In light of Lifepoint Health's net income of $283 million in 2020, did Apollo discuss returning any of the $646 million of government stimulus income that Lifepoint recognized in 2020 to the federal government? Please provide all documents that support your response.**

While Lifepoint management is responsible for administering Lifepoint's business, the Apollo Funds, through representation on the Board, were supportive of Lifepoint's decision to receive financial support during COVID. We understand Lifepoint instituted appropriate recordkeeping and procedural safeguards to ensure its uses and tracking of the government funds complied with all applicable rules.

12. **What internal reports/communications do Apollo representatives provide to Apollo senior leadership and investors regarding the performance of Lifepoint hospitals? Do these reports/communications contain any information regarding the quality and safety of Lifepoint facilities as well as any impact on access to health care in rural communities due to the discontinuation/limitation of services or lack of nurses, providers, or other health care professionals at Lifepoint facilities? Please provide all documents that support your response.**

The Apollo Funds do not have management or decision-making authority with respect to the operations and performance of specific Lifepoint hospitals or the other hospital-level matters set forth in this question, including with respect to ORHC. Each of Lifepoint's hospitals have a dedicated management team responsible for general clinical operations, human resources and administration, and other day to day matters at the hospital level. Lifepoint's management team is fully responsible for administering Lifepoint's business and making key decisions for Lifepoint's communities. The Apollo Funds support Lifepoint's mission through representation on Lifepoint's Board of Directors.

As a result, Apollo does not produce internal reports or communications for Apollo senior leadership that discuss the quality and safety of specific Lifepoint hospitals or the impact on access to health care in rural communities.

13. **Recent events have shown that other hospital operators have faced bankruptcy and other financial issues. In view of these developments, what discussions has Apollo had internally and with Lifepoint concerning Lifepoint's solvency? Would Apollo step in**

to provide financial support to Lifepoint if Lifepoint is unable to pay its rents, loans, debts, contractors/vendors, payroll, or any other bills?

Apollo does not have any concerns related to Lifepoint's solvency. Lifepoint is solvent and well-capitalized today and a significant focus of the Apollo Funds through representation on the Lifepoint Board and management is ensuring that Lifepoint is solvent and well-capitalized to continue to invest in its communities.

14. What is Apollo's exit strategy for Lifepoint Health, particularly ORHC?

The Apollo Funds have not yet identified an exit strategy for their investment Lifepoint. Indeed, Apollo Fund VIII sold Lifepoint to Apollo Fund IX in 2021 to provide the Apollo Funds with a longer time horizon to support Lifepoint's mission of investing in community healthcare and underserved markets. However, as a general matter, common exit strategies include initial public offerings and strategic sales.

The Apollo Funds are proud to support Lifepoint's mission of improving health outcomes for those in rural communities. Lifepoint has allocated over a billion dollars in capital to enhance its facilities, which encompasses constructing new buildings, refurbishing departments, developing new service lines, recruiting and hiring medical personnel, acquiring essential equipment, and bolstering technological frameworks. The Apollo Funds are eager to keep broadening the availability of healthcare in the communities served by Lifepoint, as well as to enhance the variety of service offerings in these areas.

* * *

Apollo is voluntarily providing this information, which contains customarily non-public, confidential and privileged business and commercial information. Apollo respectfully requests that this letter be maintained in confidence with the Committee and used solely for the purposes of this inquiry. Accordingly, we have designated this letter as "Confidential Treatment Requested." To the extent you intend to disclose this information, Apollo requests that your staff notify Apollo in advance to allow us to discuss the matter and to take appropriate steps to safeguard Apollo's confidential business information.

Please let us know if you have any questions, and we look forward to our continued engagement with the Committee regarding Apollo's commitment to supporting Lifepoint in its mission to provide access to high-quality healthcare.

[redacted]
of LATHAM & WATKINS LLP

[redacted]

LATHAM & WATKINS LLP

555 Eleventh Street, N.W., Suite 1000
Washington, D.C. 20004-1304
Tel: +1.202.637.2200 Fax: +1.202.637.2201
www.lw.com

September 27, 2024

HIGHLY CONFIDENTIAL
VIA ELECTRONIC TRANSMISSION

The Honorable Sheldon Whitehouse
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on the Budget
United States Senate
Washington, D.C. 20510-6100

Re: September 9, 2024 Email to Apollo Global Management, Inc.

Dear Chairman Whitehouse and Ranking Member Grassley,

On behalf of our client, Apollo Global Management, Inc. ("Apollo" or the "Company"), we write in response to the Committee Staff's supplemental requests outlined in the Committee Staff's September 9, 2024 email (the "September 9 Requests").

Consistent with our discussions with Committee Staff, including on August 28, 2024, this letter supplements our previous responses and productions from April 5, 2023, May 11, 2023, December 20, 2023, January 19, 2024, and September 6, 2024. Apollo is continuing to gather the requested information responsive to the Committee's requests, including those from the Committee Staff's August 8 email, and we anticipate providing additional information and documents on a rolling basis.

* * *

Responses

2. **We noted that the response for question #2 does not answer: "Were any Apollo representatives aware of any issues related to quality of care; patient safety; drug diversion; and the behavior, competence, and sufficiency of staff at ORHC prior to the death of Mr. Devin Caraccio in October 2022? If yes, what actions did Apollo representatives take in response? Please provide all documents that support your response."**

As an investor in Lifepoint, the Apollo Funds are aware that operating rural hospitals, like ORHC, present certain challenges, including the challenges referenced in the question. In general, Apollo Funds' approach to investing is to empower and support strong management teams at portfolio companies that manage day-to-day operations and decision-making. Consequently, Apollo representatives on the Lifepoint Board have supported Lifepoint management's emphasis on continuous improvements in quality of care, patient safety, drug diversion, and sufficiency of staffing at its hospitals, including at ORHC. In turn, Lifepoint has supported ORHC's leadership team in efforts concerning the continuous improvement of quality of care, patient safety, drug diversion, and sufficiency of staffing at ORHC.

6. **In your response to question #6, you noted that "Apollo representatives did not play a role in the matters" related to cutting or limiting services at Lifepoint facilities. Is Apollo notified or aware of when Lifepoint facilities cut or limit services, specifically ORHC's discontinuation of its home healthcare services in 2018, discontinuation of its e-ICU program in 2022, significant reduction in ICU volume in 2023 (from 783 in 2022 to 107 in 2023), and limitation of its operating room call to cesarean sections only in 2023 due to financial and/or staffing limitations? Please provide all documents that support your response.**

The Apollo Funds are investors in Lifepoint and do not operate or manage any of its hospitals, including ORHC. As a result, Apollo representatives did not play a role in the matters described above. As noted above, ORHC's local management team is responsible for general clinical operations, human resources and administration, and other day to day matters at ORHC and the Apollo representatives on Lifepoint's Board are not aware of these issues having been discussed at the Lifepoint Board level.

7. **In your response to question #7, "which asks about the role that "Apollo representatives play in reviewing the impact on access to health care in rural communities," you noted that "Apollo Funds are investors in Lifepoint and do not operate or manage any of its hospitals." However, we noted that the response does not answer whether "Apollo representatives review the impact on access to health care in rural communities that results or could result from the discontinuation/limitation of services or lack of nurses, providers, or other health care professionals at Lifepoint facilities?"**

The Apollo Funds remain committed to broadening access to health care generally. The Apollo Funds' original investment thesis in Lifepoint and its predecessor companies centered on investing in healthcare companies that provide care for underserved communities. Rural hospitals across the United States have faced challenges for decades, in part driven by underinvestment. The Apollo Funds sought to do the opposite by investing in and supporting companies, such as Lifepoint, that invest in these underserved communities to recruit physicians, expand service line offerings, and upgrade equipment in order to care for these communities.

Apollo has demonstrated its commitment to supporting Lifepoint in its investment in rural healthcare through the Apollo Funds' repeated investments in RegionalCare, Capella, and

Lifepoint, and through Fund IX's subsequent investment in Lifepoint in 2021. Since 2016, RegionalCare and its successor entities (including Lifepoint) have invested approximately $23 million in ORHC, with more than $3.5 million invested in capital projects in 2022 alone and nearly $5 million invested in 2023. Moreover, RegionalCare and its successor entities have invested an additional approximately $29 million in attracting and retaining physicians.

As noted previously, the Apollo Funds are investors in Lifepoint and do not operate or manage any of its hospitals, which are operated and run by local management teams that engage with a variety of community stakeholders to assess the community impacts of regional and national healthcare trends such as staffing shortages and systemic financial challenges experienced throughout the pandemic and beyond. The Apollo Funds rely on and empower professionals and community members to make community-centered analyses, assessments, and decisions related to access to nurses, providers, and health care professionals.

12. **In your response to question #12, you noted that "Apollo does not produce internal reports or communications for Apollo senior leadership that discuss the quality and safety of specific Lifepoint hospitals or the impact on access to health care in rural communities." What internal reports/communications do Apollo representatives provide to Apollo senior leadership and investors regarding the performance of Lifepoint hospitals, *generally*? Do these reports/communications contain any *aggregate* information regarding the quality and safety of Lifepoint facilities as well as any *aggregate* information related to access to care in the rural communities supported by Lifepoint facilities? Please provide all documents that support your response.**

Apollo does not produce aggregate reports regarding the quality and safety of Lifepoint facilities or aggregate reports related to access to care in rural communities supported by Lifepoint facilities for Apollo Global Management senior leadership.

13. **We noted that the response for question #13 does not answer: "Would Apollo step in to provide financial support to Lifepoint if Lifepoint is unable to pay its rents, loans, debts, contractors/vendors, payroll, or any other bills?"**

Apollo does not have concerns related to Lifepoint's solvency. Lifepoint is solvent and well-capitalized today and a significant focus of the Apollo Funds through representation on the Lifepoint Board and management is ensuring that Lifepoint is solvent and well-capitalized to continue to invest in its communities. While Apollo does not have any current or future plans to invest additional fund capital in Lifepoint, Apollo remains open to the possibility, if necessary, and is supportive of Lifepoint's investments in the hospitals it operates.

* * *

Apollo is voluntarily providing this information, which contains customarily non-public, confidential and privileged business and commercial information. Apollo respectfully requests that this letter be maintained in confidence with the Committee and used solely for the purposes of this inquiry. Accordingly, we have designated this letter as "Confidential Treatment Requested." To the extent you intend to disclose this information, Apollo requests that your staff notify Apollo in advance to allow us to discuss the matter and to take appropriate steps to safeguard Apollo's confidential business information.

Please let us know if you have any questions, and we look forward to our continued engagement with the Committee regarding Apollo's commitment to supporting Lifepoint in its mission to provide access to high-quality healthcare.

Sincerely,

[redacted]

[redacted]

LATHAM & WATKINS LLP

555 Eleventh Street, N.W., Suite 1000
Washington, D.C. 20004-1304
Tel: +1.202.637.2200 Fax: +1.202.637.2201
www.lw.com

October 18, 2024

HIGHLY CONFIDENTIAL
VIA ELECTRONIC TRANSMISSION

The Honorable Sheldon Whitehouse
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on the Budget
United States Senate
Washington, D.C. 20510-6100

Re: September 9, 2024 Email to Apollo Global Management, Inc.

Dear Chairman Whitehouse and Ranking Member Grassley,

On behalf of our client, Apollo Global Management, Inc. ("Apollo" or the "Company"), we write in response to the Committee Staff's supplemental requests outlined in the Committee Staff's September 9, 2024 email (the "September 9 Requests").

Consistent with our discussions with Committee Staff, including on August 28, 2024, this letter supplements our previous responses and productions from April 5, 2023, May 11, 2023, December 20, 2023, January 19, 2024, September 6, 2024, and September 27, 2024. Apollo is continuing to gather the requested information responsive to the Committee's requests, including those from the Committee Staff's August 8 email, and we anticipate providing additional information and documents on a rolling basis.

* * *

Responses

1. **We noted that the response for question #1 does not answer: "What measures of quality of care, patient safety, patient experience (such as HCAHPS), patient volume, staffing, hospital employee/provider turnover, and employee/provider satisfaction do Apollo representatives *[currently Maxwell David and formerly Holly McMullan]* review in regards to Lifepoint and its facilities? ... Do Apollo representatives review these measures at a system-level, hospital-level, or at another level of aggregation (e.g. division)? Have Apollo representatives ever voiced concerns and/or taken any actions in response to the performance of Lifepoint or any Lifepoint facility/division on these measures, specifically at Ottumwa Regional Health Center (ORHC)? If yes, please**

describe the concerns and/or actions. Please describe any steps Lifepoint took to address Apollo's concerns and their sufficiency. Please provide all ORHC scorecards reviewed by Apollo representatives and all other relevant documents, including meeting minutes and communication, that support your response to all above questions." Additionally, your response notes that the Quality Committee reviews quarterly "quality and patient experience data…as well as action plans to address the areas of opportunity." Please provide the quarterly data and action plans reviewed by the Lifepoint Board Quality Committee from Q1 2019 through Q2 2024. Please note if Apollo representatives on the RCCH and RegionalCare boards also reviewed quarterly quality and patient experience data and action plans. If yes, please provide the quarterly quality and patient experience data and action plans reviewed by the Apollo representatives on the RCCH and RegionalCare boards from Q1 2016 through Q4 2018.

The Apollo Funds do not have management or decision-making authority with respect to the hospital-level operational and clinical matters set forth in the original question. In general, Apollo Funds' approach to investing is to back and support strong management teams at portfolio companies that manage day-to-day operations and decision-making. Consistent with this approach, Lifepoint's management team is fully responsible for administering Lifepoint's business. Lifepoint's hospitals, including Ottumwa Regional Hospital Center ("ORHC"), each have a local management team responsible for general clinical operations, human resources and administration, and other day to day matters.

The Apollo Funds support Lifepoint's mission through representation on the Board of Directors and certain Board Committees, including the Quality Committee.[1] As described in Apollo's December 20, 2023 correspondence, Maxwell David has served on the Quality Committee from December 13, 2018 to present; in addition, Holly McMullan served on the Quality Committee from December 13, 2018 to July 13, 2023. The Quality Committee assists the Lifepoint Board in its efforts to monitor and provide leadership with respect to the quality of care, patient safety, and the appropriate environment for care at the Lifepoint system level; the members of the Quality Committee meet with Lifepoint management and review certain information on Lifepoint hospitals and aggregated quality and patient experience data quarterly. The Apollo Funds are not aware of any ORHC-specific scorecards that were provided to and reviewed by the Lifepoint Board's Quality Committee. In these meetings, members of the Quality Committee and Lifepoint management discuss areas of success as well as action plans to address areas of opportunity, all with a goal of programmatically strengthening Lifepoint's National Quality Program and continuing Lifepoint's system-wide trend of achieving improvements in quality of care and patient experience at Lifepoint hospitals.

[1] *See* Lifepoint Charter of the Quality Committee of the Board of Directors, previously produced at AP-SBC-000873.

5. **When were Apollo representatives, including but not limited to Apollo's representatives to the Lifepoint Board of Director's Quality Committee, notified by Lifepoint senior management that surveyors identified an immediate jeopardy situation at ORHC on October 12, 2023 involving the hospital's failure to "have adequate numbers of RN, LPNs, CNA/Techs and sitters to provide supervision, monitoring, and timely 15 minute safety checks to all patients with acute and ongoing mental health issues?" What actions did Apollo representatives take in response? Please provide all documents that support your response.**

The Apollo Funds are committed to improving the quality of care at all Lifepoint's hospitals, including ORHC. Ensuring that Lifepoint's management has the support and direction it needs to create system-wide programs and establish a world-class patient care culture is an utmost priority for the Lifepoint Board, including the Apollo representatives who serve on the board. As noted above, ORHC's local management team, with oversight and assistance from Lifepoint, is responsible for driving patient safety and ensuring appropriate staffing at ORHC. We understand that investigators from the Kansas City Regional office of the Centers for Medicare and Medicaid Services concluded that ORHC did not lack adequate staffing as a result of their investigation in October 2023, but did identify opportunities for improving screening protocols at ORHC. The Apollo representatives were not aware of issues identified by surveyors prior to October 2023 and understand that ORHC and Lifepoint developed and implemented a plan to address the issues identified by the CMS surveyors.

8. **What role do Apollo representatives play in reviewing Lifepoint's asset purchase agreements, including but not limited to whether Lifepoint is fulfilling its commitments and how Lifepoint is monitoring its compliance with its commitments (or being monitored)? Are Apollo representatives notified when Lifepoint does not fulfill its commitment to its facilities under its asset purchase agreements or renegotiates its commitments to its facilities? If Lifepoint is unable to finance its commitments to its facilities as set forth in its asset purchase agreements, would Apollo step in to provide financial resources?**

    1. **Were Apollo representatives notified that Lifepoint did not meet its annual routine capital expenditure obligations to ORHC in 2019? Please provide all documents that support your response.**

    2. **Were Apollo representatives notified that Lifepoint and ORHC's Board of Directors amended the asset purchase agreement to allow for operating/capital leases to be included in the definition of routine capital expenditures and to change the 5% of net operating revenue designated for annual routine capital expenditures to a split of 3.75% for capital expenditures and 1.25% for physician recruitment and retention? Please provide all documents that support your response.**

The Lifepoint Board did not play a role in reviewing the asset purchase agreement referenced in your question. The Apollo Funds understand the asset purchase agreement dates back

to 2010, which is well before the Apollo Funds' original investment in ORHC. The Apollo representatives, through their service on the Lifepoint Board, were not notified of ORHC's performance pursuant to the asset purchase agreement nor of amendments to the asset purchase agreement. However, consistent with the Apollo Funds' and Lifepoint's commitment to investing in ORHC, we understand that Lifepoint's aggregate investment in ORHC is well in excess of the asset purchase agreement obligations since 2010, including significant increased investment in ORHC during the COVID pandemic and in the years since. Indeed, Lifepoint's commitment to ORHC enabled the hospital to provide crucial healthcare services to the Ottumwa community and the broader rural community in Wapello County at a time when other hospitals and hospital systems were substantially curtailing basic services and, in some cases, closing altogether.

As noted above, the Apollo Funds are supportive of Lifepoint's mission to provide the highest quality patient care possible at all its facilities, including at ORHC. Apollo does not have concerns related to Lifepoint's solvency. Lifepoint is solvent and well-capitalized today and a significant focus of the Apollo Funds through representation on the Lifepoint Board is ensuring that Lifepoint is solvent and well-capitalized to continue to invest in its communities. While Apollo does not have any current or future plans to invest additional fund capital in Lifepoint, Apollo remains open to the possibility, if necessary, and is supportive of Lifepoint's investments in the hospitals it operates.

* * *

Apollo is voluntarily providing this information, which contains customarily non-public, confidential and privileged business and commercial information. Apollo respectfully requests that this letter be maintained in confidence with the Committee and used solely for the purposes of this inquiry. Accordingly, we have designated this letter as "Confidential Treatment Requested." To the extent you intend to disclose this information, Apollo requests that your staff notify Apollo in advance to allow us to discuss the matter and to take appropriate steps to safeguard Apollo's confidential business information.

Please let us know if you have any questions, and we look forward to our continued engagement with the Committee regarding Apollo's commitment to supporting Lifepoint in its mission to provide access to high-quality healthcare.

Sincerely,

[redacted]

[redacted]

LATHAM & WATKINS LLP

555 Eleventh Street, N.W., Suite 1000
Washington, D.C. 20004-1304
Tel: +1.202.637.2200 Fax: +1.202.637.2201
www.lw.com

November 8, 2024

HIGHLY CONFIDENTIAL
VIA ELECTRONIC TRANSMISSION

The Honorable Sheldon Whitehouse
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on the Budget
United States Senate
Washington, D.C. 20510-6100

Re: October 23, 2024 Email to Apollo Global Management, Inc.

Dear Chairman Whitehouse and Ranking Member Grassley,

We write on behalf of Apollo Global Management, Inc. ("Apollo" or the "Company") in response to the Committee Staff's supplemental requests outlined in the Committee Staff's October 23, 2024 correspondence.

Consistent with our discussions with Committee Staff, including on August 28, 2024 and October 22, 2024, this letter supplements our previous responses and productions from April 5, 2023, May 11, 2023, December 20, 2023, January 19, 2024, September 6, 2024, September 27, 2024, and October 18, 2024. Apollo is continuing to gather the requested information responsive to the Committee's requests, including those from the Committee Staff's August 8 email, and we anticipate providing an additional submission by November 15, 2024.

* * *

Responses

1. **Please provide clarity on all mechanisms by which Apollo, Apollo employees, and Apollo representatives (hereto forth referred to as Apollo) review the financial and non-financial performance of Lifepoint. Please provide documents that support this review structure.**

Apollo representatives on the Lifepoint Board of Directors serve the traditional functions that directors of any company, healthcare or otherwise, typically serve: providing oversight and strategic guidance to the company's management, ensuring that the corporation operates in the best interests of its shareholders, setting broad company policies, approving major business

decisions, and ensuring the integrity of financial statements, among other high-level assignments. Much like boards of other corporations, the Lifepoint Board, including the Apollo representatives on the Board, provides this high-level strategic guidance to ensure management is performing according to expectation, but ultimately Lifepoint's management team is responsible for just that—operationalizing the Board's high-level guidance and managing the business, including all clinical decision-making and patient quality elements at Lifepoint's individual hospitals. This is consistent with Apollo's general investment approach to empower and support strong management teams at portfolio companies that manage day-to-day operations and decision-making.

Consistent with this approach, Lifepoint's management team is fully responsible for administering Lifepoint's business. Lifepoint's hospitals, including Ottumwa Regional Hospital Center ("ORHC"), each have a local management team responsible for general clinical operations, human resources and administration, and other day to day matters. Consequently, Apollo representatives on the Lifepoint Board have supported Lifepoint management's emphasis on continuous improvements in quality of care, patient safety, drug diversion, and sufficiency of staffing at its hospitals, including at ORHC. In turn, Lifepoint has supported ORHC's leadership team in efforts concerning the continuous improvement of quality of care, patient safety, drug diversion, and sufficiency of staffing at ORHC.

2. **Please provide all financial and non-financial measures that Apollo reviews regarding the performance of Lifepoint and explain who at Apollo reviews these measures, how frequently these measures are reviewed, and how these measures are used. Please provide the most recent report/presentation/scorecard that Apollo used to review these non-financial performance measures (if there are multiple mechanisms at Lifepoint reviewing non-financial performance data, please provide the most recent report/presentation/scorecard used by each of these entities). Please provide meeting minutes that demonstrate who at Apollo reviewed these non-financial measures and the results of this review (if there are multiple mechanisms at Apollo reviewing performance data, please provide meeting minutes for each of these reviews).**

We anticipate providing additional information responsive to this request by November 15, 2024.

3. **Please provide the quarterly "quality and patient experience data" and "action plans" reviewed by Apollo's representatives to the Lifepoint board since the Lifepoint acquisition. If these "quality and patient experience data" and "action plans" were reviewed by Apollo's representatives to the RegionalCare and RCCH boards, please provide these as well.**

We anticipate providing additional information responsive to this request by November 15, 2024.

4. **Please provide all financial and non-financial measures that Apollo reviews in regard to the performance of Ottumwa Regional Health Center (ORHC) and explain who at Apollo reviews these measures, how frequently these measures are reviewed, and how these measures are used. Please provide all reports/presentations/scorecards that**

Apollo has used to review ORHC's financial and non-financial performance measures (if there are multiple mechanisms at Apollo reviewing financial and non-financial performance data for ORHC, please provide the reports/presentations/scorecards used by each of these entities). Please provide meeting minutes that demonstrate who at Apollo reviewed ORHC's financial and non-financial performance measures and the results of these reviews (if there are multiple mechanisms at Apollo reviewing performance data, please provide meeting minutes for each of these reviews). Please provide documents for the entire time period in which Apollo funds have invested in ORHC's parent company (Lifepoint, RCCH, RegionalCare).

As described in our prior responses, through service on the Quality Committee, Apollo representatives on the Board meet with Lifepoint management quarterly and review certain information regarding Lifepoint hospitals and aggregated quality of care and patient experience data. Similarly, Apollo representatives on the Lifepoint Board of Directors—like all of the members of the Lifepoint Board—review Lifepoint financial and operational data and information to provide strategic guidance to Lifepoint management, ensure it is operating effectively and efficiently, and provide guidance for strategic enterprise-wide decisions. Given this role, information is typically aggregated at the Lifepoint level, rather than at the individual hospital level.

From time to time, information provided to the Lifepoint Board, including the Quality Committee, may contain references to particular hospitals, such as to note where aggregated data excludes and/or is unavailable for specific hospitals, or as exemplars to illustrate aggregated trends or outliers in patient experience, quality of care, or clinical outcomes and associated corrective and preventative actions. As previously noted, the Apollo Funds are not aware of any ORHC-specific reports, presentations, or scorecards that were provided to and reviewed by the Quality Committee of Lifepoint's Board. We are not aware of any mechanism by which Apollo representatives on the Lifepoint Board receive hospital-specific presentations or reports.

5. **Please provide all communications, including, but not limited to, emails, memos, reports and meeting minutes, between Lifepoint (and its predecessors-RegionalCare and RCCH) and Apollo regarding (a) the performance of ORHC, (b) challenges facing ORHC, (c) concerns regarding ORHC, and (d) plans for ORHC. Examples of challenges may include, but are not limited to, issues related to finances, coding/billing, quality of care, patient safety, patient experience, patient volume, staffing, hospital employee/provider turnover, employee/provider satisfaction, provider recruitment, ability to provide specific services, unprofitable service lines, drug diversion, facility and equipment, contracts with TeamHealth or other provider groups, contracted services, third-party payers and payment models, purchasing and supplies, inspection findings, commitments to the hospital/community, and reputation. Examples of plans may include, but are not limited to, service line growth, elimination of service lines, divestment, alternative payment models, alternative care delivery models, debt financing/refinancing, and facility and equipment upgrades.**

As noted above, Apollo representatives on the Quality Committee of Lifepoint's Board review certain information on Lifepoint hospitals and aggregated quality of care and patient experience data on a quarterly basis. Some of this information may contain references to specific hospitals. However, we are not aware of ORHC-specific emails, memos, or reports periodically provided to Apollo representatives on the Lifepoint Board detailing ORHC finances, coding/billing, quality of care, patient safety, patient experience, patient volume, staffing, hospital employee/provider turnover, employer/provider satisfaction, provider recruitment, ability to provide specific services, unprofitable service lines, drug diversion, facility and equipment, contracts with TeamHealth, or other provider groups, contracted services, third-party payers and payment models, purchasing and supplies, inspection findings, commitments to the hospital community, and reputation, or plans detailing/regarding ORHC-specific service line growth, elimination of service lines, divestment, alternative payment models, alternative care delivery models, debt financing/refinancing, and facility and equipment upgrades.

6. **Please provide the sections of the annual report to the Lifepoint board "on any significant failure to maintain quality and/or patient safety standards at any of the Company's facilities that poses a material financial or reputational risk to the Company" that refer to ORHC. How many years has this report been reviewed by the Lifepoint board? Was it reviewed by the RegionalCare and RCCH boards? Please provide any mentions to ORHC in these reports for as many years back as these reports have been circulated (including RegionalCare and RCCH, if applicable).**

Apollo is not aware of any reports provided from the Quality Committee to the Lifepoint Board related to "significant failure to maintain quality and/or patient safety standards at any of the Company's facilities that poses a material financial or reputational risk to the Company" that refers to ORHC. Of course, the Lifepoint Board was highly disturbed to learn of the tragic events surrounding the death of Devin Caraccio and was aware of the swift actions Lifepoint management took to safeguard patient safety at ORHC and improve quality of care, including replacing ORHC's senior management. The Board further exercised its oversight responsibilities through a Special Committee to ensure management took decisive remedial steps in the aftermath of Caraccio's death.

7. **Please provide all evaluations that Apollo has conducted or reviewed that pertain to whether the underserved communities cared for by the hospitals in the Lifepoint portfolio have been able to "recruit physicians, expand service line offerings, and upgrade equipment in order to care for these communities."**

As noted in prior responses, the Apollo Funds remain committed to broadening access to health care. The Apollo Funds' original investment thesis in Lifepoint and its predecessor companies centered on investing in healthcare companies that provide care for underserved communities. Rural hospitals across the United States have faced challenges for decades, in part driven by underinvestment. The Apollo Funds sought to do the opposite by investing in and supporting companies, such as Lifepoint, that invest in these underserved communities to recruit physicians, expand service line offerings, and upgrade equipment to care for these communities. The Apollo Funds empower local management teams to execute on this vision, including

evaluating opportunities and progress at the local level, and therefore any such analyses are conducted at the Lifepoint and/or hospital level.

8. **Please provide the goals and objectives used by the Compensation Committee of the Lifepoint Board to evaluate the performance of CEO David Dill and how Mr. Dill has performed on them.**

The Compensation Committee is responsible for discharging the Board's responsibilities related to the compensation of the CEO, approving compensation for other executive officers, directors, and other key employees, making recommendations regarding equity-based and other compensation, administering the Company's equity-based compensation plans, and overseeing the Board's evaluation of senior management, among other responsibilities. The Charter further provides that the Committee determines the CEO's compensation level, which includes salary, bonus targets, and non-equity incentive compensation, and makes recommendations regarding the CEO's equity compensation. In determining the long-term incentive component of the CEO's compensation, the Committee evaluates several factors, including Lifepoint's overall performance; the value of similar incentive awards to CEOs at comparable companies; and historical awards given to Lifepoint's CEO in past years, among other factors. For further information regarding the standards used to set Mr. Dill's compensation, please refer to the Charter of the Compensation Committee of the Lifepoint Board, produced at AP-SBC-000876 through AP-SBC-000879.

9. **Please provide all reports/communications provided to Apollo senior leadership and investors in Apollo Investment Fund IX (and previously Apollo Investment Fund VIII) regarding the performance of Lifepoint and its hospitals.**

We have not identified any Apollo Global Management Board of Director meeting agendas or minutes (or related committees) that contain any reference to Lifepoint—much less ORHC or other specific Lifepoint hospitals. We understand there are isolated references to Lifepoint in appended board book materials—such as references to Lifepoint in connection with broader fund portfolio performance. In none of these references, which again are isolated references in materials that frequently number in the hundreds of pages in length, is there any substantive discussion of patient safety issues, patient care, or any operational issue related to Lifepoint nor any specific hospital.

* * *

Apollo is voluntarily providing this information, which contains customarily non-public, confidential and privileged business and commercial information. Apollo respectfully requests that this letter be maintained in confidence with the Committee and used solely for the purposes of this inquiry. Accordingly, we have designated this letter as "Confidential Treatment Requested." To the extent you intend to disclose this information, Apollo requests that your staff notify Apollo in advance to allow us to discuss the matter and to take appropriate steps to safeguard Apollo's confidential business information.

LATHAM & WATKINS LLP

Please let us know if you have any questions, and we look forward to our continued engagement with the Committee regarding Apollo's commitment to supporting Lifepoint in its mission to provide access to high-quality healthcare.

Sincerely,

[redacted]

of LATHAM & WATKINS LLP

[redacted]

LATHAM & WATKINS LLP

555 Eleventh Street, N.W., Suite 1000
Washington, D.C. 20004-1304
Tel: +1.202.637.2200 Fax: +1.202.637.2201
www.lw.com

November 15, 2024

HIGHLY CONFIDENTIAL
VIA ELECTRONIC TRANSMISSION

The Honorable Sheldon Whitehouse
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on the Budget
United States Senate
Washington, D.C. 20510-6100

Re: October 23, 2024 Email to Apollo Global Management, Inc.

Dear Chairman Whitehouse and Ranking Member Grassley,

We write on behalf of Apollo Global Management, Inc. ("Apollo" or the "Apollo Funds") in response to the Committee Staff's supplemental requests outlined in the Committee Staff's October 23, 2024 correspondence. Consistent with our discussions with Committee Staff, including on August 28, 2024 and October 22, 2024, this letter supplements our previous responses and productions from April 5, 2023, May 11, 2023, December 20, 2023, January 19, 2024, September 6, 2024, September 27, 2024, October 18, 2024, and November 8, 2024.

* * *

Lifepoint Health, Inc. ("Lifepoint" or the "Company") serves patients, clinicians, and predominantly rural communities through a national network of 60 community hospitals, 70 rehabilitation and behavioral health hospitals, and more than 300 additional sites of care, including managed acute rehabilitation units, outpatient centers and post-acute care facilities. As noted in prior responses, the Apollo Funds are investors in Lifepoint and remain committed to broadening access to healthcare. The Apollo Funds' original investment thesis in Lifepoint and its predecessor companies centered on investing in healthcare companies that provide care for underserved communities. Rural hospitals across the United States have faced challenges for decades, in part driven by underinvestment. The Apollo Funds sought to do the opposite by investing in and supporting companies, such as Lifepoint, that invest in these underserved communities to recruit physicians, expand service line offerings, and upgrade equipment in order to care for these communities.

In general, the Apollo Funds' approach to investing is to back and support strong management teams at portfolio companies that manage day-to-day operations and decision-making. Consistent with this approach, Lifepoint's management team is fully responsible for administering Lifepoint's business and making key decisions for Lifepoint's hospitals. The Apollo Funds support Lifepoint's mission through representation on the Board of Directors (the "Lifepoint Board" or the "Board") and certain Board Committees, including Lifepoint's Quality Committee (the "Quality Committee" or the "Committee"). In turn, Lifepoint's hospitals each have a local management team responsible for general clinical operations, human resources and administration, and other day to day matters. Indeed, empowering local caregivers, communities, and stakeholders to drive patient care and quality improvements is especially important given the breadth of services described above, the geographic diversity of the areas Lifepoint serves, the importance of local knowledge for local initiatives, and the critical impact of personal touch on personal health care.

Consequently, and as we have explained, Apollo representatives on the Lifepoint Board serve the traditional functions that directors of any company, healthcare or otherwise, typically serve: providing oversight and strategic guidance to the company's management, ensuring that the corporation operates in the best interests of its shareholders, setting broad company policies, approving major business decisions, and ensuring the integrity of financial statements, among other high-level assignments. The Lifepoint Board chartered the Quality Committee in particular to assist in efforts to provide leadership with respect to quality of care, patient safety, and an environment for individualized care at Lifepoint hospitals.

Lifepoint's Quality Committee

You have asked questions about financial and non-financial measures that Apollo reviews regarding the performance of Lifepoint, including action plans, and quality and patient data. The mechanism through which Apollo representatives on the Lifepoint Board primarily evaluate and assess quality and patient data is through service on the Quality Committee. The Lifepoint Quality Committee, including its Apollo representatives, periodically receives information regarding quality of care and patient safety to assist Lifepoint in its organizational commitment to the highest level of patient care and quality. Like similar committees at large healthcare companies, the Quality Committee's scope of authority extends to reviewing the adequacy and effectiveness of quality of care and patient safety initiatives, and reporting to the Board where necessary.[1] Ultimately, however, the Board is responsible for providing high-level oversight to the Company and Lifepoint's management team is responsible for managing the business, including all clinical decision-making and patient quality elements at Lifepoint's individual hospitals.

Consistent with industry standards, the Quality Committee convenes quarterly.[2] By charter, the Committee is composed of two or more members who serve at the pleasure of the

[1] *See, e.g.,* Patient Safety and Quality of Care Committee Charter, HCA HEALTHCARE, INC. (Oct. 21, 2021), https://investor.hcahealthcare.com/governance/governance-documents/default.aspx.
[2] *See, e.g.,* Amended and Restated Quality of Care Committee Charter, AMEDISYS, INC. (Dec. 14, 2022), https://investors.amedisys.com/governance/documents/default.aspx; Fourth Amended and Restated Charter of the Corporate Compliance and Quality of Care Committee, ENCOMPASS HEALTH CO. (May 5, 2022), https://investor.encompasshealth.com/governance/governance-documents/default.aspx; Quality, Compliance &

Board and may be removed at any time, with or without cause; five members typically attend Quality Committee meetings. Members may have relevant experience in health care, patient safety, and quality, or have served on the board of a healthcare institution. The Committee has generally received quality-related briefings from the Chief Medical Officer, the Chief Nursing Officer, and the Chair of the COVID-19 taskforce. The Committee may also receive briefings concerning significant deviations from quality of care and patient safety standards and corrective actions, as applicable. The Committee notifies the Board as necessary of any significant failure to maintain quality and safety standards that might pose material risk to the Company.

Information Provided to the Quality Committee

The Quality Committee relies principally on Lifepoint's senior management for information relating to quality of care and patient safety initiatives. The Quality Committee has consistently reviewed materials related to quality and patient experience, and COVID-19. At the heart of Lifepoint's pursuit of first-in-class quality of care is Lifepoint's National Quality Program (NQP). Started by Lifepoint in 2010 and launched systemwide in 2015, the NQP is an innovative Lifepoint initiative designed to drive organization-wide change through a framework of leadership, performance improvement, and culture.[3]

Through the program, Lifepoint leadership works with individual facilities to assess a combination of quantitative and qualitative criteria regarding their current performance, existing initiatives, and resources. The collaborative effort helps hospitals identify strengths and shortcomings, provides clinical and case management support, and holds facilities accountable for continued progress. Facilities demonstrating high standards of quality of care, performance improvement and patient engagement are designated National Quality Leaders (NQLs). Thirteen Lifepoint facilities achieved NQL status as of 2021 and by Q2 2024, 19 Lifepoint facilities had earned the designation, an increase of almost 50 percent in three years.

The status of the NQP is discussed regularly at Quality Committee meetings, including periodic progress updates for individual facilities. The NQP framework also guides the Quality Committee's discussions of quality and patient experience metrics systemwide. In particular, Lifepoint management provides system-level quantitative and qualitative updates concerning patient experience, trends in preventable patient harms at Lifepoint facilities, and external barometers of patient safety and quality of care, including Leapfrog Group ratings and CMS Star Ratings. Currently, over 70 percent of Lifepoint hospitals have achieved A or B Leapfrog ratings (up from 40 percent of Lifepoint hospitals achieving A or B ratings from the Fall 2023).[4]

Ethics Committee Charter, TENET HEALTHCARE CO. (May 22, 2024), https://investor.tenethealth.com/governance/default.aspx.

[3] *See* Karen Frush et al., *National Quality Program Achieves Improvements in Safety Culture and Reduction in Preventable Harms in Community Hospitals*, 44 Joint Commission J. on Quality and Patient Safety 389, 389-400 (2018), https://pubmed.ncbi.nlm.nih.gov/30008351/ (noting the NQP was designed to drive system-wide performance improvement through use of a framework of leadership, performance improvement, and culture).

[4] *See, e.g.,* Nineteen Lifepoint Hospitals Earn "A" Hospital Safety Grade, LIFEPOINT HEALTH, INC. (Nov. 15, 2024), https://lifepointhealth.net/.

In addition to these quantitative and qualitative data, the Quality Committee also reviewed pandemic-related metrics in discussions with Lifepoint management. Just 14 months after the Lifepoint Quality Committee was chartered, the World Health Organization (WHO) declared COVID-19 a global pandemic on March 11, 2020.[5] In the weeks that followed, the disease spread dramatically across the United States. The Quality Committee regularly discussed Lifepoint's response to COVID-19 as the pandemic unfolded. People in rural communities - like those that Lifepoint serves – were significantly more likely to be hospitalized.[6] Lifepoint senior management resolved to ensure patient and employee safety while minimizing the spread of the disease at its hospitals, including those serving rural communities that were hardest hit. Throughout COVID's unprecedented interruption of healthcare operations, Lifepoint's Quality Committee continued to monitor and guide quality improvement over prior, pre-pandemic levels. As a result of Lifepoint management's stewardship and the Board's oversight and guidance, Lifepoint is proud that it has not had to close a single hospital – whether in a rural community or otherwise – as a result of the pandemic.

* * *

Apollo is voluntarily providing this information, which contains customarily non-public, confidential and privileged business and commercial information. Apollo respectfully requests that this letter be maintained in confidence with the Committee and used solely for the purposes of this inquiry. Accordingly, we have designated this letter as "Confidential Treatment Requested." To the extent you intend to disclose this information, Apollo requests that your staff notify Apollo in advance to allow us to discuss the matter and to take appropriate steps to safeguard Apollo's confidential business information.

Please let us know if you have any questions.

Sincerely,

[redacted]

of LATHAM & WATKINS LLP

[5] World Health Organization, *WHO Director-General's opening remarks at the media briefing on COVID-19* (Mar. 11, 2020), https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

[6] *See, e.g.,* Alfred Jerrod Anzalone et al., *Higher Hospitalization and Mortality Rates Among SARS-CoV-2-Infected Persons in Rural America*, 39 J. of Rural Health 39, 39-54 (2023), https://ncats.nih.gov/news-events/news/n3c-data-reveal-more-severe-covid-19-outcomes-in-rural-communities.

[redacted]

LATHAM & WATKINS LLP

555 Eleventh Street, N.W., Suite 1000
Washington, D.C. 20004-1304
Tel: +1.202.637.2200 Fax: +1.202.637.2201
www.lw.com

December 11, 2024

HIGHLY CONFIDENTIAL
VIA ELECTRONIC TRANSMISSION

The Honorable Sheldon Whitehouse
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on the Budget
United States Senate
Washington, D.C. 20510-6100

Re: December 2, 2024 Email to Apollo Global Management, Inc.

Dear Chairman Whitehouse and Ranking Member Grassley,

On behalf of our client, Apollo Global Management, Inc. ("Apollo" or the "Company"), we write in response to the Committee Staff's supplemental requests outlined in the Committee Staff's December 2, 2024 correspondence. Consistent with our discussions with Committee Staff, including on August 28, 2024 and October 22, 2024, this letter supplements our previous responses and productions from April 5, 2023, May 11, 2023, December 20, 2023, January 19, 2024, September 6, 2024, September 27, 2024, October 18, 2024, November 8, 2024, and November 15, 2024.

* * *

Responses

Questions Related to Portfolio Company Management Consulting Fees

As noted in prior responses, an Apollo subsidiary receives an annual management consulting fee of $9 million from Lifepoint. The management consulting fee relates to a range of management consulting and advisory services provided by the Apollo subsidiary and its employees to Lifepoint. Agreements such as these are very standard in the industry and enable the Apollo subsidiary and its employees to provide services to Lifepoint, including advice with respect to various financial transactions and other matters. The management consulting services are completely unrelated to hospital-level clinical and operational decisions.

Questions Related to Fund Management Fees – Management Fees Paid by LPs

The Budget Committee staff asked a series of questions regarding the quantum of management fees paid by LPs in Apollo funds. These fees are paid by limited partners – not portfolio companies. Lifepoint has not paid, and does not pay, any such management fees. Fund-level management fees are not borne by portfolio companies, nor do they have any financial, operational, or clinical impact on Lifepoint or its hospitals. Consequently – given that the Budget Committee's stated legislative interest is "the impact of private equity ownership and related party transactions on the administration of health care throughout the United States"[1] – we do not believe that these fees, which reflect a fund-level economic arrangement between general partners like Apollo and the limited partners who invest in Apollo-managed funds have any impact on the administration of health care, whether at the ORHC level, Lifepoint, or otherwise.

Question 17: Have any current or previous Apollo employee-directors on the Lifepoint / ScionHealth / RCCH / RegionalCare boards ever owned stock or shares or units (hereto forth referred to as units) in Lifepoint / ScionHealth / RCCH / RegionalCare / their parent companies and how much money did they receive as a result of owning those units, including but not limited to selling those units

None of the current or former Apollo employee representatives on the Lifepoint Board owns or owned stock, shares or units in Lifepoint.

Other Questions, Including Question 18, Regarding the Total Amount that Apollo Expects to Receive "From" or "In Relation To" Lifepoint

As noted above, the Budget Committee's stated legislative interest is "the impact of private equity ownership and related party transactions on the administration of health care throughout the United States."[2] The staff's questions, including Question 18, regarding the total amount that Apollo expects to receive "from" or "in relation to" the investment in Lifepoint do not distinguish between payments made by Lifepoint, on the one hand, and payments made by third parties, such as LPs, on the other hand, nor do they draw a connection between payments such as fund-level management fees and even a theoretical impact on the administration of health care. As such, we do not believe these amounts are relevant to the Budget Committee's inquiry.

Apollo Funds have demonstrated their commitment to supporting Lifepoint in its investment in rural healthcare through the Apollo Funds' repeated investments in RegionalCare, Capella, and Lifepoint, and through Fund IX's subsequent investment in Lifepoint in 2021.

---

[1] Letter from Senator Sheldon Whitehouse, Chairman, and Senator Charles E. Grassley, Ranking Member, Senate Committee on the Budget, to Mr. Marc Rowan, Chief Executive Officer, Apollo Global Management, Inc., (December 6, 2023), available at: https://www.grassley.senate.gov/imo/media/doc/whitehouse_grassley_to_apollo_global_-_private_equity_hospital_investigation.pdf.

[2] Letter from Senator Sheldon Whitehouse, Chairman, and Senator Charles E. Grassley, Ranking Member, Senate Committee on the Budget, to Mr. Marc Rowan, Chief Executive Officer, Apollo Global Management, Inc., (December 6, 2023), available at: https://www.grassley.senate.gov/imo/media/doc/whitehouse_grassley_to_apollo_global_-_private_equity_hospital_investigation.pdf.

* * *

Apollo is voluntarily providing this information, which contains customarily non-public, confidential and privileged business and commercial information. Apollo respectfully requests that this letter be maintained in confidence with the Committee and used solely for the purposes of this inquiry. Accordingly, we have designated this letter as "Confidential Treatment Requested." To the extent you intend to disclose this information, Apollo requests that your staff notify Apollo in advance to allow us to discuss the matter and to take appropriate steps to safeguard Apollo's confidential business information.

Please let us know if you have any questions.

Sincerely,

[redacted]

of LATHAM & WATKINS LLP

Lifepoint Health

March 31, 2023

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Senator Grassley,

Thank you for your letter dated March 17, 2023. We appreciate the opportunity to share more information with you about Lifepoint Health Inc. ("Lifepoint") and Ottumwa Regional Heath Center ("Ottumwa Regional"), our hospital in Ottumwa, Iowa. We write on behalf of Lifepoint, RCHP Ottumwa, LLC, which is the Lifepoint indirect, wholly owned subsidiary that owns and operates Ottumwa Regional, and the Board of Directors of Ottumwa Regional, which is comprised of members of the Ottumwa community, including local physicians.

Like you, we were all horrified to learn about the conduct of the now-deceased nurse practitioner at Ottumwa Regional. His actions do not reflect who we are, who we aspire to be, or how we run our hospital. Since learning of those events last fall, Lifepoint and Ottumwa Regional have been working closely together, and in partnership with local law enforcement, to address the situation and to support our employees, providers and community members affected by these events.

Lifepoint has been part of the fabric of Ottumwa since late 2018. We have always been and remain committed to meeting the community's evolving needs. The recent events at Ottumwa Regional have led to additional investments in the hospital and have reinforced our commitment to patient safety and quality care.

As we have discussed with you, our submission provides responses to certain of your questions and summarizes Lifepoint's history in, our commitment to, and investments in Ottumwa Regional and its community. We will provide additional responses in a later letter.

We appreciate your long-standing advocacy for rural hospitals and the patients they serve, and we understand the critical role this hospital plays in its community. We take seriously this responsibility and share your dedication to rural hospitals and communities both in Iowa and across the nation, and we are committed to ensuring that our facilities provide safe and reliable healthcare to the communities they serve.

Our history and commitments

As you may know, Lifepoint was founded in 1999 with 23 rural hospitals that had been spun out from Hospital Corporation of America (HCA). Today, 47 of our 62 acute care hospitals are

defined as rural based on Medicare redesignation. These rural hospitals hold 5,527 licensed beds, including 4,518 acute care beds. As of December 2022, Lifepoint's total acute care licensed beds for our 62 acute care hospitals was 6,886, meaning that approximately 80 percent of our acute care beds are rural hospital beds.

Lifepoint is committed to investing in our hospitals and communities. Over the last four years alone, through the pandemic, we have invested over a billion dollars of capital in our facilities, including building new facilities, renovating departments, creating new service lines, recruiting medical staff, purchasing vital equipment, and shoring up technological infrastructures.

We also are dedicated to advancing quality care. As you may know, Lifepoint was among the first for-profit health system in the nation to establish a national quality program. We have been recognized for our quality and safety leadership and were the first for-profit health system to receive a John M. Eisenberg Award for Innovation in Patient Safety from The Joint Commission and the National Quality Forum. This award recognized Lifepoint's health and safety achievements, including reducing preventable harms across our system by more than 60 percent.

We understand the importance of engagement between our facilities and their local communities, including governance structures that engage a community and its leaders. That is why each of the acute care hospitals we operate – including Ottumwa Regional – has a Board of Directors comprised of local community members, physicians, and a member of the hospital management team. We share with our boards the strategic plans and capital and operating budgets to confirm their support for the important objectives we pursue together.

Lifepoint is the largest employer in many of the communities we serve, and we take our role as a community partner seriously. Across the country we employ over 50,000 medical professionals, clinical experts, and support staff from these communities. As part of this role, we contribute to and support local non-profit organizations and participate in local health programs. Each of our facilities has robust charitable care and discount programs. In fact, for each of the past four years, through the pandemic, we have provided over a billion dollars of uncompensated care.

These are commitments that Lifepoint has upheld since 1999 and that have not wavered in our mission of *making communities healthier* since we were acquired by funds affiliated with Apollo Global Management in late 2018.

Lifepoint was able to manage the challenges of the COVID-19 pandemic, prioritizing protecting and supporting our more than 50,000 employees. We avoided significant layoffs and furloughs during the height of the pandemic, notwithstanding steep declines in patient volume, which in April 2020 reached over 40 percent reductions in volume, as a consequence of government restrictions on elective procedures, shelter-in-place initiatives, and the increased costs associated with delivering high-quality COVID care. Employees who were placed on temporary leaves of absence early in the pandemic were provided partial pay and enjoyed continuity of health insurance. We also were able to offer additional measures to support our employees, including

dependent care stipends, pay for employees forced to quarantine at home, and increased access to our employee assistance fund.

Our company has evolved, and today, we are serving a larger and more diverse population of patients, clinicians, communities, and partner organizations across the healthcare continuum. We are developing meaningful solutions to enhance quality, increase access to care, and improve value across the Lifepoint footprint and communities across the country, including a commitment to expand needed rehabilitative and behavioral services across the country with many of our facilities in areas heavily hit by the opioid crisis and in significant need of mental health and drug addiction services.

Ottumwa Regional Health Center

Over the past few months, Lifepoint has invested considerable resources in investigating and remediating the tragic events at Ottumwa Regional. We are doing everything we can to learn from this situation and to regain the trust of all our stakeholders. To this end, we have invested significant resources into preventing any recurrence. These measures have included strengthening security protocols, adding new cameras and similar equipment, conducting staff training, and enhancing our pharmacy operations.

Immediately following Devin Caraccio's death, the hospital took a number of steps to respond to the events, including taking swift action to replace the leadership at the facility. The hospital appointed a new chief executive officer, which was followed over the subsequent weeks and months by the transition of the chief financial officer, chief nursing officer (CNO), and the director of pharmacy. The hospital, working closely with Lifepoint, also took immediate steps to engage with the community and communicate regularly with regulators, law enforcement, and political stakeholders at the local, state, and federal levels. This engagement included outreach by one of our Board members to your office.

We also focused on – and continue to focus on – supporting everyone affected by Mr. Caraccio's conduct. The police investigation into Mr. Caraccio's conduct remains ongoing, and we continue to cooperate closely with local authorities to attempt to identify, locate, and support affected patients. As we are able to identify individuals, we continue to notify them, to apologize, and to offer support, including financial and mental health resources.

In addition, we have sought to assist hospital employees. Within two days of Mr. Caraccio's death, Ottumwa Regional deployed onsite Employee Assistance Program (EAP) services, providing group and private sessions with licensed counselors to provide support. The program remained on-site until November 17, and continues online today.

Mr. Caraccio's behavior does not reflect the care and compassion that Ottumwa Regional staff exhibit daily. We are committed to supporting and advancing the critical work everyone on our team does on behalf of this community and patients.

Lifepoint Health

1. **Describe your company's financial or operational relationship with Ottumwa Regional Health Center and provide the exact dollar amount your company has invested in Ottumwa Regional. Please answer in timeline form and include any agreements or contracts between your company and Ottumwa Regional.**

The operations of Ottumwa Regional are carried out by RCHP-Ottumwa, LLC, a Delaware limited liability company. RCHP-Ottumwa, LLC is an indirect, wholly owned subsidiary of Lifepoint. Ottumwa Regional is operated through a shared governance model, in which the local management team is responsible for day-to-day general and clinical operations, human resources, and administration of Ottumwa Regional, with oversight by the hospital's Board of Trustees and RCHP-Ottumwa, LLC.

In 2022 alone, Lifepoint invested more than $3.5 million in capital projects at Ottumwa Regional Health Center, and in the last four years since Lifepoint acquired Ottumwa Regional, we have invested over $15 million in the hospital and over $16 million in attracting and retaining physicians, providing needed services to a rural community. These investments have supported broad facility updates as well as new equipment and technology in core service lines such as surgical services, cardiology, medical oncology, and imaging, and include the following:

- In 2019, we made nearly $2 million in capital investments including surgical equipment upgrades.
- In 2020, we renovated the McCreery Cancer Center and installed a new $4.5 million linear accelerator, enabling radiation oncologists to provide a higher level of care closer to home through Stereotactic Body Radiation Therapy (SBRT).
- In 2021, we invested $5.2 million in OR video towers, a portable digital X-ray machine and equipment for Ottumwa Regional's radiation oncology department.

Already this year, we have invested $2 million into a new DaVinci robot, significantly upgrading Ottumwa Regional's minimally invasive surgery capabilities. Additionally, we are nearing completion of a $4.5 million project that substantially expands and upgrades our cardiac catheterization lab. The new 3,800 square foot department will encompass a fully upgraded procedure room and two pre/post-procedure bays and ensures the department is more readily accessible from the emergency department and operating room.

Beyond our capital investments in the hospital, we are fully committed to investing in our people and in the communities we serve. In the last four years, we have paid more than $185.6 million in payroll, more than $20.7 million in taxes, and more than $39.1 million in charity, discounted, and uncompensated care to patients in need. In the last four years, we also have added over 150 employed, affiliated, and telehealth providers to support the hospital's core service lines, as well as advanced telemedicine capabilities. Ottumwa Regional is the only hospital in Wapello

County, and we have invested in partnerships with leading health systems and providers in Iowa to expand the hospital's capabilities and bring new resources to the broader community in areas such as telepsychiatry, teleneurology, and teleradiology, among others.

2. **If your company no longer has a financial or operational relationship with Ottumwa Regional, explain the reasons for which your company withdrew its investment, including the date you exited and your return on investment.**

This is not applicable as our relationship with Ottumwa Regional remains ongoing.

4. **Does your company have plans to invest capital in Ottumwa Regional? If so, please describe them. If not, why not?**

Lifepoint is committed to investing in Ottumwa Regional. Since 2018, we have been contractually obliged to reinvest at least 5 percent of Ottumwa Regional's annual net patient revenue in the hospital. We have always met or exceeded that obligation. Indeed, as of December 31, 2022, we are $2 million ahead of our commitment.

In addition, as discussed in more detail in the introduction of this letter, following Mr. Caraccio's death, Lifepoint promptly provided all necessary personnel and resources to address the situation that came to light as a consequence of his death.

5. **How was your company involved in the 2019 sale-leaseback?**

In late 2019, Lifepoint completed a sale-leaseback transaction as part of a broader capital structure initiative. Lifepoint coordinated with local hospital management teams, including the Ottumwa Regional team, to develop a transaction that would optimize and enhance Lifepoint's capacity to reinvest in its hospitals.

6. **Explain in detail the reasons for the 2019 sale-leaseback of Ottumwa Regional. What were the terms of the 2019 sale-leaseback transaction? How did you sell this to the local communities and hospitals? Please provide all records.**

The 2019 sale-leaseback transaction was intended to improve Lifepoint's capital structure and to lower our overall cost of financing by taking advantage of the favorable interest rate environment in place at the time. The sale-leaseback transaction and associated capital structure activity enabled Lifepoint to reduce its interest expenses by approximately $50 million. These savings enabled Lifepoint to invest more in our communities, including Ottumwa.

The sale-leaseback transaction involved six markets, of which Ottumwa was one. The full balance of the proceeds was used to repay a portion of Lifepoint's indebtedness and to invest in Lifepoint communities across the nation by recruiting new providers, growing vital services, and making needed renovations and technology purchases, among other things.

Lifepoint Health

Lifepoint did not issue dividends or otherwise distribute the proceeds of the sale-leaseback to shareholders.

8. **What happens if one of the medical facilities that are subject to a sale-leaseback is unable to pay rent?**

Lifepoint is responsible for its facilities' rent expenses, including that of Ottumwa Regional.

9. **Describe in detail your company's expertise regarding rural or non-urban hospitals. Please include the full name and curriculum vitae of every person your company relies on for rural or non-urban hospital advice.**

Lifepoint was founded in 1999 on the idea that all people deserved access to quality care close to home. We began as a system of 23 rural hospitals, and our dedication to this idea – and to the non-urban communities we serve – has been unwavering for nearly 25 years. As noted above, today, 47 of our 62 acute hospitals are defined as rural based on Medicare redesignation.

Lifepoint is led by a dedicated team of healthcare executives with decades of experience in the industry and significant tenure with the company.

- Chairman and CEO David Dill has been with Lifepoint since 2007 and has more than 25 years of operational leadership experience in diverse healthcare roles.
- Division president Sandy Podley has been with Lifepoint since 2019 (and previously as a hospital CEO from 2006-2012). She has more than 20 years of experience in supporting and leading community hospitals.
- Division chief financial officer Bob Barrett has been at Lifepoint since 2004 and has more than 15 years of experience in finance and accounting roles within Lifepoint at both the hospital and division level.
- Senior vice president of government relations David Critchlow has been at Lifepoint since 2010 and has more than 25 years of experience in government relations roles within the hospital and healthcare industry.
- William Kiefer, DNP, MBA, RN, ACHE, chief executive officer of Ottumwa Regional, joined Lifepoint in spring of 2022 as chief operating officer of Canyon Vista Medical Center and has 15 years of experience in diverse clinical and administrative leadership roles at community hospitals.

There are numerous other executives who support the operations of our business. All of these leaders are committed to our mission of making communities healthier, and to our people, our communities, and our growth.

Lifepoint Health

Across the nation, our hospitals and other sites of care are led by thousands of both veteran and up and coming healthcare leaders – many who joined our company because of our mission and our focus on serving non-urban communities.

We focus on development and recruitment of talented executives and succession planning across our leadership teams because it is important that we have experienced, mission-driven healthcare leaders at the helm of our company.

10. How much money did your company receive in COVID-19 stimulus aid, including CARES Act dollars and grants? Provide an explanation as to why your company needed federal stimulus aid. Describe in detail how these funds were allocated.

Like most hospitals across the nation, Lifepoint's facilities received financial support from the federal government through the CARES Act Public Health and Social Services Emergency Fund. Grant aid was distributed to hospitals on a formulaic basis by HHS. Lifepoint received a total of $677 million over three years (from 2020 – 2022) from federal and local governments.

Lifepoint also received $991 million in accelerated Medicare Accelerated Advance Payments (MAAP). This amount was fully repaid to the government months ahead of schedule.

The CARES Act and other government relief dollars Lifepoint received were spent in conformance with all the applicable guidelines. To ensure our compliance, we proactively engaged with advisors and with government representatives throughout the process to ensure our uses and tracking of government funds were compliant and in keeping with issued guidance.

As is the case with other health care companies, COVID had a significant adverse effect on Lifepoint. We estimate that we experienced more than $1 billion in lost revenue and incremental expenses in 2020 alone – resulting from government restrictions on elective procedures, shelter-in-place initiatives, and the increased costs associated with delivering high-quality COVID care. As you appreciate, the pandemic was a particularly challenging time for rural hospitals. An American Hospital Association (AHA) report found that 136 rural hospitals closed between 2020 and 2021; the report also noted that rural hospitals face particularly challenging staffing shortages, with only 10 percent of physicians practicing in rural areas.[1] The AHA report explained that access to capital, including through mergers, can provide important scale and support to rural hospitals, many of which are financially challenged or distressed.[2]

---

[1] *Rural Hospital Closures Threaten Access: Solutions to Preserve Care in Local Communities*, AMERICAN HOSPITAL ASSOCIATION 3 (Sept. 2022).
[2] *Id.*

These relief programs helped Lifepoint keep our facilities open and our employees on the payroll. Consequently, we were able to remain on the frontlines fighting the pandemic notwithstanding COVID's profound financial impact on Lifepoint and its hospitals.

Because COVID-related losses were significantly in excess of government grants and loans, Lifepoint raised additional liquidity through the issuance of new debt and accessing available lines of credit. The current liquidity position the company has today is because it is well-managed, with a responsible and forward looking leadership team. We have been able to continue to build and grow Lifepoint during and since the riskiest days of the pandemic because of our disciplined approach to operations and our deliberate emphasis on conservative financing of the business.

11. Explain your company's role in the decision to hire William Kiefer as CEO of Ottumwa Regional.

William Kiefer, DNP, MBA, RN, ACHE, was chosen to lead Ottumwa Regional for a number of reasons, most importantly because of his clinical background and experience in effectively engaging and mobilizing high-performing teams. He was also chosen because of his track record in leading facilities going through significant and challenging events.

Following Mr. Caraccio's death on October 15, Ottumwa Regional and Lifepoint together looked into the circumstances of his death. We brought an interdisciplinary team on-site to support the inquiry and simultaneously worked to address the urgent and immediate needs of our frontline staff.

It instantly became clear that the hospital would need to make a number of changes. It also became clear that Ottumwa Regional's incumbent CEO was not the right leader to see the hospital through the crisis. He consequently left Ottumwa Regional on November 1.

With division president Sandy Podley's leadership and close communication with the Ottumwa Regional board, our team identified Mr. Kiefer as the ideal candidate for interim leadership and announced that decision on November 2. After serving in the interim role for more than two months, Mr. Kiefer was appointed CEO on January 26 with the board's full support. He continues in that role today.

A nurse for nearly 20 years, Mr. Kiefer has substantial experience both at the bedside and in healthcare management in rural communities. Prior to his appointment at Ottumwa Regional, Mr. Kiefer served as the chief operating officer for Canyon Vista Medical Center, a Lifepoint hospital in Sierra Vista, Arizona. Before that, he served as CEO and CNO at hospitals including OmniPoint Health in Anahuac, Texas, Marias Medical Center in Shelby, Montana, and Rehoboth McKinley Christian Health Care Services in Gallup, New Mexico. He also held leadership and clinical positions at Texas hospitals including Red River Regional Hospital in Bonham, and

Lifepoint Health

Sierra Medical Center, El Paso. Through these diverse leadership roles, Mr. Kiefer's evidenced an ability to lead by example and achieve meaningful quality, operational and compliance goals.

12. Explain your company's relationship with William Kiefer, including any prior positions he held with your company or a related company.

Mr. Kiefer's prior experience is described in our response to item 11. Mr. Kiefer's first position with Lifepoint was in 2022 as chief operating officer Canyon Vista Medical Center, a Lifepoint hospital in Sierra Vista, Arizona.

In his short time at Ottumwa Regional, Mr. Kiefer has already had a significant impact. In addition to managing the hospital though the difficult months since Mr. Carracio's death and playing a central role in leading Ottumwa Regional's response to the ensuing investigations, he has focused on supporting our team and patients. Mr. Kiefer has improved staff engagement, introducing regular and open communications among stakeholders, including executive rounding, department meetings, town halls, and a CEO newsletter. He reintroduced monthly service and excellence awards to build staff pride and morale.

Mr. Kiefer has also focused on improving patient care. He instituted new customer service standards and launched training to roll these out and provide guidance to staff on how they can improve patient and family experiences. He has reconstituted and reinvigorated Ottumwa Regional's quality of care committees and has overseen the addition of new equipment, including new anesthesia carts, the progress of facility repairs and upgrades such as new flooring, and the implementation of new technology, including Omnicell software which is used in the hospital's pharmacy. He navigated changes in regional EMS services and oversaw pay increases for EMTs and paramedics to improve retention of these important emergency personnel. He led a reorganization of the hospital's dietary department, which has improved quality and services. He also is supporting expansion efforts including the catheterization lab initiative described in our response to item 1 and the reopening of Ottumwa Regional's intensive care unit.

*** ***

Lifepoint is proud of our nearly 25-year legacy of helping rural hospitals across the nation enhance the quality care and services provided and expand the many ways they support the health and wellbeing of their communities. We understand the critical role that rural hospitals play in supporting their communities' growth, and we welcome the opportunity to share more

Lifepoint Health

about Lifepoint, our work in Iowa, and our priorities at Ottumwa Regional. Thank you for the opportunity to engage on these important issues.

Sincerely,

Jennifer Peters

[redacted]

April 21, 2023

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Senator Grassley,

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint") and Ottumwa Regional Health Center ("Ottumwa Regional"). We again write on behalf of Lifepoint, RCHP Ottumwa, LLC—the Lifepoint indirect, wholly owned subsidiary that owns and operates Ottumwa Regional—and the Board of Directors of Ottumwa Regional.

This submission responds to a second subset of the questions set forth your March 17, 2023, letter. We herein summarize how Lifepoint, Ottumwa Regional, and affiliated entities work with one another and describe our policies, procedures, and approaches to various issues, including drug testing, medication safety, staff training, and security. In this submission, we also review some of the safety-related reforms we have adopted since the incident at Ottumwa. In the coming weeks, we will submit additional responses to your initial inquiries and the follow-up questions you have raised.

As always, we appreciate your commitment to and advocacy on behalf of rural hospitals and communities and welcome engaging with you as we work to achieve our mission of making communities healthier, both in Iowa and across the nation. Across the country, our employees and providers are celebrating being named last month by *Newsweek* as one of its five most trusted health systems based on a survey of approximately 25,000 people in the United States, confirming the esteem in which our patients and communities hold us.

---

3. **While invested in Ottumwa Regional Center or any related entity that has an interest in Ottumwa Regional, please describe your company's authority to:**
    a. **Manage its care delivery;**
    b. **Manage its billing practices;**
    c. **Determine its annual net income goals;**
    d. **Determine its charge per patient goals;**
    e. **Determine its staff-to-patient ratios;**
    f. **Determine its charge-to-cost ratios;**
    g. **Enter into contracts for staffing; and**
    h. **Enter into any contracts on behalf of Ottumwa Regional.**

Lifepoint supports care delivery at Ottumwa Regional and our other acute care hospitals through our National Quality Program and through assistance in recruitment and retention to meet national benchmarks. With its national scale, Lifepoint offers its facilities financial stability and security and access to clinical, quality, and operational experts by attracting talent across the country to advance care, improve operations, and support growth. Lifepoint at times provides its facilities with capital to invest in facility improvements, technology and people, and dedicated resources to help recruit providers and employees. Lifepoint has engaged Lifepoint Corporate Services, General Partnership ("LCSGP"), an indirect, wholly owned subsidiary of Lifepoint, through a Managerial and Administrative Support Agreement.

In addition, the Quality Committee of the Lifepoint Board of Directors has the authority to monitor and evaluate Lifepoint hospitals' quality of care metrics and patient safety programs, to review and discuss those metrics with Lifepoint senior management, and to receive reports from Lifepoint senior management on the hospital network's safety standard and preventative actions.

With respect to billing, Ottumwa Regional's finance team manages day-to-day billing responsibilities. Lifepoint engages a national third-party vendor with healthcare expertise, R1, to process claims generated by its facilities, including Ottumwa Regional as is customary in the healthcare industry. R1 is responsible for billing compliance and Lifepoint oversees its operations and monitors overall performance. In addition, Lifepoint has policies and procedures to monitor and manage billing practices at the facilities and ensure compliance.

Lifepoint does not set annual net income, charge per patient or charge-to-cost goals for Ottumwa Regional or any of our other acute care hospitals.

With respect to hiring, RCHP Ottumwa, LLC is responsible for selecting the hospital Chief Executive Officer after consultation with the Ottumwa Regional Board of Directors, which is comprised of community leaders, the hospital CEO, and members of the Ottumwa Regional medical staff. In addition to its responsibility regarding the selection of the hospital CEO, the Ottumwa Board of Directors oversees the overall quality and efficiency of patient care at Ottumwa Regional and the organization and governance of medical staff.

Lifepoint believes that empowering Ottumwa Regional's management team is critical to successfully identifying and meeting the needs of patients, medical staff, and the community as a whole. In addition to the CEO, Ottumwa Regional's management team includes a chief operating officer, a chief financial officer, and a chief nursing officer (CNO). The hospital management team has broad authority to conduct the day-to-day operations of Ottumwa Regional. The CEO is responsible for decisions concerning day-to-day general and clinical operations, human resources, and administration of Ottumwa Regional, with oversight by the Ottumwa Board of Directors. The Ottumwa Regional management team more generally is responsible for managing clinical care, developing an annual operating and capital budget for review with the Ottumwa Board of Directors, making staffing decisions and policies, and entering into contracts on behalf of Ottumwa Regional, including staffing contracts.

7. **To what extent does your company contractually shield itself from liability for activities that occur at the hospitals you invest in, operate, or manage?**

As detailed above, each of Lifepoint's hospitals is responsible for decisions relating to day-to-day delivery of care and operations and for the clinical staff and providers who practice in those hospitals, all of whom are licensed by the states in which the hospitals are located. Each acute care hospital subsidiary therefore is responsible for liabilities resulting from delivery of care or operations, such as professional liability and other claims. Lifepoint itself is not a licensed healthcare provider, nor does it hold provider numbers as a member of the Medicare and Medicaid programs. Lifepoint and its affiliates manage the collective liability risk of all our hospitals through programs of insurance, including professional liability, general liability, workers' compensation, and other types of coverage. This approach to insurance is typical for health systems.

Ottumwa Questions

4. **Explain Ottumwa Regional's relationship with LifePoint Health. Does the hospital rely on LifePoint for any management or operational services? Please provide all contracts with LifePoint.**

The response to Question 3 above provides an overview of Lifepoint's relationship with Ottumwa Regional. Lifepoint has engaged LCSGP, an indirect, wholly owned subsidiary of Lifepoint, through a Managerial and Administrative Support Agreement (MASA). Pursuant to the MASA, LCSGP provides management, administration, consulting, and purchasing services to Ottumwa Regional. Lifepoint and LCSGP are also party to a HIPAA Business Associate Agreement.

5. **Please describe how LifePoint's involvement impacted Ottumwa Regional's authority to:**
    a. **Manage its care delivery;**
    b. **Manage its billing practices;**
    c. **Determine its annual net income goals;**
    d. **Determine its charge per patient goals;**
    e. **Determine its staff-to-patient ratios;**
    f. **Determine its charge-to-cost ratios; and**
    g. **Enter into contracts for staffing.**

The response to Question 3 above provides an overview of Lifepoint's relationship with Ottumwa Regional and its operations.

6. **Describe Ottumwa's policies and procedures for vetting staff, including drug testing, from January 1, 2010, to the present.**

Once an applicant has accepted a position, Ottumwa Regional's human resources (HR) department sends out a background check to be completed electronically through Sterling, a third-party vendor.

The HR department at Ottumwa Regional uses the online background check program as well as relevant websites (including SING, OIG, SAM) to verify that the prospective employee meets standards for employment.

The designated background investigation level assigned to each applicant is based on that individual's role and level of responsibility. Ottumwa Regional reserves the right to conduct background investigations on individuals throughout the course of their employment or provision of volunteer services.

We have included additional information about the background checks for each level of employment at Appendix A.

Drug Screening

With respect to drug screening, all candidates being offered a position are required to complete a pre-employment drug screen as a condition of hiring and may not begin work prior to receipt and review of the test results. Ottumwa Regional works with Sterling as its third-party vendor for this as well. Pre-employment drug screening also applies to students, volunteers, and auxiliary personnel. A refusal to undergo the test, or a confirmed positive test result, as well as any attempt to tamper with, substitute, adulterate, or otherwise falsify a test sample will result in denial of employment. When a prospective employee has a test result that is confirmed as positive, the prospective employee is considered to be in violation of company policy, and the conditional offer of employment is rescinded for a minimum of one year.

Before results are reported to Ottumwa Regional, an independent Medical Review Officer (MRO) (a medical doctor with an expertise in toxicology) reviews and interprets any confirmed positive test results, ensures the chain of custody is complete and sufficient on its face, and confirms that any additional relevant information provided by the individual is considered. Any individual whose test is positive for the presence of drugs is notified by the MRO and then given an opportunity to provide the MRO, in confidence, with any legitimate explanation he or she may have that would explain the positive drug test (all documentation must be sent to the MRO no later than five business days after notification).

7. Describe all policies and procedures related to controlled substances, including medication safety, facility security, and staff training, from January 1, 2010, to the present.

Ottumwa Regional is accredited by The Joint Commission (TJC) for Hospitals. The most recent TJC survey took place in July 2022. Ottumwa Regional is compliant with Joint Commission Medication Management standards and elements of performance. This includes the following critical areas of performance in the Medication Management Chapter:

- Managing high-alert and hazardous medications
- Selecting and procuring medications

- Storing medications
- Managing emergency medications
- Controlling medications brought into the hospital by patients, their families, or licensed independent practitioners
- Managing medication orders
- Preparing medications
- Labeling medications
- Dispensing medications
- Retrieving recalled or discontinued medications
- Administering medications
- Managing investigational medications
- Monitoring patients' reactions to medications
- Responding to real or potential adverse drug events, adverse drug reactions, and medication errors

In addition to TJC requirements for Medication Management, the Iowa Board of Pharmacy conducts an on-site inspection approximately every two years; the most recent inspection took place in February 2021. The inspection included no adverse findings. The facility has policies to support safe medication use and to enhance processes, oversight, and security of medications, including controlled substances. Required policies to support safe medication use are in place and have been in place at the facility since 2018.

The facility uses automated dispensing cabinets (ADC) for the majority of medications distributed to patients, and the pharmacy reviews medication orders prior to administration (including after hours when the pharmacy is closed, when remote order entry pharmacists review medication orders). Medication overrides (vending from ADC prior to pharmacy order review) are limited to urgent situations. The pharmacy routinely reviews and audits medication overrides and discrepancies and deploys various other strategies to support safe medication use.

The pharmacy leads a Pharmacy and Therapeutics Committee to oversee medications, processes, and policies for medications available on formulary and processes to support medication safety and patient monitoring. This includes but is not limited to adverse drug events, drug recalls/shortages, hazardous medication handling, high alert medications, and medication safety and clinical initiatives (e.g., Antibiotic Stewardship, antibiotic dosing optimization, renal dosing, pharmacokinetic dosing, and IV to PO conversion by pharmacists).

The facility uses Computerized Provider Order Entry (CPOE) at the point of medication ordering and Barcode Medication Administration (BCMA) at the point of care for scanning patients and medications.

In December 2022, Ottumwa Regional voluntarily instituted a Controlled Substance Compliance Program with oversight from Guidepost Solutions, a third-party consulting firm made up principally of former DEA agents/investigators. Guidepost was onsite at the facility frequently during the first

90 days of the Program and is conducting additional oversight. The facility also contracted with another third-party company - CPS Solutions - to provide additional on-the-ground pharmacist support services on a day-to-day basis.

In addition to the manual report review, Ottumwa Regional in February 2023 implemented drug diversion prevention surveillance software, which matches controlled substance medications dispensed from the ADC with documentation in the EHR, as well as documentation of waste, if applicable, on a patient-specific basis. Routine audits are completed for clinical areas with manual documentation for medications administered.

Training related to controlled substances:

In December 2022, Guidepost Solutions also conducted 16 in-person training sessions at Ottumwa Regional regarding the facility's Controlled Substance Compliance Program. The training was provided to all Ottumwa Regional employees; over 500 employees attended the training.

Guidepost provided two additional trainings in February 2023. One training provided to all employees, "Drug Diversion in Healthcare Facilities and Tampering," covered DEA regulations, recognizing the impaired individual, and the impact of drug diversion, as well as recognizing/reporting tampering and potential drug diversion. A second training, "Pyxis Controlled Substance Training," was provided to all employees with access to controlled substances, focusing on Pyxis functionality for controlled substances, requirements for controlled substance vending, administration, documentation, and wastage, and recordkeeping and reporting requirements related to all medications, including controlled substances. All trainings emphasized the compliance hotline and support available as it relates to controlled substance diversion prevention and detection.

Ottumwa Regional presents a General Hospital Orientation to new employees that covers drug diversion prevention and other policy requirements around medication management. Since 2019, annual required trainings for Ottumwa Regional staff include training on "ORHC Pyxis" and "Drug Diversion Prevention Program."

Facility security:

In addition to the detailed facility Controlled Substance policy that outlines security requirements for all processes involving controlled substances (including physical/electronic surveillance, key accountability, storage devices, badge access, door hardware, and personnel), a facility security evaluation was completed by Guidepost during onsite inspections between October 2022 and February 2023. This security evaluation led to additional camera coverage in medication storage locations and improved door security throughout the facility. Nearly 90 additional cameras were positioned throughout Ottumwa Regional. The facility has implemented tighter controls around prescription pad access since October 2022. Since on or before 2018, security-related policies in place at Ottumwa Regional include a policy on the Security Management Plan and Security Within the Pharmacy.

We have included additional detail about the policies and procedures governing controlled substances at Appendix B.

Sincerely,

Jennifer Peters

[redacted]

Appendix A

In addition to the background checks listed below, Ottumwa Regional runs the SING, which is a single contact and license background check, which includes Iowa criminal history, Iowa central abuse registries, and the Iowa sex offender registry.

Level 1 – Background Investigation for all Volunteers, Students, and Applicants for employment whose job description does not require a High School Diploma or General Education Diploma (GED)

1. Social Security Trace
2. Criminal Records Search – County Criminal and/or Statewide Criminal Record Search(es) - 7 years of resident address history or up to 5 criminal searches
3. National Wants and Warrants Submission
4. US Criminal Records Indicator (includes a simultaneous search of 50 state sex offender registries and over 200 criminal records)
5. FACIS – Level I a. OIG List of Excluded Individuals/Entities b. GSA List of Parties Excluded from Federal Programs c. U.S. Treasury, Office of Foreign assets Control (OFAC), List of Specially Designated Nationals (SDN) d. Applicable State Exclusion List

Level 1B – Background Investigation for all Applicants for employment whose job description requires a High School Diploma or General Education Diploma (GED)

1. Social Security Trace
2. Criminal Records Search – County Criminal and/or Statewide Criminal Record Search(es) - 7 years of resident address history or up to 5 criminal searches
3. National Wants and Warrants Submission
4. US Criminal Records Indicator (includes a simultaneous search of 50 state sex offender registries and over 200 criminal records)
5. FACIS – Level I a. OIG List of Excluded Individuals/Entities b. GSA List of Parties Excluded from Federal Programs c. U.S. Treasury, Office of Foreign assets Control (OFAC), List of Specially Designated Nationals (SDN) d. Applicable State Exclusion List
6. High School Diploma or GED

Level 2 – Background Investigation for all Department Managers and Finance Personnel

1. Social Security Trace
2. Criminal Records Search – County Criminal and/or Statewide Criminal Record Search(es) - 7 years of resident address history or up to 5 criminal searches
3. National Wants and Warrants Submission
4. US Criminal Records Indicator (includes a simultaneous search of 50 state sex offender registries and over 200 criminal records)

5. FACIS – Level III a. OIG List of Excluded Individuals/Entities b. GSA List of Parties Excluded from Federal Programs c. U.S. Treasury, Office of Foreign assets Control (OFAC), List of Specially Designated Nationals (SDN) d. Applicable State Exclusion List e. Professional Disciplinary Action Search f. Certifications & Designations Check
6. Education Verification (Highest level obtained that pertains to role as stated in job description)
7. Consumer Credit Report
8. Motor Vehicle Report – based on responsibilities
9. Professional License – based on responsibilities

Level 2B – Background Investigation for all licensed or certified caregivers

1. Social Security Trace
2. Criminal Records Search – County Criminal and/or Statewide Criminal Record Search(es) - 7 years of resident address history or up to 5 criminal searches
3. National Wants and Warrants Submission
4. US Criminal Records Indicator (includes a simultaneous search of 50 state sex offender registries and over 200 criminal records)
5. FACIS – Level III a. OIG List of Excluded Individuals/Entities b. GSA List of Parties Excluded from Federal Programs c. U.S. Treasury, Office of Foreign assets Control (OFAC), List of Specially Designated Nationals (SDN) d. Applicable State Exclusion List
6. Education verification highest level obtained
7. Motor Vehicle Report – based on responsibilities.
8. Professional License/Certification – based on responsibilities

Investigation Criteria: Criminal Record

A conviction within the past seven years for any of the following felonies or crimes that Lifepoint views as job-related will receive a "Review" adjudication, which bars a candidate from further consideration of employment with RCHP Ottumwa, LLC or any of its affiliates.

a) Crimes involving drugs including, but not limited to, unlawful possession or distribution or intent to distribute unlawfully, Schedule I through V drugs;
b) Crimes involving physical violence including, but not limited to, abuse of children or elderly, abduction, including kidnapping, manslaughter, murder, robbery, sexual crimes and assault and battery;
c) Crimes involving the illegal use or possession of weapons including, but not limited to, guns, knives, explosives or other dangerous objects;
d) Crimes involving fraud, dishonesty or embezzlement;
e) Crimes against property including, but not limited to, arson, theft, larceny and burglary;

f) Crimes showing dishonesty including, but not limited to, fraud, deception or financial exploitation of any person (i.e., worthless checks, extortion or falsifying documents);
g) Other felony crimes which may have job relatedness; A confirmed record of sanction, disbarment, exclusion, or other disciplinary action found on the FACIS Records Search;
h) Other serious crimes that may have job relatedness.

Appendix B

Policies and procedures related to controlled substances:

Policies involving Controlled Substances in place between 2018 and 2022 include, but are not limited to the following:

- Policies outlining access to medication;
- Medication handling;
- Administration of medications;
- Documentation of outdates, wastage, and returns of medication;
- Controlled substance destruction, handling, distribution, and control;
- Drug diversion program requirements;
- Anesthesia carts – utilization and stocking;
- Drugs used in emergency management services (EMS); and
- Automated medication dispensing system (ADC) discrepancies and reporting unresolved discrepancies.

As part of its Controlled Substance Compliance Program, Ottumwa Regional evaluated and instituted enhanced controlled substance procedures and a controlled substance policy. The procedures outlined in the policy minimize the potential for drug diversion across the entire medication use process, including medication processes involving procurement, ordering/prescribing, inventory and accountability controls, distribution, administration, disposal/waste, storage, and expired returns.

The controlled substance policy addresses:

- DEA registration and licensure,
- Power of Attorney,
- DEA Controlled Substance Ordering System,
- Controlled substance abuse, theft or significant loss,
- Purchasing/receiving records,
- Discrepancies/shortages/breakage,
- Invoice records control,
- Controlled substance security storage and restricted access,
- Inventories,
- Dispensing records,
- Waste/disposal,
- Resolving/reporting discrepancies, and
- Monitoring and evaluation of controlled substances.

This controlled substance policy requires "closed loop" accountability of all controlled substances as well as related recordkeeping, security cameras and controlled access, in addition to elevation processes for any controlled substance discrepancies or security concerns related to controlled

substances throughout the facility. The facility is also conducting weekly accountability audits (certified by the third-party consulting firm) for two schedule II controlled substances and two schedule III-V controlled substances, which are supplemented by full physical inventories of all controlled substances conducted on an annual basis.

Ottumwa Regional's controlled substance policy further outlines the manual review of various reports by pharmacy, nursing, and hospital leadership. These reports include, but are not limited to, the following:

- *Open and Closed Discrepancy Report* – Review for patterns or trends by user, medication, time of day, or day of the week
- *Compare Reports* – Review to validate that controlled substances delivered or returned are actually received and not diverted
- *Override Dispense Report* – Review to ensure order and administration documentation exists for medications overridden prior to medication order review by pharmacy
- *ADMS Dispense Compare to e-MAR Administration Discrepancy Report* – Identifies drugs dispensed or removed to ensure administration documentation including wastage
- *Dispensing Practices/Proactive Diversion or Anomalous Usage Report* – Review various time intervals to identify user practices that fall outside of the norm for that unit or a specific medication
- *Events by User* – Review for outliers discovered in the Dispensing Practices/Proactive Diversion report
- *Null/Cancel Transactions* – Review for patterns of same drug or user.

These reports are tracked on a daily, weekly, and monthly report review as part of the facility's Controlled Substance Audit Tool. Compliance with the policies and procedures established under the Controlled Substance Compliance Program is also monitored by a third-party consulting firm. Routine review of the program will be incorporated in order to consider additional risk mitigation strategies and to ensure ongoing compliance.

May 5, 2023

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Senator Grassley,

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint") and Ottumwa Regional Health Center ("Ottumwa Regional"). We again write on behalf of Lifepoint, RCHP Ottumwa, LLC—the Lifepoint indirect, wholly owned subsidiary that owns and operates Ottumwa Regional—and the Board of Directors of Ottumwa Regional.

This submission sets out additional details about the relationship between Lifepoint and Ottumwa Regional. We anticipate making additional submissions in response to the questions set forth in your March 17, 2023, letter.

We have enclosed with this production the following documents, which include documents with proprietary business information. The documents have been marked "Confidential Treatment Requested." We request that these documents not be disclosed publicly or to any third party and, to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

- The Managerial and Administrative Support Agreement between Lifepoint Corporate Services, General Partnership and RCHP-Ottumwa, LLC, at LP-CEG-000001 through LP-CEG-000029;
- The Limited Liability Company Agreement of RCHP-Ottumwa, LLC, at LP-CEG-000030 through LP-CEG-000035;
- The Asset Purchase Agreement Among Ottumwa Regional Health Center, Inc., Regional Retirement Living, Inc., Regional Enterprises, Inc., RCHP-Ottumwa, Inc., and RegionalCare Hospital Partners, Inc., at LP-CEG-000036 through LP-CEG-000120;
- Ottumwa Regional's Community Benefit Reports from 2019 to 2021, at LP-CEG-000121 through LP-CEG-000128;
- Curriculum Vitae of Bob Barrett, David Critchlow, David Dill, Jason Zachariah, Sandy Podley, and William Kiefer, individuals described in the response to Request 9 from Lifepoint's March 31, 2023, letter, at LP-CEG-000129 through LP-CEG-000147;
- A redacted version of the Second Amendment to Professional Services Agreement between RCHP Ottumwa, LLC and Apogee Medical Management, Inc., and the Business Associate Addendum to Contract., at LP-CEG-000148 through LP-CEG-000196; and

Lifepoint Health 1330 Seven Springs Way I Brentwood, TN 37027 I 615.920.7000 I www.lifepointhealth.net

- A list of third-party staffing contracts for Ottumwa Regional since November 2018, at LP-CEG-000197 through LP-CEG-000200.

Since acquiring Ottumwa Regional in 2018, Lifepoint has invested consistently in the hospital. From 2019 to the present, Ottumwa's earnings before income tax, depreciation, and amortization ("EDITDA") (excluding COVID funds) have been approximately negative $8.2 million. Taking into account COVID funds, Ottumwa Regional has realized a total positive $1.5 million in EBITDA over those same years. Ottumwa Regional's cumulative net loss since 2019, taking into account COVID funds, is approximately $33 million.

Since 2019, Ottumwa Regional's revenue has declined significantly (from a high of approximately $93 million before COVID to $80.5 million in 2022). During this period, per-paid-hour-labor costs have risen 34 percent, and patient volume has decreased 18 percent.

The challenges at Ottumwa Regional have persisted even as the pandemic has abated, consistent with the challenges health care providers across the country—and particularly in rural areas—are continuing to experience. High inflation has affected the cost of supplies and labor, and Ottumwa Regional has experienced significant staffing shortages. These difficulties are of course not unique to Ottumwa Regional but have had an acute effect on the hospital's operations. Indeed, in 2023, Ottumwa Regional's year-to-date EBITDA is negative $5 million, and its net losses exceed $8 million.

Given the financial challenges that Ottumwa Regional has faced and continues to face, Lifepoint's financial backing has been and remains integral to Ottumwa Regional's ability to serve the community. In that regard, Lifepoint has continued to invest in Ottumwa Regional as described in response to Question 1 in our March 31, 2023, letter. Since October 2022, Lifepoint has contributed over $2 million to Ottumwa Regional and plans on contributing an additional $800,000 by the end of the year. This investment includes over $1 million in capital improvements, such as the installation of a new pharmacy and medication management system, a more extensive camera system, and upgrades to the pharmacy's locks and doors, as well as investments in additional oversight and training.

Ottumwa Questions

7. Explain the vetting process utilized when selecting CPS as a third-party contractor for pharmacy solutions. Identify all individuals involved in this decision.

As part of our national drug diversion prevention efforts, Lifepoint partners with a number of outside experts to evaluate our system, identify gaps and areas for improvement, and provide support in areas such as pharmacy operations, education and training and ensuring that we have the right policies and procedures in place to protect our staff and patients.

We have partnered with leading experts including Guidepost Solutions's DEA Regulatory Compliance practice—whose work we described in our April 21, 2023, submission—and professionals from Comprehensive Pharmacy Services ("CPS"), which offers pharmacy support services to healthcare facilities across the nation.

CPS is a pharmacy management company with more than 50 years of experience and with over 2,200 pharmacy professionals on staff; it works with over 800 healthcare organizations. CPS has a number of specific resources dedicated to clinical, regulatory, and operational support, among other specific areas. The team at CPS has provided both short- and long-term onsite support in several of our facilities' pharmacies for a few years. These experts help to evaluate pharmacy operations and policies on diverse issues from medication management and wasting to documentation. Lifepoint has worked with CPS for several years at various facilities. That prior experience, CPS's known expertise in the industry, and a desire to enhance Ottumwa Regional's pharmacy operations led to the engagement of CPS.

CPS employs the Director of Pharmacy ("DOP") at Ottumwa Regional and provides additional resources to support the DOP's efforts. The DOP also reports locally to the CEO and is supported by the Lifepoint Pharmacy Operations team.

8. Provide all third-party staffing contracts from January 1, 2010, to the present.

Enclosed at LP-CEG-000148 through LP-CEG-000196 are redacted agreements between Apogee Medical Management, Inc. and RCHP-Ottumwa, LLC. Enclosed at CEG-000197 through LP-CEG-000200 is a list of third-party clinical service agreements for Ottumwa Regional that have been executed since November 2018, when Lifepoint acquired Ottumwa Regional. The list was generated from Lifepoint's contract management system.

Sincerely,

Jennifer Peters

[redacted]

Lifepoint Health 1330 Seven Springs Way I Brentwood, TN 37027 I 615.920.7000 I www.lifepointhealth.net

May 12, 2023

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Senator Grassley,

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint") and Ottumwa Regional Health Center ("Ottumwa Regional"). We again write on behalf of Lifepoint, RCHP Ottumwa, LLC—the Lifepoint indirect, wholly owned subsidiary that owns and operates Ottumwa Regional—and the Board of Directors of Ottumwa Regional.

This submission completes our response to the questions set forth in your March 17, 2023, letter and sets out additional details about the relationship between Lifepoint and Ottumwa Regional.

---

3. While invested in Ottumwa Regional Center or any related entity that has an interest in Ottumwa Regional, please describe your company's authority to:

g. Enter into contracts for staffing

Lifepoint's Division Presidents serve as the Chief Executive Officers and managers for the legal entities through which Lifepoint owns its hospitals. As officers of those entities, Division Presidents, with input from each hospital's Board of Directors, are responsible for hiring the CEOs of the hospitals within their respective divisions.

Sandy Podley is the Division President of the division that includes Ottumwa Regional, and she consequently serves as the President of RCHP Ottumwa, LLC. In that role, Ms. Podley was responsible for first appointing William Kiefer as the interim CEO of Ottumwa Regional in November 2022 and then hiring him as the permanent CEO in January 2023. Mr. Kiefer was appointed as the Chief Executive Officer of Ottumwa Regional on January 19, 2023, by the Ottumwa Board of Directors.

Following the events at Ottumwa Regional relating to the now-deceased nurse practitioner, Lifepoint and Ottumwa Regional recognized that there needed to be a change in leadership. Ms. Podley decided to choose an interim candidate from among Chief Operating Officers at Lifepoint hospitals in the Western Region whom she believed to be ready to become a CEO. Ms. Podley ultimately believed Mr. Kiefer to be the best candidate, as she knew that physicians from hospitals he oversaw had extremely positive things to say about him, and she believed he had proven himself a strong leader. At that time, Ms. Podley had known Mr. Kiefer, and the contributions Mr. Kiefer had made at the hospitals in which he was staffed, for over seven years.

Lifepoint Health 1330 Seven Springs Way I Brentwood, TN 37027 I 615.920.7000 I www.lifepointhealth.net

Mr. Kiefer's appointment as permanent CEO was similar to appointments of other CEOs at Lifepoint hospitals. Ms. Podley reviewed several candidates' applications for the position, and proposed two potential candidates for CEO to the Lifepoint Board of Directors. Ms. Podley interviewed Ottumwa Regional officers, directors, key medical staff, the Medical Executive Committee, and Ottumwa Regional Board members, about Mr. Kiefer. Ms. Podley then presented the Lifepoint Board of Directors with the hospital employees' evaluations of Mr. Kiefer, which were overwhelmingly positive. Mr. Kiefer was also interviewed by several senior Lifepoint employees. Ultimately, Mr. Kiefer was selected and appointed CEO.

As detailed in our letter on March 31, 2023, Mr. Kiefer has significant experience managing and operating rural hospitals through challenges. He has more than twenty years of experience in patient care, both as a healthcare executive and nurse, working in various rural communities where he has strived to increase and improve the delivery of healthcare services, particularly culturally competent and individualized services. Since being appointed interim CEO of Ottumwa Regional, Mr. Kiefer has been instrumental in strengthening Ottumwa Regional's compliance program and culture more generally. He has instituted a number of policies and practices aimed at opening communications channels between the staff and senior management at Ottumwa Regional and has frequently elicited feedback from hospital staff on how to improve engagement between Ottumwa Regional and the community. Mr. Kiefer has reinvigorated Ottumwa Regional's quality and safety committees and continues to provide robust leadership for the hospital. Those initiatives, Mr. Kiefer's stewardship of Ottumwa Regional through the initial difficulties following Devin Caraccio's death, and the enthusiasm for his leadership among Ottumwa Regional stakeholders led Ms. Podley and the Ottumwa Board of Directors to appoint Mr. Kiefer as the permanent CEO of the hospital.

Before joining Ottumwa Regional, Mr. Kiefer served as Chief Operating Officer at Canyon Vista Medical Center ("Canyon Vista"), a Lifepoint hospital in Sierra Vista, Arizona for seven months. At Canyon Vista, Mr. Kiefer frequently engaged with employees to enhance morale and staff trust during the COVID-19 pandemic. During his time at Canyon Vista, Mr. Kiefer also improved the direct admission process and inbound acceptance rate. His successful efforts to support and engage operating room staff and providers resulted in increased staffing support and expanded access to timely surgical care for Canyon Vista's patients.

Mr. Kiefer previously served as CEO and Chief Nursing Officer at non-Lifepoint hospitals including OmniPoint Health in Anahuac, Texas, Marias Medical Center in Shelby, Montana, and Rehoboth McKinley Christian Health Care Service in Gallup, New Mexico. During his tenure at these facilities, he improved operational efficiency; developed new mission, vision, and values for the facilities; partnered with local health systems; participated in frequent communications with the staff to improve culture; and improved patient experience scores. He also was not afraid of making changes to improve facilities, even when that created personal or professional hardship for him. He also was instrumental in developing strategic plans that included capital projects to provide new equipment to facilities.

Mr. Kiefer has shown strength and integrity in his previous roles, which he continues to exhibit as a leader at Ottumwa Regional.

Mr. Kiefer is deeply committed to and engaged with the broader professional community of healthcare facility managers. He has served as Vice President of the Texas Medical Foundation Executive Board, is a member of the American College of Healthcare Executives, and has been a Healthcare Fellow of both the National Rural Health Association (NRHA) and the Texas Organization for Rural and Community Hospitals (TORCH). Mr. Kiefer is also a partner in the Billion Pill Pledge Program, launched by former-Iowa State Attorney General Tom Miller, which seeks to reduce the number of opioid pills in homes and communities by a billion pills per year, and thereby reducing reliance on opioid medications.

4. Does your company have plans to invest capital in Ottumwa Regional? If so, please describe them. If not, why not?

Lifepoint and Ottumwa Regional are in the planning stages of investing an additional $3.1 million in Ottumwa Regional this year. Among other things, the investments are intended to upgrade Ottumwa Regional's physical facilities and enhance its medical equipment. Lifepoint and Ottumwa Regional are dedicated to raising the standard of care for patients of Ottumwa Regional and intends to continue making investments at Ottumwa Regional.

6. Explain in detail the reason for the 2019 sale-leaseback of Ottumwa Regional. What were the terms of the 2019 sale-leaseback transaction? How did you sell this to the local communities and hospitals? Please provide all records.

Lifepoint's sale-leaseback transaction involved 11 facilities, including Ottumwa Regional, within six markets. The transaction resulted in $700 million total proceeds to Lifepoint. In addition, although the sale-leaseback transaction led to a $50 million annual rent expense for Lifepoint as a whole, the transaction helped lower Lifepoint's interest payments by approximately $96 million, resulting in annual net savings of approximately $46 million.

The sale-leaseback was part of a multi-step plan for Lifepoint to lower its monthly costs paid in connection with debt Lifepoint incurred in 2018. A portion of the $700 million in proceeds from the sale-leaseback ($400 million) was used to pay off Lifepoint's existing debt, which lowered overall interest costs for all involved Lifepoint facilities, including Ottumwa Regional. In addition to selling 11 facilities and leasing them back, Lifepoint also refinanced its remaining outstanding debt to lower its interest payments; by redeeming notes with a rate of 8.25 percent and 11.5 percent in favor of notes with a rate of 4.375 percent, Lifepoint saved significant amounts over the life of the loans. The interest rate on the term loan facility was also decreased from LIBOR plus 4.5 percent to LIBOR plus 3.75 percent.

With this improved financial position, Lifepoint was able to invest $300 million in Lifepoint communities across the country. That investment, along with other money Lifepoint regularly contributes to its hospitals, was used to recruit new providers, grow vital services, and make needed renovations and technology purchases, among other things. At Ottumwa Regional, the investments during this period permitted, as we described in our March 31, 2023, letter, a new $4.5 million linear accelerator in 2020, $5.2 million in OR video towers, a portable digital X-ray machine, and

equipment for Ottumwa Regional's radiation oncology department in 2021, $2 million in a new DaVinci robot, and $4.5 million in expansions and upgrades to the cardiac catheterization lab.

None of the proceeds from the sale leaseback were paid out to Lifepoint's shareholders.

9. **How much money did your company receive in COVID-19 stimulus aid, including CARES Act dollars and grants? Provide an explanation as to why your company needed federal stimulus aid. Describe in detail how these funds were allocated. Specifically, you asked:**

    a. **Why did Lifepoint need COVID aid?**
    b. **How did Lifepoint allocate and use its COVID aid?**
    c. **How much went to each hospital?**
    d. **How much went to rural hospitals (Woodard commented critically that it would be useful to know whether federal funds went to facilities in Wyoming or North Carolina)?**

Ottumwa Regional received approximately $9.15 million in federal COVID-related grants and approximately $417,000 in state grants. These funds helped Ottumwa Regional navigate nearly $33 million in revenue losses during the COVID pandemic and compensate for more than $3 million in COVID-related expenses. Across the broader Lifepoint system, rural facilities received approximately $314.21 million in federal COVID-related grants and approximately $31.12 million in state grants.

Prior to receiving the funds, Lifepoint attested to the terms and conditions required for obtaining CARES Act funds, including that Lifepoint facilities that received the funds:

- Provided, after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19;
- Would use the payments only to prevent, prepare for, and respond to coronavirus;
- Would accept the payment as reimbursement only for health care related expenses or lost revenues that are attributable to coronavirus;
- Would not use the payment to reimbursement expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse;
- Would maintain appropriate records and cost documentation; and
- Would refrain from balance billing for all care for individuals with a presumptive or actual case of COVID-19 (e.g., that any out-of-pocket expenses collected would not be greater than if the same treatment was provided by an in-network provider).

After attesting to the above conditions, Lifepoint was provided funding from the CARES Act based on calculations by the federal government.

Following receipt of the CARES Act funds, Lifepoint was required to provide financial data to the United States Department of Health and Human Services ("HHS") to show that the funds it received were used either to (1) prevent, prepare for, or respond to COVID-19; or (2) for

reimbursement of lost revenues that were attributable to COVID-19. The financial data included information about expenses attributable to COVID-19 that was not reimbursed by other sources, as well as lost revenues attributable to COVID-19. The data demonstrated that Lifepoint did not receive more than it was entitled to under the CARES Act, which would have required Lifepoint to refund funds back to the government.

Lifepoint used a two-step reporting process in evaluating its use of COVID-related funding:

First, Lifepoint calculated the amount of COVID-related expenses incurred by its facilities, removing any funds that were reimbursed by other means, including payments received from business insurance, patients, and/or federal, state, or local government. Lifepoint facilities' COVID-19 expenses included both (1) general and administrative ("G&A) expenses, including personnel and other workforce-related actual expenses paid to prevent, prepare for, or respond to the coronavirus, such as expense for workforce training, staffing, and temporary employee or contractor payroll, and (2) healthcare related expenses, including supplies, such as personal protective equipment ("PPE"), hand sanitizer, or supplies for patient screening. Lifepoint did not account for any of its capital expenditures or long-term expenses in calculating COVID-expenses, even though Lifepoint facilities had collectively spent approximately $5 million in capital and long-term expenses as a result of COVID-19 (e.g., for long-term construction projects such as emergency room redesign to better accommodate patients being treated for COVID-19). Lifepoint discussed this two-step approach for calculating COVID-losses with its auditors and several reputable accounting firms, all of which concurred that Lifepoint's approach was reasonable. Further, Lifepoint consulted with several peer organization regarding these accounting processes, and they had largely followed the same reporting process as described.

Second, Lifepoint calculated lost revenues attributable to coronavirus by looking at the negative change in year-over-year revenue losses from patient care at each hospital. Lifepoint then aggregated the revenue losses of the hospitals.

Lifepoint's CARES Act funding, which included the total from the expenses category and the lost revenue category, was then placed into a segregated, central account. Funds were drawn from that account only when needed to pay for expenses or lost revenue related to COVID-19.

Lifepoint applied for CARES Act funds only pursuant to the HHS's guidance from September 19, 2020. Although HHS later revised the guidance and made new guidance available in October 2020, Lifepoint did not apply for additional funds. Lifepoint understands that, if it had applied under the October 2020 guidance, an additional $18 to $20 million in COVID-related expenses and losses would have been eligible for reimbursement under the Cares Act Fund.

Lifepoint completed provider relief funds audits to ensure that Lifepoint and its subsidiaries complied with all federal regulations regarding COVID funds.

Ottumwa Questions

1. **Who oversaw and authorized the 2019 sale-leaseback transaction? Why did the hospital believe it was in the best interest of Ottumwa Regional? Please provide the names and titles of all individuals involved in this transaction.**

The Lifepoint Board approved the sale leaseback agreement at a special meeting of the Board of Directors on October 30, 2019.

2. **How did the sale-leaseback impact operations at Ottumwa Regional? Please list staffing ratios per patient before and after the transactions. Please list any cost-cutting measures following the sale-leaseback.**

Although the sale-leaseback transaction led to a $50 million annual rent expense for Lifepoint, the transaction helped lower Lifepoint's interest payments by approximately $96 million, resulting in annual net savings of approximately $46 million, which has allowed Lifepoint to make investments in its hospitals. As we stated in our March 31, 2023, letter, Lifepoint is responsible for the facilities' rent expenses.

Since the sale-leaseback, Lifepoint's investment has exceeded its contractual commitment under the asset purchase agreement, which requires that Lifepoint reinvest a minimum of 5 percent of net patient revenue in Ottumwa Regional. The average percent invested since the sale-leaseback has been 5.42 percent.

Staffing ratios for direct patient care have remained relatively stable since 2019, despite significant staffing challenges posed by the COVID pandemic. Current staffing ratios for direct patient care at Ottumwa Regional exceed Lifepoint benchmarks. Man-hours/patient ratios in intensive care/critical care increased from 19.44 in 2019 to 25.55 in 2022. For medical/surgical nursing, those ratios decreased from 11.99 in 2019 to 10.90 in 2022, and in the emergency room, the ratios decreased slightly from 2.87 in 2019 to 2.75 in 2022. Although Ottumwa Regional's operations were largely suspended in 2020 as a result of the COVID-19 pandemic, Lifepoint and Ottumwa Regional strived to ensure that staffing ratio stayed stable, and in the case of intensive care and critical care, improved. Moreover, at the height of the pandemic in 2020, Ottumwa Regional continued to pay full-time employees, even when their jobs were limited by COVID-19 restrictions.

Additionally, since 2019, wages for individual employees have increased at Ottumwa Regional. In 2019 and 2021, wages increased by 1.5 percent annually, and in 2022, wages increased by 3 percent annually. Ottumwa Regional plans on increasing individual wages by an average of 3 percent annually again in 2023. Even in 2020, during the beginning of COVID, Ottumwa Regional ensured that wages did not decrease.

More generally, Ottumwa Regional's cost-related decisions are influenced directly by the demands and needs of patients, as well as staffing availability at the hospital. Similar to medical providers across the world, Ottumwa Regional was significantly affected by COVID-19, and was forced to reevaluate its spending in light of federal regulations and state regulations prohibiting elective

procedures and a shortage of nurses. The sale-leaseback transaction did not influence Ottumwa Regional's budgeting.

3. Describe in detail how Ottumwa utilized the funds it received from the 2019 sale-leaseback.

The response to Question 6 above provides an overview of the allocation of funds Lifepoint received from the 2019 sale-leaseback transaction.

Sincerely,

Jennifer Peters

[redacted]

WILMERHALE

December 20, 2023

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint" or the "Company").

This submission responds to a subset of the questions set forth in your letters of December 6, 2023 (the "Requests"). Enclosed with this letter are documents regarding the Lifepoint Board of Directors and aspects of its authority, as well as information on liability and insurance. We plan to make our next production of documents on or before January 17, with rolling responses thereafter.

We have included in this production documents with proprietary business information. The documents have been marked "Confidential Treatment Requested." We request that these documents not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Lifepoint Questions

10. From 2018 to the present, provide the name, title, Board tenure, and committee assignments of all individuals on Lifepoint's Board. Produce all documents that support your answer.

We have included this information in a chart at Appendix A.

11. Explain how Lifepoint contractually shields itself from liability of any kind for activities that occur at the hospitals the company invests in, operates, or manages. Produce all documents that support your answer, including any provisions related to liability of any kind in any of your written agreements.

Enclosed is the Lifepoint Health Annual Report for Fiscal Year 2022, at LP-CEG-001886 through LP-CEG-002025. The Annual Report includes a section on "Risk Management and Insurance" is located at LP-CEG-001920.

As we explained in our letter of April 21, 2023, each of Lifepoint's hospitals is responsible for decisions relating to day-to-day delivery of care and operations and for the clinical staff and providers who practice in those hospitals, all of whom are licensed by the states in which the hospitals are located. Each acute care hospital subsidiary therefore is responsible for liabilities resulting from delivery of care or operations, such as professional liability and other claims. Lifepoint itself is not a licensed healthcare provider; nor does Lifepoint hold provider numbers as a member of the Medicare and Medicaid programs.

Lifepoint and its affiliates manage the collective liability risk of all our hospitals through programs of insurance, including professional liability, general liability, workers' compensation, and other types of coverage. This approach to insurance is typical for health systems.

Given the nature of the healthcare operating environment, Lifepoint and its subsidiary hospitals and employed providers, are subject to claims of liability, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("SIR") and deductible levels.

As of December 31, 2022, the Company's deductible for workers' compensation claims at each of its acute care and behavioral health hospitals was $1 million per claim in all states in which it operates except for Montana and Washington. The Company participates in state-specific programs for its workers' compensation claims in these states. There is no deductible for workers' compensation claims at inpatient rehabilitation facilities ("IRFs"). The Company's SIR and deductible levels are evaluated annually as a part of the Company's insurance program's renewal process.

Further, each hospital requires its medical staff members to maintain adequate insurance limits to protect themselves and patients in the event of a patient injury and/or a claim following care. The limits of insurance required at each location vary by state.

We anticipate producing additional materials responsive to this request in subsequent productions.

14. From 2018 to the present, please produce all documents related to the authority of Lifepoint's Board of Directors to:

- **a. Monitor and evaluate Lifepoint hospitals' quality of care metrics and patient safety programs;**
- **b. Review and discuss those metrics with Lifepoint senior management; and**
- **c. Receive reports from Lifepoint senior management on the hospital network's safety standards and preventative actions.**

i. **For each of these requests, please produce all documents, including all internal or external communications, for all instances where the Board exercised its authority in these areas.**
ii. **Please also describe, with supporting documents, what officials the Board considers to be "Lifepoint senior management."**

Enclosed at LP-CEG002026 through LP-CEG-002076 are:

- Board committee charters: Audit Committee Charter, at LP-CEG-002026 through LP-CEG-002032; Compensation Committee Charter, at LP-CEG-002033 through LP-CEG-002036; Compliance and Enterprise Risk Committee Charter, at LP-CEG-002037 through LP-CEG-002041; Executive Committee Charter, at LP-CEG-002042 through LP-CEG-002045; Nominating and Corporate Governance Committee Charter at LP-CEG-002046 through LP-CEG-002048; and Quality Committee Charter, at LP-CEG-002049 through LP-CEG-002051;
- Related Person Transactions Policy, at LP-CEG-002052 through LP-CEG-002058; and
- Delegation of Authority Policy, at LP-CEG-002059 through LP-CEG-002076.

We anticipate producing additional materials responsive to this request in a subsequent production.

* * *

You asked on December 18, 2023, whether Lifepoint has entered "a joint defense or common interest agreement, written or oral, with Apollo Global or any of the entities that are currently the subject of this investigation related to their respective responsibilities for responding to the investigation." Lifepoint entered an oral common interest agreement with Ottumwa Regional, Apollo and MPT in March 2023. Although Lifepoint, Ottumwa Regional, Apollo, and MPT did not have any formal agreement regarding the production of documents, we understood at the time that coordinated production of documents to avoid duplication was acceptable to Senator Grassley's staff. We now understand that you would prefer that each party produce its own responsive material, and Lifepoint therefore plans produce its own documents, even when they might be duplicative of another party's production.

* * *

Lifepoint is proud to play a critical role in providing services to underserved rural communities, and we take seriously our role in supporting community growth. It is also proud of the many healthcare workers who make up its talented workforce and serve these areas. In fact, Newsweek just recognized Lifepoint as one of "America's Greatest Workplaces for Diversity 2024" and awarded Lifepoint the full five-star rating.[1] Lifepoint welcomes the opportunity to

[1] *America's Greatest Workplaces for Diversity 2024*, Newsweek (last accessed Dec. 18, 2023) https://www.newsweek.com/rankings/americas-greatest-workplaces-diversity-2024.

share more about Lifepoint, its work in Iowa, and its priorities at Ottumwa Regional. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

[redacted]

Appendix A

The following chart reflects the name, title, Board tenure, and committee assignments of all individuals on Lifepoint's Board, in response to Question 10.

Director Name	Title	Board Appointment Date	Committee Assignments	Committee Assignment Dates	Resignation Date
Christine Cahill	Director	3/23/2022	Executive Nominating & Corporate Governance	6/15/2023 6/15/2023	N/A
David M. Dill	Director	9/23/2021	Quality	3/22/2022	N/A
G. Rodney Wolford	Director	<12/13/2018	Audit Compliance & Enterprise Risk	12/13/2018 12/13/2018	N/A
Matthew Nord	Director	<12/13/2018	Executive Compensation	12/13/2018 12/13/2018	N/A
Maxwell David	Director	12/13/2018	Executive Quality Compensation Nominating & Corporate Governance	12/13/2018 12/13/2018 6/15/2023 6/15/2023	N/A
Nell Buhlman	Director	3/23/2022	Compliance & Enterprise Risk Audit Quality	6/5/2022 - 11/27/2023 12/7/2022 6/5/2022	N/A
Norman Brownstein	Director	<12/13/2018	Quality	12/13/2018	N/A
Wendell Pritchett	Director	9/21/2022	Quality Audit Compliance & Enterprise Risk	9/21/2022 - 11/27/2023 9/22/2022 11/27/2023	N/A
Heather Berger	Director	9/27/2023	N/A	N/A	N/A
Bill Lewis	Director	6/15/2023	N/A	N/A	N/A
Evan Bayh	Director	9/27/2023	Compliance & Enterprise Risk	11/27/2023	N/A
Kenneth Shea	Director	6/15/2023	Audit Compliance & Enterprise Risk	7/21/2023 7/21/2023	N/A
Christopher J. Christie	Director	12/13/2018	Nominating & Corporate Governance	12/13/2018	6/8/2023

Eric L. Press	Director	<12/13/2018	Executive Compensation Nominating & Corporate Governance	12/13/2018 12/13/2018 12/13/2018	5/22/2023
Holly McMullan	Director	12/13/2018	Quality	12/13/2018	7/13/2023
Daniel Morrissette	Director	<12/13/2018	Audit (Chair) Compliance & Enterprise Risk	12/13/2018 12/13/2018	10/26/2022
Michael P. Haley	Director	12/13/2018	Audit Quality	12/13/2018 12/13/2018	6/5/2022
Steven Levin	Director	<12/13/2018	Compliance & Enterprise Risk	12/13/2018	3/22/2022
Olivia Wassenaar	Director	12/13/2018	N/A	N/A	3/22/2022
Martin S. Rash	Director	<12/13/2018	Compliance & Enterprise Risk Nominating & Corporate Governance	12/13/2018 12/13/2018	6/24/2021
William F. Carpenter III	Director	<12/13/2018	Quality	12/13/2018	8/3/2020
James H. Simmons	Director	9/15/2020	N/A	N/A	3/22/2022

December 20, 2023

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Ottumwa Regional Health Center ("Ottumwa Regional").

This submission responds to a subset of the questions set forth in your letters of December 6, 2023 (the "Requests"). Enclosed with this letter are documents regarding Ottumwa Regional's Board and Ottumwa Regional's staff vetting and controlled substances policies and procedures. We plan to make our next production of documents on or before January 17, with rolling responses thereafter.

We have included in this production documents with proprietary business information. The documents have been marked "Confidential Treatment Requested." We request that these documents not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Ottumwa Questions

7. **From 2015 to the present, broken down by year, produce all documents demonstrating that the policies and procedures for vetting staff, including drug testing, were implemented at Ottumwa Regional. Produce also all documents demonstrating that the procedures for vetting staff, including drug testing, were implemented with respect to Devon M. Caraccio.**

Enclosed at LP-CEG-002077 through LP-CEG-002122 are documents concerning the implementation of policies and procedures for vetting staff, including drug testing, at Ottumwa Regional, including:

- Application and Background Screening Policy, effective March 2018, at LP-CEG-002077 through LP-CEG-002082;

- Application and Background Screening Policy, effective March 2023, at LP-CEG-002083 through LP-CEG-002088;
- Background and Record Check Policy, revised January 2013, at LP-CEG-002089 through LP-CEG-002090;
- Background and Record Check Policy, revised March 2018, at LP-CEG-002091 through LP-CEG-002093;
- Education Verification Policy, at LP-CEG-002094 through LP-CEG-002095;
- Health Assessment for New Associates Policy, revised February 2015, at LP-CEG-002096 through LP-CEG-002098;
- Health Assessment for New Employee Policy, revised February 2016, at LP-CEG-002099 through LP-CEG-002101;
- Human Resources Hiring Policy, revised February 2015, at LP-CEG-002102 through LP-CEG-002104;
- Hospital Policy – Applicant Screening and Background Checks, effective 2019, at LP-CEG-002105 through LP-CEG-002111;
- Certification/Licensure Policy, revised February 2016, at LP-CEG-002112;
- Background Checks Policy, revised 2012, at LP-CEG-002113 through LP-CEG-002114;
- Licensures and Certifications policy, revised February 2015, at LP-CEG-002115 through LP-CEG-002118;
- Sanctioned Individuals – Employee Handbook, at LP-CEG-002119 through LP-CEG-002120; and
- Temporary, Contractual and Volunteer Requirements, at LP-CEG-002121 through LP-CEG-002122.

8. **From 2015 to the present, broken down by year, produce all documents demonstrating that the policies and procedures for controlled substances, including medication safety, facility security, and staff training, were implemented at Ottumwa Regional, including but not limited to, the dates of each training, attendee sign-in sheets, and the names of the individual(s) responsible for such training. Produce also all documents demonstrating that Devon M. Caraccio participated in staff training related to the policies and procedures in the above question.**

Enclosed at LP-CEG-002123 through LP-CEG-002159 are documents concerning the implementation of policies and procedures for controlled substances, including medication safety, facility security, and staff training, at Ottumwa Regional, including:

- Drug and Alcohol Policy, revised February 2013, at LP-CEG-002123 through LP-CEG-002131;
- Drug and Alcohol Free Workplace Policy, revised March 2015, at LP-CEG-002133 through LP-CEG-002139;
- Drug and Alcohol Free Workplace Policy, revised February 2016, at LP-CEG-002140 through LP-CEG-002147; and
- Drug and Alcohol Free Workplace Policy, effective March 2023, at LP-CEG-002148 through LP-CEG-002159.

We anticipate producing additional materials responsive to this request in subsequent productions.

10. Please produce all third-party staffing contracts for Devon M. Caraccio.

We previously produced an agreement between Apogee Medical Management, Inc. and RCHP-Ottumwa, LLC, on May 5, 2023, located at LP-CEG-000148 through LP-CEG-000196. This agreement is the only third-party staffing agreement with respect to Devin Caraccio.

* * *

You asked on December 18, 2023, whether Ottumwa Regional has entered "a joint defense or common interest agreement, written or oral, with Apollo Global or any of the entities that are currently the subject of this investigation related to their respective responsibilities for responding to the investigation." Ottumwa Regional entered an oral common interest agreement with Lifepoint, Apollo and MPT in March 2023. Although Ottumwa Regional, Lifepoint, Apollo, and MPT did not have any formal agreement regarding the production of documents, we understood at the time that coordinated production of documents to avoid duplication was acceptable to Senator Grassley's staff. We now understand that you would prefer that each party produce its own responsive material, and Ottumwa Regional therefore plans to produce its own documents, even when they might be duplicative of another party's production.

* * *

Ottumwa Regional welcomes the opportunity to share more about its operations, policies, and procedures. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

[redacted]

WILMERHALE

January 17, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Ottumwa Regional Health Center ("Ottumwa Regional").

This submission responds to a subset of the questions set forth in your letter of December 6, 2023 (the "Requests"). Enclosed with this letter are documents regarding Ottumwa Regional's emergency medical services fleet, controlled substance policies and procedures, and third-party contracts related to Ottumwa Regional. We plan to make our next production of documents on or before January 31, with rolling responses thereafter.

We have included in this production documents with proprietary business information. The documents have been marked "Confidential Treatment Requested." We request that these documents not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Ottumwa Questions

5. **From 2015 to the present, describe in detail Ottumwa Regional's emergency medical services vehicle fleet, including but not limited to, the current service area, any reduction in services and any reliance on other hospitals or facilities to transport patients. Please answer in timeline form and produce all documents that support your answer.**

Ottumwa Regional, unlike its peers, provides emergency medical services ("EMS") that are more typically provided by local municipalities or regional authorities. EMS services are costly to provide, particularly in rural areas. Nevertheless, to meet the needs of the community, Ottumwa Regional operates its own EMS services, not just for transport but for 911 responses, and has been doing so at a loss since the beginning of 2022.

From 2015 to 2023, the service area for Ottumwa Regional's EMS fleet was Wapello County, with a mutual aid agreement with surrounding areas. The EMS fleet provided 911 response, received dispatch from Wapello County and the City of Ottumwa, and provided interfacility transfers for Ottumwa Regional.

Ottumwa Regional also used Blank Children's Hospital and University of Iowa for pediatric transports and Mercy Medical Center, St. Luke's Methodist Hospital, and University of Iowa for air transport support. In instances where Ottumwa Regional's ground transport resources were exhausted, the resources of Mercy Medical Center and surrounding counties were occasionally used, and in 2022, Ottumwa Regional added Heartland Medical Transport to the list for backup transport when resources were exhausted.

In January 2023, Ottumwa Regional modified its status as an EMS service with the State of Iowa. Ottumwa Regional's status changed from advanced life support ("ALS") to conditional ALS, which eliminated the requirement that every EMS run include a paramedic. The vast majority of 911 calls do not require a paramedic, as they require only life support rather than advanced life support; this modification permitted increased staffing flexibility, as Ottumwa Regional's EMS function, like much of the healthcare industry, has been subject to staffing challenges.

a. Have any of Ottumwa Regional's ambulances failed an inspection? If yes, please explain the reasons for these failure(s). Produce all documents that support your answer.

No. Ottumwa Regional's ambulances are inspected every three years consistent with Iowa law. For the period 2015 through 2023, the ambulances were inspected in 2015, 2018, and 2021. None of Ottumwa Regional's ambulances failed an inspection. The 2015 inspection report is enclosed at LP-CEG-002358 through LP-CEG-002359; the 2018 inspection report is at LP-CEG-002360 through LP-CEG-002362; and the 2021 report is at LP-CEG-002363 through LP-CEG-002366. Additional maintenance records are enclosed at LP-CEG-002367 through LP-CEG-002380.

b. Has Lifepoint ever transferred any EMS vehicles from other hospitals the company owns or operates in other states to Ottumwa Regional? If yes, please explain why your company transferred vehicles from other institutions. Produce all documents that support your answer.

In June 2023, Ottumwa Regional received three EMS ambulances from Lifepoint Central Carolina Hospital, a Lifepoint hospital with a large fleet and excess capacity that it was able to share with Ottumwa Regional. Enclosed at LP-CEG-002381 through LP-CEG-002383 are Inter-Entity Asset Transfer Forms for these three vehicles.

8. From 2015 to the present, broken down by year, produce all documents demonstrating that the policies and procedures for controlled substances, including medication safety, facility security, and staff training, were implemented at Ottumwa Regional, including

but not limited to, the dates of each training, attendee sign-in sheets, and the names of the individual(s) responsible for such training. Produce also all documents demonstrating that Devon M. Caraccio participated in staff training related to the policies and procedures in the above question.

Ottumwa Regional has robust policies and procedures related to controlled substances. To supplement the documents accompanying Ottumwa Regional's December 20, 2023 letter, enclosed at LP-CEG-002384 through LP-CEG-002423 are documents related to management discussions on and approval of controlled substances policies, including:

- Pharmacy & Therapeutics Committee January 2016 Minutes, at LP-CEG-002384 through LP-CEG-002385;
- Pharmacy & Therapeutics Committee May 2016 Minutes, at LP-CEG-002386 through LP-CEG-002388;
- Pharmacy & Therapeutics Committee May 2017 Minutes, at LP-CEG-02389 through LP-CEG-002392;
- Pharmacy & Therapeutics Committee October 2021 Minutes, at LP-CEG-002393 through LP-CEG-002396;
- Pharmacy & Therapeutics Committee February 2023 Minutes, at LP-CEG-002397 through LP-CEG-002399;
- Board of Directors October 21, 2021 Meeting Minutes, at LP-CEG-002400 through LP-CEG-002402;
- Controlled Substance Action Plan, which was shared with the Board in July 2023, at LP-CEG-002403;
- Board of Directors July 20, 2023 Meeting Minutes, at LP-CEG-002404 through LP-CEG-002408;
- Board of Directors August 17, 2023 Meeting Minutes, at LP-CEG-002409 through LP-CEG-002414;
- Human Resources Policy Approvals by Board in August 2023, at LP-CEG-002415 through LP-CEG-002416;
- Pharmacy Policy Approvals by Board in August 2023, at LP-CEG-002417 through LP-CEG-002420; and
- Survey Update to the Board of Directors December 4, 2023 Minutes, at LP-CEG-002421 through LP-CEG-002423.

We have also included at LP-CEG-002423 through LP-CEG-003295 additional documents concerning policies and procedures for controlled substances, including medication safety, facility security, and staff training, at Ottumwa Regional, including:

- 2023 GHO Schedule, at LP-CEG-002423 through LP-CEG-002425;
- Bedside Glucometer Quiz 2021, at LP-CEG-002426;

- Critical Value Test, at LP-CEG-002427;
- General Hospital Orientation – Participant Guide 2023, at LP-CEG-002428 through LP-CEG-002429;
- General CNA Orientation (PowerPoint), at LP-CEG-002430 through LP-CEG-002488;
- General CNA Orientation (Word), at LP-CEG-002489 through LP-CEG-002490;
- General Nursing Orientation Competency Checklist, at LP-CEG-002491 through LP-CEG-002495;
- GHO - ORHC Orientation Slide Deck, at LP-CEG-002496 through LP-CEG-002631;
- General Nursing Orientation 2023, at LP-CEG-002632 through LP-CEG-002894;
- Meditech 6.0 PCS Training Competency Checklist, at LP-CEG-002895 through LP-CEG-002900;
- ORHC Nursing Orientation Handbook, at LP-CEG-002901 through LP-CEG-002985;
- RN - Quiz Moderate Sedation Education, at LP-CEG-002986 through LP-CEG-002987;
- Therapeutic Duplication Test, at LP-CEG-002988 through LP-CEG-002989;
- Pharmacy Scope of Service, at LP-CEG-002990 through LP-CEG-002993;
- Clinical Staff Education Packet, at LP-CEG-002994 through LP-CEG-003167;
- Controlled Substance Management, at LP-CEG-003168 through LP-CEG-003193;
- Guidepost December 2022 Training, at LP-CEG-003194 through LP-CEG-003215;
- National Employee Handbook Acknowledgement, at LP-CEG-003216;
- ORHC ADMS Pyxis Controlled Substances, at LP-CEG-003217;
- ORHC Drug Diversion in Healthcare Facilities and Tampering, at LP-CEG-003218; and
- Read and Sign Forms, at LP-CEG-003219 through LP-CEG-003295.

9. From 2015 to the present, broken down by year, identify and produce all documents for all third-party contracts associated with Ottumwa Regional.

Enclosed at LP-CEG-003296 through LP-CEG-004433 are 76 final, executed third-party contracts associated with Ottumwa Regional related to hospital administration and operations.

We have included a list of these contracts in a chart at Appendix A, organized by effective date.

11. Please produce Devon M. Caraccio's personnel file.

We believe that we are restricted by applicable law from voluntarily producing Devin M. Caraccio's personnel file. However, we are able to share the following: Mr. Caraccio was employed at Ottumwa Regional from 2016 to 2020 as an intensive/critical care nurse and from 2020 to 2021 as an emergency department charge nurse. On August 19, 2021, Apogee Medical Management, Inc., a third-party vendor for Ottumwa Regional, offered Mr. Caraccio, a Board-certified nurse practitioner, a position as a nurse practitioner (inpatient), which he accepted. We have produced the third-party staffing agreement between Apogee Medical Management, Inc. and RCHP-Ottumwa, LLC at LP-

CEG-000148 through LP-CEG-000196. In this role, Mr. Caraccio had nurse practitioner inpatient clinical privileges, including the ability to administer or dispense controlled substances, for a two-year term.

Mr. Caraccio signed all applicable codes of conduct and medical staff expectations forms required of similarly situated Ottumwa Regional employees and participated in all required training programs. Ottumwa Regional also verified, prior to Mr. Caraccio's commencement of employment, his stated degrees, relevant experience, licenses, and certifications, including pharmacy permissions, and he satisfactorily completed the pre-employment drug test required of all similarly situated employees. Mr. Caraccio also satisfactorily passed the pre-employment background check required by Ottumwa Regional of all similarly situated employees. Mr. Caraccio's performance evaluations were all satisfactory.

* * *

Ottumwa Regional welcomes the opportunity to share more about its operations, policies, and procedures. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

[redacted]

Appendix A

List of Third-Party Contracts for Ottumwa Regional, Organized by Effective Date

Vendor (Other Party)	Department	Effective Date	Expiration Date
Stereotactic Biopsy Services, LC	Radiology	8/1/1996	7/31/2022
Foodliner, Inc.	Hospital Administration	2/15/2005	12/31/2050
LocumTenens.com, LLC	Hospital Administration	12/21/2009	12/31/2050
G&K Services	Hospital Administration	12/17/2010	12/31/2050
The Iowa Clinic, P.C.	Hospital Administration	3/1/2012	2/28/2020
Vista Staffing Solutions, Inc.	Hospital Administration	4/25/2012	12/31/2050
Avant Healthcare Professionals, LLC	Human Resources	10/18/2012	1/24/2024
AthenaHealth Services	Hospital Administration	10/31/2012	10/30/2018
Mayo Medical Laboratories	Hospital Administration	11/8/2012	12/31/2050
American Academy of Sleep Medicine	Hospital Administration	5/15/2013	5/14/2019
Kobuk Dialysis, LLC	Hospital Administration	6/5/2013	6/4/2024
Mercy Clinics, Inc.	Hospital Administration	7/12/2013	12/31/2050
UnitedHealth Military & Veterans Services, LLC	Hospital Administration	8/1/2013	12/31/2050
Vista Woods Care Center	Hospital Administration	8/15/2013	8/14/2021
Specialists On Call, Inc. & Tele-Physicians, P.C.	Hospital Administration	2/14/2014	2/13/2024
Specialists on Call, Inc.	Hospital Administration	2/14/2014	2/13/2024
Iowa Department of Public Health	Hospital Administration	4/11/2014	12/31/2050
Echo Locum Tenens, Inc d/b/a EchoLT	Hospital Administration	4/17/2014	4/16/2022
Catholic Health Initiatives–Iowa, Corp. d/b/a MercyOne Iowa Heart Center	Hospital Administration	4/23/2014	4/22/2020

Apogee Medical Management, Inc	Hospital Administration	8/1/2014	7/31/2023
Apogee Medical Management, Inc.	Hospital Administration	8/1/2014	7/31/2020
Mayo Medical Laboratories	Hospital Administration	8/14/2014	12/31/2050
Upper Iowa University	Hospital Administration	4/1/2015	3/31/2024
Hologic LP	Hospital Administration	10/9/2015	12/31/2050
Signature Healthcare, LLC	Human Resources	12/8/2015	12/7/2023
Indian Hills Community College	Hospital Administration	12/16/2015	12/31/2050
American Cancer Society, Inc.	Hospital Administration	3/1/2016	2/27/2021
River Hills Community Health Center	Hospital Administration	5/9/2016	5/8/2024
Hologic LP	Hospital Administration	3/9/2017	12/31/2050
Radiology Partners of Iowa, Inc.	Hospital Administration	3/30/2017	3/29/2023
Triage, LLC	Hospital Administration	7/19/2017	9/18/2023
Aureus Radiology, LLC	Human Resources	8/16/2017	9/16/2023
Iowa Pathology Associates, PC	Hospital Administration	10/1/2017	11/30/2020
Catholic Health Initiatives–Iowa, Corp. d/b/a MercyOne Iowa Heart Center	Hospital Administration	11/10/2017	10/30/2020
Iowa Department of Public Health	Hospital Administration	1/1/2018	12/31/2023
Xygent, Inc.	Hospital Administration	2/8/2018	5/24/2024
Nalco Company	Hospital Administration	4/1/2018	2/28/2021

Catholic Health Initiatives–Iowa, Corp. d/b/a MercyOne Des Moines Medical Center.	Hospital Administration	6/6/2018	6/5/2023
The Advantage Companies, LLC	Hospital Administration	6/17/2018	6/16/2019
South Central Behavioral Health Region	Hospital Administration	7/21/2018	7/20/2024
Randstad Professionals US, LLC d/b/a Tatum	Hospital Administration	8/6/2018	8/5/2022
CareFusion Solutions, LLC	Hospital Administration	10/1/2018	9/30/2023
JBS USA Food Company Holdings	Hospital Administration	10/1/2018	4/1/2021
Kindred (RehabCare Group)	Hospital Administration	10/1/2018	6/30/2021
Iowa Board of Pharmacy	Hospital Administration	11/26/2018	11/25/2023
Pharmacy Support Services	Pharmacy	2/1/2019	2/1/2021
United Shockwave Services, Ltd.	Hospital Administration	2/14/2019	2/13/2024
Mississippi Valley Regional Blood Center	Hospital Administration	2/27/2019	2/26/2024
Southeastern Emergency Physicians, LLC	Hospital Administration	3/1/2019	12/31/2023
University of Iowa Healthcare	Hospital Administration	7/1/2019	5/31/2022
Catholic Health Initiatives–Iowa, Corp. d/b/a MercyOne Iowa Heart Center	Hospital Administration	11/4/2019	7/31/2023
Catholic Health Initiatives–Iowa, Corp. d/b/a MercyOne Iowa Heart Center	Hospital Administration	11/4/2019	5/11/2025
Iowa Hospital Association	Hospital Administration	4/10/2020	4/10/2025

River Hills Community Health Center	Hospital Administration	4/29/2020	4/28/2024
Iowa Illinois Pain Consultants, PC	Hospital Administration	6/16/2020	6/15/2023
River Hills Community Health Center	HSC - LifePoint Health	6/22/2020	6/21/2023
Burlington Neurology and Sleep Clinic, PLC	Hospital Administration	11/9/2020	11/8/2023
MercyOne Ottumwa Family & Internal Medicine Clinic	Hospital Administration	1/4/2021	1/3/2024
Per Mar Security and Research Corp.	Hospital Administration	1/16/2021	1/16/2024
Intuitive Surgical, Inc.	Hospital Administration	6/30/2021	6/29/2024
Iowa Department of Public Health	Cardiopulmonary	9/10/2021	Evergreen
Iowa Department of Public Health	Cardiopulmonary	10/8/2021	Evergreen
Iowa Economic Development Authority	Finance	10/22/2021	10/22/2022
Signature Healthcare, LLC	Human Resources	10/22/2021	10/21/2023
Iowa Lions Eye Bank	Quality	11/3/2021	11/2/2023
Bloomfield Anesthetists, PLLC	Hospital Administration	1/1/2022	12/31/2024
Healogics Wound Care & Hyperbaric Services, LLC	Hospital Administration	1/1/2022	12/31/2024
Associates in Kidney Care, PLC	Hospital Administration	3/31/2022	3/30/2025
Catholic Health Initiatives–Iowa, Corp. d/b/a MercyOne Des Moines Medical Center.	Hospital Administration	5/1/2022	4/30/2025
Southeast Iowa Link	Hospital Administration	7/1/2022	6/30/2023

River Hills Community Health Center	Hospital Administration	8/1/2022	7/31/2023
Optimae Life Solutions	Administration	9/26/2022	9/25/2030
Ezra Free Clinic	Hospital Administration	12/25/2022	12/24/2024
Iowa Department of Public Health	Performance Excellence and Quality	1/1/2023	12/31/2028
Spectracorp Rural Health Care Program Agreement	Administration	1/3/2023	6/30/2028
University of Iowa Hospitals and Clinics - Department of Radiology	Hospital Administration	12/31/2050	12/31/2050

WILMERHALE

January 17, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint" or the "Company").

This submission responds to a subset of the questions set forth in your letter of December 6, 2023 (the "Requests"). Enclosed with this letter are documents regarding the 2019 sale-leaseback transaction, the authority of Lifepoint's Board, the hiring of the Chief Executive Officer of Ottumwa Regional Health Center ("Ottumwa Regional"), and legal proceedings. We plan to make our next production of documents on or before January 31, with continued rolling responses thereafter.

We have included in this production documents with proprietary business information. The documents have been marked "Confidential Treatment Requested." We request that these documents not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Lifepoint Questions

7. Describe in detail how Lifepoint's Board was involved in the 2019 sale-leaseback transaction, including the names of any Board members involved, as referenced in your May 12, 2023 letter. Produce all documents that support your answer, including but not limited to all relevant Board meeting minutes.

The Lifepoint Board considered and approved the sale-leaseback transaction at a special meeting of the Board of Directors on October 30, 2019. The following Board members attended, either in person or via teleconference: Matt Nord, Norm Brownstein, Bill Carpenter, Max David, Mike Haley, Steve Levin, Holly McMullan, Dan Morissette, Olivia Wassenaar, Rick Press, Marty Rash, and David Dill. Enclosed at LP-CEG-002160 are the minutes for the October 30, 2019 meeting.

At the meeting, the Board discussed the sale leaseback transaction, and Mr. Dill, Lifepoint's President and Chief Executive Officer, answered questions about the proposed transaction. The Board then unanimously approved the resolution for the sale-leaseback transaction, which is attached to the meeting minutes and located at LP-CEG-002161 through LP-CEG-002167.

The Board also received materials, enclosed at LP-CEG-002168 through LP-CEG-002179, on the sale-leaseback transaction. The presentation provided information on the financial impact of the sale leaseback and other details about the transaction.

15. Explain Lifepoint's role in the decision to hire William Kiefer as CEO of Ottumwa Regional. Produce all documents that support your answer, including but not limited to, his personnel file and any background checks.

As discussed in our March 31 and May 12, 2023, letters, William Kiefer was not CEO of Ottumwa Regional at the time of the events relating to Devin Caraccio, the now-deceased nurse practitioner. Rather, following Mr. Caraccio's death, Lifepoint and Ottumwa Regional recognized that there needed to be a change in leadership at the hospital. Since joining Ottumwa Regional, Dr. Kiefer has stabilized the hospital's operations and initiated a number of enhancements to patient safety and care, including implementation of new customer service standards and accompanying training for staff, new equipment, facility repairs and upgrades, and new technology.

The Division President who oversaw Ottumwa Regional and who served concurrently as President of RCHP Ottumwa, LLC, Sandy Podley, was responsible for first appointing William Kiefer as the interim CEO of Ottumwa Regional in November 2022 and then for hiring him as the permanent CEO in January 2023. Dr. Kiefer was appointed formally as the Chief Executive Officer of Ottumwa Regional on January 19, 2023, by the Ottumwa Board of Directors.

Ms. Podley believed that one of the then in-role Chief Operating Officers at Lifepoint hospitals in the Western Region would be best suited to immediately take the interim CEO position at Ottumwa Regional. Ms. Podley determined Dr. Kiefer was the best candidate. Ms. Podley believed Dr. Kiefer was a strong leader, and she knew that physicians from hospitals Dr. Kiefer oversaw spoke positively about his leadership. At the time of his appointment to Ottumwa Regional, Dr. Kiefer had over 20 years of experience in patient care, both as a healthcare executive and nurse. He previously was the Chief Operating Officer at Canyon Vista Medical Center ("Canyon Vista"), a Lifepoint hospital in Sierra Vista, Arizona for seven months. Before that, Dr. Kiefer served as CEO and Chief Nursing Officer at non-Lifepoint hospitals, including OmniPoint Health in Anahuac, Texas, Marias Medical Center in Shelby, Montana, and Rehoboth McKinley Christian Health Care Service in Gallup, New Mexico.

Dr. Kiefer's appointment as permanent CEO was similar to appointments of other CEOs at Lifepoint hospitals. Ms. Podley reviewed several candidates' applications for the position and proposed two potential candidates for CEO to the Lifepoint Board of Directors. Ms. Podley interviewed Ottumwa Regional officers, directors, key medical staff, the Medical Executive Committee, and Ottumwa Regional Board members, about Dr. Kiefer. Ms. Podley then presented

the Lifepoint Board of Directors with the hospital employees' evaluations of Dr. Kiefer, which were overwhelmingly positive. Several senior Lifepoint employees also interviewed Dr. Kiefer as part of the process. The Ottumwa Regional Board ultimately selected Dr. Kiefer and appointed him CEO of the hospital.

Dr. Kiefer's leadership has already had significant positive impacts at Ottumwa Regional. He is focused on supporting staff and improving staff engagement, and he has introduced regular and open communications among stakeholders, including executive rounding, department meetings, five all-staff town hall meetings over the last year, and a CEO newsletter. His reintroduction of monthly service and excellence awards has built staff pride and morale.

Dr. Kiefer is also focused on improving patient care. To enhance patient and family experiences, he instituted new customer service standards and accompanying staff training to provide guidance. He has also strengthened Ottumwa Regional's quality of care committee by adding front line staff to the meeting as well as a community patient representative to the committee. Dr. Kiefer's patient care focus has also resulted in enhancements to hospital equipment, facilities, and technology. He has overseen the addition of new equipment, like anesthesia carts and a DaVinci robot for minimally invasive surgeries, the completion of repairs and upgrades, like new flooring, and the implementation of new technology, including upgrading the hospital's pharmacy to Omnicell software. Dr. Kiefer has overseen pay increases for EMTs and paramedics to stabilize 911 services for Ottumwa and Wapello County. Indeed, Dr. Kiefer and Ottumwa Regional have been working closely with local agencies and communities to ensure a safe level of full-time emergency ambulance service to Wapello County, even as other rural areas are scaling back such services because of staffing and funding pressures—efforts praised by Ottumwa Mayor Rick Johnson. Under Dr. Kiefer's leadership, RNs, LPNs and a variety of other roles have seen market salary increases, helping stabilize the workforce at ORHC and drive positive patient outcomes. He has also led a reorganization of the hospital's dietary department, resulting in healthier and increased variety of menu options for staff and patients. In addition, he has focused on increasing the cleanliness of the hospital environment to safeguard patients from infection. Dr. Kiefer's support for expansion efforts, including a $4.5 million expansion and upgrade of the catheterization lab, has significantly contributed to the enhancement of patient care at the hospital.

Throughout his tenure at Ottumwa Regional, Dr. Kiefer has focused on patient safety. Under his leadership, the hospital has added over 100 cameras to increase overall safety for patients and staff and to prevent drug diversion. Dr. Kiefer has also added ligature-free furniture to the hospital's behavioral health unit and enclosed the nurses' station in the unit to increase safety for patients and staff. In addition, Ottumwa Regional is now participating in the Billion Pill Pledge initiative to decrease opioids following surgery, and it was certified as a drug disposal location for the community, where individuals can dispose of any unused or unwanted medication, including narcotics. Ottumwa Regional has also reintroduced sleep medicine as a service for the community.

Dr. Kiefer is also deeply personally involved in the local community. He serves on the Board of Directors for the Greater Ottumwa Partners in Progress ("GOPIP"), which is a combined Ottumwa chamber of commerce and economic development organization. Mark Roe, the CEO of GOPIP, recently applauded Dr. Kiefer for his efforts in spearheading a community collaborative partnership

to purchase and redevelop for residential use property in Ottumwa that was previously occupied by now-shuttered St. Joseph's Hospital and that had remained dormant for years. Dr. Kiefer is also an Ottumwa Rotarian. In December 2023, he provided an update on Ottumwa Regional to the Ottumwa City Council.

Enclosed are the following documents related to Dr. Kiefer's hiring:

- Voluntary Self-Identification of Veterans form, at LP-CEG-002180 through LP-CEG-002181;
- Voluntary Self-Identification of Disability form, at LP-CEG-002182;
- Resumé on file of William Kiefer through employment at Marias Medical Center, at LP-CEG-002183 through LP-CEG-002185;
- Resumé on file of William Kiefer through employment at OmniPoint Health, at LP-CEG-002186 through LP-CEG-002188;
- Application for Chief Operating Officer at Canyon Vista Medical Center, at LP-CEG-002189 through LP-CEG-002193;
- Offer letter for Chief Operating Officer at Canyon Vista Medical Center, at LP-CEG-002194 through LP-CEG-002201;
- Background check results from May 4, 2022, at LP-CEG-002202 through LP-CEG-002231;
- Drug Test results from May 21, 2022, at LP-CEG-002232 through LP-CEG-002233;
- Signed Lifepoint Code of Conduct Acknowledgement form from May 3, 2022, at LP-CEG-002234;
- Signed Confidentiality and Security Agreements from April 14, 2022, at LP-CEG-002235 through LP-CEG-002238;
- Emergency Contact Information form, at LP-CEG-002239;
- Lifepoint Health Executive Profile form from April 14, 2022, at LP-CEG-002240 through LP-CEG-002242;
- Chief Operating Officer Job Description, at LP-CEG-002243 through LP-CEG-002244;
- Relocation Repayment Agreement from April 14, 2022, at LP-CEG-002245 through LP-CEG-002246;
- Voluntary Self-Identification Form from April 14, 2022, at LP-CEG-002247 through LP-CEG-002248;
- Relocation Promissory Note, at LP-CEG-002249;
- Relocation Repayment Agreement from January 25, 2023, at LP-CEG-002250 through LP-CEG-002251;
- Continuing education transcript through December 15, 2023, at LP-CEG-002252 through LP-CEG-002258;
- Letter for promotion/transfer to Chief Executive Officer at Ottumwa Regional Health Center, at LP-CEG-002259 through LP-CEG-002261; and
- Chief Executive Officer Job Description, at LP-CEG-002262 through LP-CEG-002264.

17. From 2015 to the present, identify and provide a brief description of all lawsuits, arbitrations, or other similar legal proceedings related to patient care that have been initiated against Lifepoint and/or Ottumwa Regional.

The following is a list of quality-of-care complaints or demands for arbitration related to patient care that have been filed or initiated against Ottumwa Regional.

	Case	Brief Description	Date Filed	Disposition
1	[redacted] v. RCHP-Ottumwa, LLC et al.	Family of baby alleged the child was not timely delivered.	28-Oct-19	Confidential settlement
2	[redacted] v. RCHP- Ottumwa, LLC et al.	Alleged inpatient fall resulting in fractured femur and other complications.	17-Feb-23	Litigation ongoing
3	[redacted] v. RCHP-Ottumwa, LLC et al.	Patient committed suicide one day post-discharge.	15-Apr-22	Hospital dismissed
4	[redacted] v. RCHP-Ottumwa, LLC et al	Patient experienced cardiac arrest shortly after ER discharge.	14-May-20	Hospital dismissed
5	[redacted] v. RCHP- Ottumwa, LLC et al	Patient experienced complications secondary to gall bladder removal.	10-Jul-17	Hospital dismissed
6	[redacted] v. RCHP- Ottumwa, LLC et al.	Patient alleged failure to timely diagnose breast cancer.	19-Apr-19	Confidential settlement

We anticipate producing additional materials responsive to this request with respect to Lifepoint in a subsequent production.

18. Describe in detail Lifepoint's financial and operational relationship with TeamHealth. Produce all documents that support your answer.

As a care provider for communities with significant healthcare needs that are often underserved, Lifepoint seeks strategic, thoughtful ways to maximize operational efficiencies so that its hospitals can continue capably serving the areas that need medical services the most.

To that end, Lifepoint Corporate Services General Partnership, an indirect, wholly-owned subsidiary of Lifepoint, entered into an agreement with Southeastern Emergency Physicians, LLC, ("Southeastern") a subsidiary of TeamHealth, in January 2023 ("the 2023 Agreement") that amended its 2018 service agreement. Recognizing the operational efficiencies in combining emergency medicine and hospital medicine services into a single, combined service offering, Lifepoint contracted with Southeastern to supply combined professional and administrative services in some of its hospitals.[1] The 2023 Agreement amended the 2018 agreement through memorializing the current services under one agreement and adding anesthesia services.

Under the 2023 Agreement, Lifepoint has an exclusive relationship with Southeastern for the specific service lines identified for each covered hospital, which vary from hospital to hospital. Lifepoint determined that such an agreement would enhance the quality of patient care through, among other things, facilitating the delivery of efficient, effective, and consistent services for patients, building relationships between Southeastern and the medical staffs at each hospital, allowing for effective use of the hospitals' equipment, providing prompt availability of professional services, simplifying scheduling of patients and physician coverage, and enhancing efficient administration.

As an overview of the parties' financial relationship, Southeastern is responsible for billing and collection of charges for the services it provides. Generally, Lifepoint pays to Southeastern in monthly installments a cost-plus subsidy amount for the services provided equal to the total estimated semi-annual practice expense amount incurred by Southeastern in fulfilling its obligations, plus a 10 percent management fee that covers administrative services provided by Southeastern, less Southeastern's semi-annual professional service revenue. The applicable management fee may vary based on factors such as when a hospital is added to the Agreement or other factors. Lifepoint and Southeastern annually and jointly perform a financial reconciliation of payments and expenses to calculate any under- or over-payments.

Enclosed at LP-CEG-002265 through LP-CEG-002337 is the 2023 Agreement between Lifepoint and Southeastern. There are several attachments to the 2023 Agreement, including a subsidy calculation for the applicable hospitals, at LP-CEG-002280 through LP-CEG-002284, as well as the HIPAA Business Associate Agreement, at LP-CEG-002285 through LP-CEG-002304, and an example of an Exclusive Professional Services Agreement that an applicable hospital would enter, at LP-CEG-002305 through LP-CEG-002337. Ottumwa Regional's Exclusive Professional Services Agreement and amendment is located at LP-CEG-002338 through LP-CEG-002357.

* * *

[1] A full list of the applicable hospitals and service lines is attached to the 2023 Agreement, at LP-CEG-002278 through LP-CEG-002279.

Lifepoint is proud to play a critical role in providing services to underserved rural communities, and it welcomes the opportunity to share more about Lifepoint, its work in Iowa, and its priorities at Ottumwa Regional. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

[redacted]

February 2, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint" or the "Company").

This submission responds to a subset of the questions set forth in your letter of December 6, 2023 (the "Requests"). Enclosed with this letter are documents consisting of final, third-party staffing agreements.

We have included in this production documents with proprietary business information. The documents have been marked "Confidential Treatment Requested." We request that these documents not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Lifepoint Questions

16. Does Lifepoint have plans to bring Scion Health or any Lifepoint-related entity to Ottumwa Regional or to any other hospitals or health facilities in Iowa? If yes, please explain. Produce all documents that support your answer.

Lifepoint has no current plan to sell Ottumwa Regional or any other Iowa facility to Scion Health.

17. From 2015 to the present, identify and provide a brief description of all lawsuits, arbitrations, or other similar legal proceedings related to patient care that have been initiated against Lifepoint and/or Ottumwa Regional.

The following is a list of quality-of-care complaints or demands for arbitration related to patient care that have been filed or initiated against the parent entity, Lifepoint Health, Inc.

	Case	Brief Description	Date Filed	Disposition
1	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	7/20/2020	Litigation ongoing
2	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	11/4/2020	Litigation ongoing
3	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	12/23/2022	Litigation ongoing
4	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	3/17/2023	Litigation ongoing
5	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	5/1/2023	Litigation ongoing
6	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	8/28/2023	Litigation ongoing
7	[redacted] v. Lifepoint Health, Inc., et al.	Alleged medical negligence.	9/13/2023	Litigation ongoing
8	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	7/23/2018	Settled
9	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	4/10/2020	Settled
10	[redacted]. v. Lifepoint Health, Inc., et al.	Alleged medical negligence.	1/25/2021	Settled
11	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	9/11/2019	Lifepoint dismissed
12	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	11/22/2019	Lifepoint dismissed
13	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	12/2/2020	Lifepoint dismissed
14	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	12/16/2020	Lifepoint dismissed
15	[redacted] et al. v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	12/23/2020	Lifepoint dismissed
16	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	1/15/2021	Lifepoint dismissed
17	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	6/16/2021	Lifepoint dismissed
18	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	6/25/2021	Lifepoint dismissed
19	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	7/13/2021	Lifepoint dismissed

	Case	Brief Description	Date Filed	Disposition
20	[redacted] v. Legacy Lifepoint Health, LLC et al.	Alleged medical negligence.	10/6/2021	Lifepoint dismissed
21	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	11/5/2021	Lifepoint dismissed
22	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	11/18/2021	Lifepoint dismissed
23	[redacted] . Lifepoint Health, Inc.	Alleged medical negligence.	3/22/2022	Lifepoint dismissed
24	[redacted] v. Lifepoint Health, Inc. et al	Alleged medical negligence.	10/25/2022	Lifepoint dismissed
25	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	2/13/2023	Lifepoint dismissed
26	[redacted] v. Lifepoint Health, Inc. et al.	Alleged medical negligence.	8/8/2023	Lifepoint dismissed

19. From 2015 to the present, produce all third-party staffing contracts, including but not limited to, all contracts between and among Lifepoint, any of its subsidiaries or related entities, and TeamHealth.

Enclosed at LP-CEG-004417[1] through LP-CEG-004612 are 6 executed, final third-party staffing contracts entered into by Lifepoint's managing entity, Lifepoint Corporate Services, General Partnership.

We previously produced the operative agreement between Lifepoint Corporate Services, General Partnership and Southeastern Emergency Physicians LLC, a subsidiary of TeamHealth, on January 17, 2024, located at LP-CEG-002265 through LP-CEG-002337.

20. In 2021, Apollo sold Lifepoint back to itself, from Apollo Fund VIII to Fund IX, for a $1.6 billion gain. Explain in detail any involvement in, including but not limited to knowledge or approval of, this transaction by Lifepoint executives or Lifepoint's Board. Produce all documents that support your answer.

While the 2021 transaction referenced in this question was Apollo Fund's decision, Lifepoint's executives and its Board were aware and supportive of it. Lifepoint's role was limited primarily to assisting with due diligence. The transaction had no direct impact on daily operations at any

[1] In Ottumwa Regional's letter of January 17, the final Bates number of the produced documents was inaccurately labeled as LP-CEG-004433, when it should have been listed as LP-CEG-004416. This document set thus begins with LP-CEG-004417.

Lifepoint-owned or -operated facilities. Lifepoint viewed the fund to fund transfer as further indication of Apollo's long-term investment in community healthcare, since the second fund has a longer term investment horizon.

* * *

Lifepoint is proud to play a critical role in providing services to underserved rural communities, and it welcomes the opportunity to share more about Lifepoint, its work in Iowa, and its priorities at Ottumwa Regional. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

[redacted]

February 2, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Ottumwa Regional Health Center ("Ottumwa Regional").

This submission responds to a subset of the questions set forth in your letter of December 6, 2023 (the "Requests"). Enclosed with this letter are documents regarding Ottumwa Regional's operations and staffing.

We have included in this production documents that include proprietary business information. The documents have been marked "Confidential Treatment Requested." We request that these documents not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Ottumwa Questions

12. Describe both historical and current operational challenges that pose a threat to quality care and access to medical services at Ottumwa Regional. Produce all documents that support your answer.

Ottumwa Regional is proud to provide critical healthcare in a rural community. Across the entire United States, rural areas have significant and often unmet healthcare needs and an accompanying dearth of other social services. Meeting the needs of these communities is extraordinarily complex and demanding, and Ottumwa Regional's operational challenges stem from the problems associated with resources, location, and characteristics of the community's population.

First, the population served by Ottumwa Regional faces a variety of significant social, economic, and health challenges, and the region's socioeconomic and demographic characteristics complicate recruiting to the area. A meaningful proportion of the population in the region suffers from opioid, alcohol, and/or methamphetamine addiction and/or its consequences. In fact, as of 2021, Wapello

County—in which Ottumwa sits—had the highest rate of methamphetamine-related treatment admission in the state of Iowa (1,011 per 100,000) and the highest rate of opioid-related treatment admission in the state (171 per 100,000).[1] And Iowa has one of the highest rates of opioid abuse in the country, in the top quintile of all states.[2] Alcohol is the most reported primary substance of choice at treatment admission in the state, and in 2020, one third of Iowans aged 18-34 reported binge drinking in the past 30 days.[3] There is also a high rate of behavioral health issues in the community, much of which is related to addiction and lack of social services.[4] And this area is experiencing disproportionately high rates of poverty and unemployment.

In addition to the challenges the socioeconomic condition of the region brings to health care provision for this population, it is difficult to recruit highly trained and experienced professionals, including physicians and nurses, to relocate and settle in the community. Ottumwa Regional cannot offer retirement benefits because the organization does not qualify for Iowa Public Employees' Retirement ("IPER") program unlike the other hospitals in our region and throughout the state. Moreover, retention issues are compounded by the limited housing and food options in a town with a population of just over 25,000.[5] This, added to the reputational harm caused by the apparent suicide of a contracted nurse practitioner who was accused of sexually assaulting patients, has affected Ottumwa Regional's ability to hire and retain staff and attract new patients.

Regional closures have compounded the challenges of recruiting staff. In 2016, the Indian Hills Community College ("IHCC") Nursing School—an important source of healthcare workers in the region—lost accreditation. This drastically decreased the number of students enrolled in the program while the school worked to obtain accreditation, which in turn reduced the flow of new nurses into the area workforce. Enrollment at IHCC remains down from historical numbers. In 2021, a loss of grant funding for e-ICU services resulted in the closure of that program, leading to the loss of e-ICU providers and, with that, certain required expertise. In 2023, Iowa Wesleyan University, another source of much-needed healthcare workers, closed its doors. This further limited new nurses entering the workforce and reduced the number of students completing clinical rotations at Ottumwa Regional.

---

[1] *2020 State of Iowa Substance Use Epidemiological Profile*, Iowa Dep't of Health and Human Services (June 2021). In a 2022 statewide survey, 3% of Iowan adults reported using methamphetamine at least one day during the past month. *Methamphetamine Use and Trends in Iowa*, Iowa Dep't of Health and Human Services (Jan. 2023).

[2] *2020 State of Iowa Substance Use Epidemiological Profile*, Iowa Dep't of Health and Human Services (June 2021).

[3] *Id.*

[4] For example, 14 percent of Iowans reported having a major depressive episode in 2019. *2020 State of Iowa Substance Use Epidemiological Profile*, Iowa Dep't of Health and Human Services (June 2021). The Centers for Disease Control and Prevention indicated that Wapello County is among the most socially vulnerable counties in Iowa (top quarter), a term that factors in socioeconomic status, household characteristics, racial and ethnic minority status, and housing type/transportation. Wapello County performs more poorly than the state of Iowa in many health and socioeconomic metrics, including rates of obesity and diabetes, smoking, food insecurity, physical inaction and access to exercise opportunities, health insurance enrollment, vaccinations, frequent mental and physical distress, severe housing cost burden and housing problems, unemployment, rates of child poverty, rates of free- and reduced-lunch enrollment, single-family households, access to broadband, high school graduation rates, and college attendance. *Opportunities for Improvement in Wapello County*, Iowa Hospital Association (June 2022).

[5] Compare this number to, for example, a population of nearly 70,000 people ***just*** in the 20002 zip code—the zip code that encompasses the Russell Senate Building. *2023 Demographics*, DC Health Matters (last accessed Jan. 30, 2024), https://www.dchealthmatters.org/demographicdata?id=9402.

Notwithstanding these hurdles, Ottumwa Regional has and will continue to work tirelessly to recruit, train, and retain healthcare providers. For example, to attract full-time applicants to Ottumwa Regional, in 2023, hospital leadership strategically decided to invest an additional $1.6 million dollars annually in salary adjustments to employees in a number of critical roles, including EMTs, registered nurses, respiratory therapists, and surgical technicians, among others. Also in 2023, Ottumwa Regional added attractive, competitive sign-on bonuses up to $35,000 for select, hard-to-fill positions such as ICU and ER registered nurses with greater than one year of experience and night shift paramedics. Ottumwa Regional also offers tuition reimbursement for professionals who are pursuing additional education that is in line with their current or future role. To encourage employees to refer their professional colleagues, Ottumwa Regional instituted a referral bonus program where employees will receive compensation up to $7,500 for referring a qualified person for a hard-to-fill position. In addition, to entice individuals who left the organization to return, Ottumwa Regional offers reinstatement benefits for people who leave and come back within 12 months of their departure, so they do not lose any of their earned benefits and seniority. Ottumwa Regional currently employs two full-time recruiters to seek qualified, talented candidates locally, regionally, and across the country. Moreover, Ottumwa Regional posts open job listings on its website and various social media pages, and partners with Indian Hills Community College and local high schools to help develop, mentor, and train the next generation of healthcare professionals. Ottumwa Regional is currently recruiting—and in ongoing discussions with—three OB/GYNs, two general surgeons, one orthopedist in addition to an Iowa-based orthopedic group, and a certified nurse midwife. Ottumwa Regional is also committed to continuing its efforts to work with state leaders and legislatures to find solutions to the industry-wide staffing shortages, including by seeking to expand the availability of J-1 and H-1 visa slots available for foreign-trained medical graduates to obtain Iowa medical licensure and support rural communities throughout the state.

To foster an environment where providers want to practice, Ottumwa Regional's leadership team is available to its physicians 24/7 to respond to any concerns they have. Leadership regularly checks in on providers to listen to the challenges and opportunities they have so they remain engaged in the organization and the community. To that end, Ottumwa Regional has provided leadership training in the past six months to its management team to increase their knowledge and competency. Additionally, Ottumwa Regional has introduced new medical staff meetings to provide providers a forum where they can communicate with one another across service lines and with the administrative team.

Enclosed at LP-CEG-004613 through LP-CEG-004624 are documents related to Ottumwa Regional's efforts to recruit and maintain staff, namely:

- Student Loan Repayment Program Agreement, at LP-CEG-004613;
- Your Benefits At-a-Glance brochure, at LP-CEG-004614 through LP-CEG-004620;
- Jump-Start Your Nursing Career brochure, at LP-CEG-004621 through LP-CEG-004623; and
- Referral Bonus Program policy, at LP-CEG-004624.

Second, Ottumwa Regional faces challenges that many other hospitals in the region do not. Ottumwa Regional is the only health center with emergency or critical care services in the town of Ottumwa, IA—indeed, within an approximately 25-mile radius. However, nearly every other hospital in Iowa, Ottumwa Regional does not receive any tax support to render the services provided to the community. Ottumwa Regional paid $1.8 million in property taxes in 2023 alone, as it is not eligible for tax-exempt status, unlike many other hospitals. *See* Iowa Code Ann. § 427.1(8) (exempting grounds and buildings owned by nonprofits from property taxes). Unlike other areas, which are served by a county-owned EMS fleet, Ottumwa Regional provides EMS services at a loss—approximately a $600,000 loss in 2023. And unlike other hospitals, Ottumwa Regional does not have the critical access hospital reimbursement structure that is largely cost-based. Additional challenges navigated by Ottumwa Regional over the last eight years have compounded the complexity of providing consistent patient care. In 2016, Ottumwa Regional shifted to managed Medicaid, and subsequently poor reimbursement rates led to the closure of home health care in 2018. This was not unique to Ottumwa Regional; indeed, many other Iowa home health cares struggled and closed, leading to difficulty with care transitions and discharge planning for patients.

Third, like many other healthcare facilities, Ottumwa Regional faced increased and unprecedented challenges resulting from the COVID-19 pandemic. In addition to increased volume, Ottumwa Regional was required to implement new Occupational Safety and Health Administration ("OSHA") standards, including the Healthcare Emergency Temporary Standard (ETS)[6] issued on June 21, 2021 and other safeguards to protect against spread of the virus. Supply chain shortages, particularly of personal protective equipment ("PPE"), challenged operations during the height of the pandemic, and the implementation of a COVID vaccine program posed staffing and resource challenges. Moreover, because of the increased volume and longer stays, Ottumwa Regional faced a shortage of available inpatient rooms. Ottumwa Regional was also required to provide increased reporting, specifically on COVID-19 data, bed availability, and vaccinations, for both the federal government and the State of Iowa. Required COVID testing also led to discharge and placement challenges for individuals who tested positive. From a staffing standpoint, Ottumwa Regional dealt with dramatic changes in workforce due to the COVID-19 pandemic, coupled with an aging provider and employee population—resulting in an increased number of retirements from 2020 to the present.

Ottumwa Regional works diligently to provide reliable, quality healthcare to a community with elevated needs, even in the face of operational challenges in the industry and challenges faced uniquely by Ottumwa Regional. Ottumwa Regional will continue to strive to enhance patient care as a cornerstone health provider in rural Iowa.

To provide additional context on Ottumwa and the county in which it sits, Wapello County, enclosed at LP-CEG-004625 through LP-CEG-005001 are the following documents:

- Methamphetamine Use and Trends in Iowa, January 2023, created by Iowa Department of Health and Human Services, at LP-CEG-004625 through LP-CEG-004628;
- Opportunities for Improvement in Wapello County, July 2022, created by the Iowa Hospital Association, at LP-CEG-004629;

[6] OSHA, "Occupational Exposure to COVID-19; Emergency Temporary Standard," 86 Federal Register 32376, June 21, 2021.

- Hospital Dashboard for Ottumwa Regional Health Center, updated January 2023, created by the Iowa Hospital Association, at LP-CEG-004630;
- Social Vulnerability Index: Interactive Map for Service Area 5, created by the Centers for Disease Control and Prevention, at LP-CEG-004631 through LP-CEG-004667;
- State of Iowa Substance Use Epidemiological Profile 2020, created by the Iowa Department of Public Health, at LP-CEG-004668 through LP-CEG-004818; and
- Evaluation of Community Prevention Strategies for Preventing Prescription Drug Misuse by the Iowa Department of Human Rights, at LP-CEG-004918 through LP-CEG-005001.

13. From 2015 to the present, broken down by year, explain in detail the clinical operations of Ottumwa Regional's operating rooms, including but not limited to, the number of operating rooms the hospital is licensed for, the hours of operation (on and off hours), and all doctor-to-patient and nurse-to-patient staffing ratios. Produce all documents that support your answer.

From 2015 through 2019, Ottumwa Regional had 4 operating rooms and 2 procedure rooms.[7] The surgical hours of operation were 7:00 AM to 3:15 PM, Monday through Friday. The surgical on-call hours were 3:15 PM to 7:00 AM, Monday through Friday, and 24 hours per day on Saturday and Sunday. An anesthesiologist, surgeon, nurse, and scrub technician were required to attend each surgery.

In 2015, 15 surgeons completed 6,200 surgeries. In 2016, 15 surgeons completed 6,056 surgeries. In 2017, 16 surgeons completed 6,039 surgeries. In 2018, 19 surgeons completed 6,204 surgeries. In 2019, 17 surgeons completed 6,362 surgeries.

In 2020, Ottumwa Regional had 4 operating rooms and 2 procedure rooms. The hours of operation were 7:00 AM to 3:15 PM, Monday through Friday. The surgical on-call hours were 3:15 PM to 7:00 AM, Monday through Friday, and 24 hours/day on Saturday and Sunday. As a consequence of the Covid-19 pandemic and related restrictions that year, Ottumwa Regional reduced elective surgical cases and conducted only urgent and emergent cases. An anesthesiologist, a surgeon, a nurse, and a scrub technician attended each surgery. In 2020, 17 surgeons completed 5,406 surgeries.

In 2021 and 2022, Ottumwa Regional continued to have 4 operating rooms and 2 procedure rooms. The hours of operation remained 7:00 AM to 3:15 PM, Monday through Friday, with surgical on-call hours between 3:15 PM and 7:00 AM, Monday through Friday, and 24 hours per day on Saturday and Sunday. An anesthesiologist, a surgeon, a nurse, and a scrub technician were required to attend each surgery. During 2021, 17 surgeons completed 6,032 surgeries, and over the course of 2022, 13 surgeons completed 4,844 surgeries. In 2022, several surgeons departed due to retirement, term limitations, and family relocation, all of which are typical happenings in the healthcare industry.

[7] Procedure rooms are where endoscopies and colonoscopies are performed.

In 2023, Ottumwa Regional continued to have 4 operating rooms and 2 procedure rooms. The hours of operation were the same (7:00 AM to 3:15 PM, Monday through Friday; on call the remainder of the weekday hours and all weekend). Because of critical staffing shortages—which were consistent with both the challenges inherent to staffing a rural hospital and industry-wide staffing difficulties[8]—Ottumwa Regional modified the operating room call to cesarean-section only in April 2023 and again beginning in September 2023. Multiple surgeons either retired or took leave during Fall 2023, and the director of the operating room and one operating room nurse also left in September 2023. Notwithstanding the staffing shortages, Ottumwa Regional nevertheless performed 4,710 surgeries in 2023. And, as described in our response to question 12 above, Ottumwa Regional has taken and continues to take instrumental steps to recruit critical physicians.

In a significant investment for the community, Ottumwa Regional brought a new DaVinci Robot (to perform minimally invasive surgeries) into service in January 2023, representing a capital investment of over $1 million. In October 2023, Ottumwa Regional celebrated having completed 1,000 robotic surgeries.

a. Have there been any reductions in hours or closures of Ottumwa Regional's operating rooms? If yes, explain the reasons for any reductions or closures, including but not limited to, the hospital's ability—for financial, personnel, or other reasons—to perform emergency surgery cases. Produce all documents that support your answer.

[8] Staffing shortages represent a significant challenge across the healthcare industry, both in the United States and worldwide:

> In the complex landscape of challenges facing the U.S. healthcare industry, none is more pressing than the acute shortage of skilled personnel. According to an American Hospital Association fact sheet, there will be an estimated shortage of up to 3.2 million healthcare workers by 2026. Additionally, a recent McKinsey and Company study reports resignations among healthcare professionals have surged, escalating from approximately 400,000 per month in 2020 to a staggering 600,000 per month by May 2023. This situation is exacerbated by the increasing departure and turnover of first- and second-year nurses. With more healthcare workers expected to exit the workforce over the next several years, these staffing shortages will only worsen unless organizations intervene.

Andrew Malley, *Navigating The Healthcare Staffing Crisis: A Treatment Plan For Workforce Stability*, Forbes (Dec. 23, 2023) https://www.forbes.com/sites/forbesbusinesscouncil/2023/12/29/navigating-the-healthcare-staffing-crisis-a-treatment-plan-for-workforce-stability/; *see also Key Insights: Health Care Staffing Shortages*, U.S. Pandemic Response Accountability Committee (Nov. 6, 2023), https://www.pandemicoversight.gov/oversight/our-publications-reports/health-care-staffing-shortages (discussing staffing shortages at federal health facilities and acknowledging contributing factors of limited labor pool, noncompetitive pay, COVID-19 requirements, and challenging hiring processes); Aleksander Džakula, et al., *Health Workforce Shortage - Doing the Right Things or Doing Things Right?*, 63 Croat. Med. J. 2, 107 (Apr. 2022), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/ PMC9086817/ ("Healthcare workforce shortage is a worldwide problem. Workforce shortage may be defined as not having the right number of people with the right skills in the right place at the right time, to provide the right services to the right people. In this regard, the trends are worrisome, and the situation is getting worse. The consequences are also very consistent – limited care health services and limited quality of health care. In short, there is an imbalance between need and supply.")

b. Identify any sentinel events, any operational, staffing, and/or regulatory issues that caused reductions in the day-to-day clinical operations or closures of Ottumwa. Regional's operating rooms. Describe any staffing concerns or shortages. Produce all documents that support your answer.

As described above, there are two periods during which Ottumwa Regional modified its operating rooms procedures.

The first was during 2020, when the Covid-19 pandemic and relevant restrictions caused Ottumwa Regional to reduce elective surgical cases and conduct only urgent and emergent cases.

In 2023, Ottumwa Regional then modified the operating room call to cesarean-sections only for the month of April and then again beginning in September (continuing through today) due to critical staffing levels. Although there is a sufficient number of staff to run the same number of operating rooms, there are insufficient staff levels to attend to both operating rooms and cesarean section calls. Ottumwa Regional's operating room is staffed by a large number of contract staff. Staffing both the OR call and OB call requires two full on-call teams. Ottumwa Regional has always had sufficient on-call staff to operate the obstetrics call—that is, for cesareans—but it had to pause operating room call coverage on nights and on weekends while it assembles a contract labor staff to consistently provide coverage for the operating room call. In order to ensure the highest standards of safety and patient care, contract labor staff must be fully oriented and safely capable of providing care without additional resources that are available during normal daytime operations. Enclosed at LP-CEG-005002 through LP-CEG-005004 is an August 2023 email from the Chief Nursing Officer with information about the change.

15. From 2015 to the present, broken down by year, explain in detail the clinical operations of Ottumwa Regional's medical-surgical floor, including but not limited to, the number of medical-surgical beds for which the hospital is licensed and all doctor-to-patient and nurse-to-patient staffing ratios. Were there any sentinel events, any operational, staffing, and/or regulatory issues that caused Ottumwa Regional to reduce capacity or close the med-surge floor? If so, explain. Produce all documents that support your answer.

From 2015 through 2023, Ottumwa Regional maintained 24 medical-surgical beds, with a doctor-to-patient ratio of 1:17 and a nurse-to-patient ratio of 1:5, on average. The medical-surgical floor is staffed with approximately 22 nurses and 10 patient care technicians—between days and nights—so that Ottumwa Regional can maintain a 1:5 nurse-to-patient ratio. Each day, there are two to four nurses and one to three technicians on the floor, depending on the number of patients.

- In 2015, Ottumwa Regional provided 5,481 patient days[9] on its medical-surgical floor. That same year, the medical-surgical unit merged with telemetry to maximize volume by combining limited resources. One urologist left Ottumwa Regional, leaving only one urologist.

[9] "Patient days" refers to the number of inpatients admitted to a hospital multiplied by the number of midnights each patient stayed. This number does not include nursery patients or patients admitted to observation status.

- In 2016, Ottumwa Regional provided 5,596 patient days on its medical-surgical floor. In terms of provider staffing, Ottumwa Regional contracted with Apogee Medical Management Inc. ("Apogee") to initiate the hospitalist program, which staffed the medical-surgical floor with four medical doctors and two nurse practitioners.[10] Two of the medical doctors were present during daytime operations, which is the busiest time. One nurse practitioner was added for overnight coverage, with one medical doctor on call for guidance or assistance as needed.
- In 2017, Ottumwa Regional provided 6,201 patient days on its medical-surgical floor. Ottumwa Regional's remaining urologist left in 2017, leaving no urology services.
- In 2018, Ottumwa Regional was able to hire a urologist, and urology services resumed. That year, Ottumwa Regional provided 6,072 patient days on its medical-surgical floor. In 2019, Ottumwa Regional provided 5,703 patient days on its medical-surgical floor.
- In 2020, the COVID-19 pandemic began, resulting in changes to safety practices, social distancing, and other related protocols. Ottumwa Regional provided 5,732 patient days on its medical-surgical floor in 2020.
- In 2021, Ottumwa Regional was still adjusting to pandemic-related changes as described above but nevertheless provided 5,615 patient days on its medical-surgical floor.
- In 2022, due to staffing challenges and limited availability of travel nurses, Ottumwa Regional experienced a decrease in volume of its medical-surgical floor. To ensure that patients received the care they needed, Ottumwa Regional combined the remaining ICU staff with the medical-surgical staff. That year, Ottumwa Regional provided 4,363 patient days on its medical-surgical floor.
- In 2023, Ottumwa Regional was able to increase staffing because more travel staff were available and was consequently able to increase its volume for the medical-surgical floor slightly. Ottumwa Regional provided 4,404 patient days on its medical-surgical floor in 2023.

* * *

Ottumwa Regional welcomes the opportunity to share more about its operations, policies, and procedures. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

[redacted]

[10] It is common practice for healthcare facilities like Ottumwa Regional to contract with companies such as Apogee to provide specific specialty medical service, including in the delivery of radiology services. Providers like Apogee enable Ottumwa Regional's administration and medical executive committee to work hand-in-hand with the larger group of professionals to enhance their ability to recruit caregivers to markets like Ottumwa and provide the highest level and quality of radiology services.

March 4, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint" or the "Company").

This submission responds to a subset of the questions set forth in your letter of December 6, 2023 (the "Requests").

We have included in this production documents that include proprietary business information. The documents have been marked "Confidential Treatment Requested." We request that these documents not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Lifepoint Questions

1. Describe Lifepoint's financial and operational relationship with Ottumwa Regional. Produce all documents that support your answer, including those related to RCHP-Ottumwa, LLC.

The operations of Ottumwa Regional are carried out by RCHP-Ottumwa, LLC, a Delaware limited liability company. RCHP-Ottumwa, LLC is an indirect, wholly owned subsidiary of Lifepoint. Ottumwa Regional is operated through a shared governance model, in which the local management team is responsible for day-to-day general and clinical operations, human resources, and administration of Ottumwa Regional, with oversight by the hospital's Board of Trustees and RCHP-Ottumwa, LLC. Lifepoint provides extensive operational and financial support to Ottumwa Regional.

The Managerial and Administrative Support Agreement between Lifepoint Corporate Services, General Partnership, and RCHP-Ottumwa, LLC (the "Managerial and Administrative Support Agreement"), previously produced at LP-CEG-000001 through LP-CEG-000029, sets forth the relationship between Lifepoint Corporate Services, General Partnership (the "Manager") and

RCHP-Ottumwa, LLC. Lifepoint's role as Manager is to provide management, administration, consulting and purchasing services and support, and other management services (collectively, "Management Services") as needed for the operation of Ottumwa Regional. The Management Services provided by Lifepoint as Manager include but are not limited to: providing consulting services in the areas of long-range planning, management planning, and productivity improvement; arranging for the purchase of hazard, liability, professional, and other necessary insurance coverage; and providing operational guidelines, including but not limited to protocols and medical guidelines.[1] The comprehensive scope of Management Services provided by Lifepoint under the Managerial and Administrative Support Agreement are included in Articles III, IV, and V of the agreement.

As further detailed in our response to Question 4 below, Lifepoint also supports care delivery at Ottumwa Regional through its National Quality Program and through assistance in staff recruitment and retention to help Ottumwa Regional meet national benchmarks. With its national scale, Lifepoint offers its facilities financial stability and security, as well as access to clinical, quality, and operational experts by attracting talent across the country to advance care, improve operations, and support growth.

Additionally, as detailed in the Managerial and Administrative Support Agreement, Lifepoint's financial relationship with Ottumwa Regional is set forth in the Asset Purchase Agreement Among Ottumwa Regional Health Center, Inc., Regional Retirement Living, Inc., Regional Enterprises, Inc., RCHP-Ottumwa, Inc., and RegionalCare Hospital Partners, Inc. (the "Asset Purchase Agreement"), which was previously produced at LP-CEG-000036 through LP-CEG-000120. As set out in further detail in our responses to Questions 2 and 3 below, Lifepoint agreed to fund certain capital projects as they are defined in the Asset Purchase Agreement and to make annual routine capital expenditures equal to at least 5 percent of Ottumwa Regional's net revenue.[2] Ottumwa Regional's Board of Directors is responsible for overseeing the development of the annual operating and capital budgets.[3] Since Lifepoint's acquisition of Ottumwa Regional in 2019, Lifepoint has been committed to its investment in Ottumwa Regional and has spent approximately $15 million to finance capital projects, and has exceeded its required investment commitment by $16 million, to permit the hospital to provide needed healthcare services to a rural community.

Lifepoint also invests in Ottumwa Regional's physician recruitment and development. Indeed, in the last five years, Lifepoint invested in the addition of over 230 employed, affiliated, and telehealth providers to support Ottumwa Regional's core service lines and advanced telemedicine capabilities. In 2023 alone, Lifepoint supported the addition of 78 providers in fields including pediatrics, tele-neurology, tele-radiology, tele-psychiatry, emergency medicine, and sleep medicine.

Lifepoint further has invested in partnerships with leading health systems and providers in Iowa to expand Ottumwa Regional's capabilities and bring new resources to the broader community. For

[1] *See* Managerial and Administrative Support Agreement, Article III.
[2] *See* Asset Purchase Agreement, Section 10.6, 10.7.
[3] *Id.* at 10.7.

example, Lifepoint has a long-standing relationship with the University of Iowa and together provide radiation and oncology services to Ottumwa and the surrounding region. Additionally, Lifepoint has supported Ottumwa Regional's donations of millions of dollars in services to those in need in the community, amounting to approximately $43 million in services over the past five years.

The Limited Liability Company Agreement of RCHP-Ottumwa, LLC (the "LLC Agreement"), previously produced at LP-CEG-000030 through LP-CEG-000035, documents the formation of RCHP-Ottumwa, LLC in accordance with the Delaware Limited Liability Company Act.

2. Provide the exact dollar amount of Lifepoint's own capital that Lifepoint has invested in Ottumwa Regional. Please answer in timeline form and provide all documents that support your answer, including but not limited to, all agreements or contracts between your company and Ottumwa Regional.

Over the past five years (the period of Lifepoint's ownership of Ottumwa Regional), on a cumulative basis, Lifepoint has invested $15 million of its own capital in Ottumwa Regional, which included $14 million in capital projects and $1 million to fund the hospital's losses.

As we have emphasized in our prior letters, rural areas, like Wapello County where Ottumwa Regional sits, pose significant operational challenges for a healthcare facility that stem from the problems associated with resources, location, and the characteristics of the community's population. Specifically, the population served by Ottumwa Regional faces a variety of social, economic, and health challenges, and the region's socioeconomic and demographic characteristics complicate recruiting to the area. Although Ottumwa Regional has worked diligently to provide reliable, quality healthcare despite these operational challenges, Ottumwa Regional has operated at a net loss over the past five years, before accounting for any interest or rent expenses. Therefore, Ottumwa Regional was in need of capital each of those years, which Lifepoint provided. Lifepoint's investments have supported facility updates and new equipment and technology in core service lines, as further detailed below and reflected at LP-CEG-005005 through LP-CEG-005006. Lifepoint is committed to investing in Ottumwa Regional, the only hospital in Wapello County, to ensure that Ottumwa Regional can continue to provide quality healthcare services to a community in need.

In 2019, Lifepoint invested approximately $2 million of its own capital in projects at Ottumwa Regional, which included purchasing new endoscopy equipment and updating existing surgical equipment, acquiring new surgery towers to improve safety and outcomes, and making structural updates to the facility. Lifepoint also invested in physician recruitment, adding 52 providers in 2019 in fields including pediatrics, obstetrics and gynecology, emergency medicine, radiation oncology, and heart care.

In 2020, Lifepoint invested approximately $2 million of its own capital in projects at Ottumwa Regional. Lifepoint remodeled the hospital's cancer center and launched its telehealth services for primary care, urology, obstetrics and gynecology, and gastroenterology to support patient needs and continue providing quality care during the COVID-19 pandemic. Lifepoint invested in significant equipment enhancements in 2020, purchasing a linear accelerator for use in radiation treatments and

a new CT machine with enhanced imaging capabilities, and upgrading its Steris surgical sterilization system. Lifepoint also invested in physician recruitment, adding 30 providers in 2020 in fields including tele-psychiatry, tele-neurology, tele-radiology, and emergency care.

In 2021, Lifepoint invested approximately $5 million of its own capital in projects at Ottumwa Regional. Lifepoint purchased two new ventilator machines, a digital portable x-ray machine, three anesthesia machines, a new operating room video tower, and new ambulance defibrillator monitors; it also upgraded the facility's power system. Lifepoint also invested in physician recruitment, adding 32 providers in 2021 in fields including emergency medicine, hospital medicine, cardiology, surgery, tele-psychiatry, tele-neurology, and tele-radiology.

In 2022, Lifepoint invested approximately $3 million of its own capital in projects at Ottumwa Regional. Lifepoint made broad equipment improvements, purchasing a new laryngoscope system, a Trimano Fortis arm support for surgical use, new transesophageal echocardiogram equipment, new IV pumps throughout the hospital, and a new automatic ultrasonic system. Lifepoint also invested in facility upgrades to enhance patient safety and experience, which included adding additional patient lifts and upgrading the patient room furniture, HVAC controls, arthroscopes, and laparoscopes. Lifepoint further invested in physician recruitment, adding 42 providers in 2022 in fields including urology.

In 2023, Lifepoint invested approximately $2 million of its own capital in projects at Ottumwa Regional. Lifepoint invested in an electroencephalogram amplifier to enhance the hospital's neurology capabilities. Lifepoint also purchased a new medication management system, transitioned to a highly advanced sharps disposal system for improved drug diversion prevention, and added three new ambulances to the hospital's fleet. Lifepoint further acquired Sensoscientific temperature monitoring equipment to enhance patient safety and quality. Lifepoint also invested in physician recruitment, adding 78 providers in 2023 in fields including pediatrics, tele-neurology, tele-psychiatry, emergency medicine, and sleep medicine.

In sum, from 2019 to 2023, Lifepoint invested $14 million in capital projects and funded $1 million of Ottumwa Regional's losses (before accounting for any interest or rent expenses).

Additionally, on the same basis, Lifepoint expects to invest an additional $11 million in Ottumwa Regional over the next two years, $6 million in capital projects and $5 million to fund additional losses.

3. **Please produce all documents that obligate Lifepoint to reinvest at least 5 percent of Ottumwa Regional's annual net patient revenue in the hospital.**
   a. **From 2018 to the present, broken down by year, provide the exact dollar amount and percentage of Ottumwa Regional's revenue that has been reinvested in the hospital. Produce all documents that support your answer.**
   b. **For each investment, describe how the money was allocated, and provide an explanation. Produce all documents that support your answer.**

Pursuant to the Asset Purchase Agreement, Lifepoint is obligated to make annual routine capital expenditures in connection with the operation of Ottumwa Regional equal to at least 5 percent of Ottumwa Regional's annual net patient revenue (the "Required Investment Percentage" or "RIP").[4] Under the agreement, routine capital expenditures are counted toward the RIP and include expenditures for unforeseen maintenance, new equipment, equipment replacement, facility renovations, and other capital improvements.[5] Expenditures on physician recruitment and retention are also counted toward the RIP.[6]

Since Lifepoint acquired Ottumwa Regional in 2019, Lifepoint's capital expenditures in Ottumwa Regional have exceeded the required commitment by $16 million. As illustrated below, on a cumulative basis from 2019 to 2023, Lifepoint was required to invest $18 million in Ottumwa Regional. Lifepoint exceeded that commitment, investing $34 million in capital expenditures and physician recruitment and retention at Ottumwa Regional.

A detailed breakdown of the amount (in millions) and percentage of Ottumwa Regional's revenue that has been reinvested in the hospital from 2019 through 2023, along with how Lifepoint's investments correspond to the enumerated capital projects (listed under Total investments toward RIP), is below.

	Cumulative Inception thru 12/31/23	Cumulative 2019 - 2023	2023	2022	2021	2020	2019	Cumulative Inception thru 12/31/18
Required investment percentage (RIP)	$ 41	$ 18	$ 3	$ 3	$ 4	$ 3	$ 4	$ 22
Total investments toward RIP	61	34	7	8	9	7	2	27
Investment exceeding / (below) RIP	$ 20	$ 16	$ 4	$ 5	$ 5	$ 4	$ (2)	$ 5
Total capital expenditures and leased assets applicable to RIP	$ 42	$ 15	$ 3	$ 3	$ 4	$ 3	$ 2	$ 27
Total operating lease applicable to RIP	1	1	-	-	-	-	-	-
Total physician recruitment & retention applicable to RIP	18	18	4	5	5	4	-	-
Total investments toward RIP	$ 61	$ 34	$ 7	$ 8	$ 9	$ 7	$ 2	$ 27
Linear Accelerator and CT Simulation Replacement		$ 3	$ -	$ -	$ -	$ 3	$ -	
Monitoring & Telemetry Replacement & Expansion		2	-	-	2	-	-	
Cathetarization Lab Expansion		2	1	1	-	-	-	
DaVinci Robot		1	1	-	-	-	-	
Omnicell Software for Pharmacy		1	1	-	-	-	-	
Medical Office Building Renovation		1	-	1	-	-	-	
Smart/Optiflex Implementation		1	-	-	1	-	-	
Elevator Upgrades		1	-	-	-	-	1	
IT Hardware Replacement		1	-	-	1	-	-	
Facility Infrastructure		1	-	1	-	-	-	
Total of all other "smaller" projects		1	-	-	-	-	1	
Total capital expenditures and leased assets applicable to RIP		$ 15	$ 3	$ 3	$ 4	$ 3	$ 2	

[4] *See* Asset Purchase Agreement, Section 10.7.

[5] In December 2020, Ottumwa Regional's Board of Directors approved an amendment to the Asset Purchase Agreement to allow for operating/capital leases to be included in the definition of routine capital expenditures. *See* LP-CEG-005007 through LP-CEG-005008.

[6] In December 2020, Ottumwa Regional's Board of Directors approved an amendment to the Asset Purchase Agreement to change the 5% of net operating revenue designated for annual routine capital expenditures to a split of 3.75% capital expenditures and 1.25% physician recruitment and retention. *See* LP-CEG-005007 through LP-CEG-005008.

4. While invested in Ottumwa Regional or any related entity that has an interest in Ottumwa Regional, please describe—and produce all documents that support your answer with respect to—Lifepoint's authority to:

a. Manage its care delivery;
b. Manage its billing practices;
c. Determine its annual net income goals;
d. Determine its charge per patient goals;
e. Determine its staff-to-patient ratios;
f. Determine its charge-to-cost ratios;
g. Enter into contracts for staffing; and
h. Enter into any contracts on behalf of Ottumwa Regional.

Lifepoint supports care delivery at Ottumwa Regional and our other acute care hospitals through its National Quality Program and through assistance in recruitment and retention to meet national benchmarks. With its national scale, Lifepoint offers its facilities financial stability and security, as well as access to clinical, quality, and operational experts by attracting talent across the country to advance care, improve operations, and support growth. Additionally, as detailed in the Managerial and Administrative Support agreement, previously produced at LP-CEG-000001 through LP-CEG-000029, LifePoint provides consulting services across a wide range of areas, including long-range planning, quality assurance programs, educational programs, and physician recruiting, among other areas.

Lifepoint also provides its facilities with capital to invest in facility improvements, technology and people, and dedicated resources to help recruit providers and employees. Lifepoint has engaged Lifepoint Corporate Services, General Partnership ("LCSGP"), an indirect, wholly owned subsidiary of Lifepoint, through a Managerial and Administrative Support Agreement, previously produced at LP-CEG-000001 through LP-CEG-000029.

In addition, the Quality Committee of the Lifepoint Board of Directors has the authority to monitor and evaluate Lifepoint hospitals' quality of care metrics and patient safety programs, to review and discuss those metrics with Lifepoint senior management, and to receive reports from Lifepoint senior management on the hospital network's safety standard and preventative actions. Ultimately, however, matters requiring the professional medical judgment of a provider are the responsibility of Ottumwa Regional and Lifepoint has an obligation to respect the medical judgment of the Ottumwa Regional's medical staff and has no right to make medical judgments.

With respect to billing, Ottumwa Regional is responsible for determining the general and fiscal policies at the hospital. Ottumwa Regional's finance team manages day-to-day billing responsibilities, but Lifepoint has policies and procedures to monitor and manage billing practices at the facilities and ensure compliance.

Lifepoint does not set annual net income, charge per patient, or charge-to-cost goals for Ottumwa Regional or for any of our other acute care hospitals.

With respect to hiring, RCHP Ottumwa, LLC is responsible for selecting the hospital Chief Executive Officer after consultation with the Ottumwa Regional Board of Directors, which is comprised of community leaders, the hospital CEO, and members of the Ottumwa Regional medical staff. In addition to its responsibility regarding the selection of the hospital CEO, the Ottumwa Board of Directors oversees the overall quality and efficiency of patient care at Ottumwa Regional and the organization and governance of medical staff. To the extent Ottumwa needs human resources assistance, Lifepoint can provide human resource functions to the hospital.

Lifepoint believes that empowering Ottumwa Regional's management team is critical to successfully identifying and meeting the needs of patients, medical staff, and the community as a whole. In addition to the CEO, Ottumwa Regional's management team includes an associate administrator, a chief financial officer, and a chief nursing officer ("CNO"). The hospital management team has broad authority to conduct the day-to-day operations of Ottumwa Regional. The CEO is responsible for decisions concerning day-to-day general and clinical operations, human resources, and administration of Ottumwa Regional, with oversight by the Ottumwa Regional Board of Directors. The Ottumwa Regional management team more generally is responsible for managing clinical care, developing an annual operating and capital budget for review with the Ottumwa Board of Directors, making staffing decisions and policies, and entering into contracts on behalf of Ottumwa Regional, including staffing contracts.

With respect to contracts, Lifepoint can work with Ottumwa Regional to enter into certain contracts and agreements. For example, pursuant to the Managerial and Administrative Support Agreement referenced above, Lifepoint can engage consultants on behalf of Ottumwa Regional when both Lifepoint and Ottumwa regional consider it necessary and appropriate. Additionally, subject to applicable legal and regulatory requirements, Lifepoint can negotiate, enter, and terminate contracts for services on behalf of Ottumwa Regional.

13. **How much money, broken down by year, did Lifepoint receive in COVID-19 stimulus aid, including CARES Act dollars and grants? Produce all documents that support your answer.**
    a. **Provide an explanation as to why Lifepoint needed COVID-19 stimulus aid, including CARES Act dollars and grants. Produce all documents that support your answer.**
    b. **Describe in detail how COVID-19 stimulus aid and CARES Act funds were allocated, including but not limited to, their allocation among or between Lifepoint owned or operated facilities. Produce all documents that support your answer.**
    c. **Did Lifepoint use any COVID-19 stimulus aid or CARES Act dollars or grants for acquisitions or mergers? If so, please explain. Produce all documents that support your answer.**

Like most hospitals across the nation, Lifepoint's facilities received financial support from the federal government through the CARES Act Public Health and Social Services Emergency Fund.

All CARES Act funds received were spent in compliance with Department of Health and Human Services rules and regulations, which was verified by an independent audit. Lifepoint received a total of $677 million over three years (from 2020 through 2022) in CARES Act dollars. Lifepoint did not use COVID-19 stimulus aid or CARES Act dollars or grants for acquisitions or mergers.

COVID-19 had a significant adverse effect on Lifepoint, as was the case for many other healthcare companies. Per the CARES Act attestation process, funds are attributed to lost revenue[7] and COVID expenses, which LifePoint tracked diligently. Due to government-ordered shutdowns, restrictions on elective procedures, and the increased costs associated with delivering high-quality COVID care, Lifepoint sustained approximately $1.3 billion in COVID-related losses and expenses.

A breakdown of the aforementioned CARES Act funding (in millions) is below.

	Ottumwa	All Other Lifepoint Facilities	Lifepoint Total
Total CARE Act Stimulus $'s Received			
2020	$ 8	$ 628	$ 636
2021	-	27	27
2022	1	13	14
Subtotal	$ 9	$ 668	$ 677
COVID-Related Losses and Expenses			
2020	$ 13	$ 984	$ 997
2021	6	209	215
2022	5	88	93
Subtotal	$ 24	$ 1,281	$ 1,305
Difference	$ (15)	$ (613)	$ (628)

* * *

Lifepoint is proud to play a critical role in providing services to underserved rural communities, and it welcomes the opportunity to share more about Lifepoint, its work in Iowa, and its priorities at Ottumwa Regional. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

[redacted]

[7] The methodology for calculating lost revenues attributable to COVID-19 is promulgated by the Department of Health and Human Services, produced at LP-CEG-005009 through LP-CEG-005012.

March 4, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Ottumwa Regional Health Center ("Ottumwa Regional").

This submission responds to a subset of the questions set forth in your letter of December 6, 2023 (the "Requests").

We have included in this production documents that include proprietary business information. The documents have been marked "Confidential Treatment Requested." We request that these documents not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Ottumwa Questions

4. **Describe in detail Ottumwa Regional's relationship with Lifepoint. Explain how the hospital relies on Lifepoint for any management or operational services. Please produce all documents that support your answers, including all contracts and agreements between Lifepoint and Ottumwa Regional. Please also produce all documents related to Lifepoint Corporate Services, General Partnership, referenced in your April 21, 2023 letter.**

The operations of Ottumwa Regional are carried out by RCHP-Ottumwa, LLC, a Delaware limited liability company. RCHP-Ottumwa, LLC is an indirect, wholly owned subsidiary of Lifepoint. Ottumwa Regional is operated through a shared governance model, in which the local management team is responsible for day-to-day general and clinical operations, human resources, and administration of Ottumwa Regional, with oversight by the hospital's Board of Trustees and RCHP-Ottumwa, LLC. Lifepoint provides extensive financial and operational support to Ottumwa Regional.

The Managerial and Administrative Support Agreement between Lifepoint Corporate Services, General Partnership, and RCHP-Ottumwa, LLC (the "Managerial and Administrative Support Agreement"), previously produced at LP-CEG-000001 through LP-CEG-000029, sets forth the relationship between Lifepoint Corporate Services, General Partnership (the "Manager") and RCHP-Ottumwa, LLC. Lifepoint's role as Manager is to provide management, administration, consulting and purchasing services and support, and other management services (collectively, "Management Services") as needed for the operation of Ottumwa Regional. The Management Services provided by Lifepoint as Manager include but are not limited to: providing consulting services in the areas of long-range planning, management planning, and productivity improvement; arranging for the purchase of hazard, liability, professional, and other necessary insurance coverage; and providing operational guidelines, including but not limited to protocols and medical guidelines.[1] The comprehensive scope of Management Services provided by Lifepoint under the Managerial and Administrative Support Agreement are included in Articles III, IV, and V of the agreement.

As further detailed in the Lifepoint letter, Lifepoint also supports care delivery at Ottumwa Regional through its National Quality Program and through assistance in recruitment and retention to meet national benchmarks. With its national scale, Lifepoint offers its facilities financial stability and security, as well as access to clinical, quality, and operational experts by attracting talent across the country to advance care, improve operations, and support growth. Additionally, as detailed in the Managerial and Administrative Support Agreement, LifePoint provides consulting services across a wide range of areas, including long-range planning, quality assurance programs, educational programs, and physician recruiting, among other areas.

Lifepoint's financial relationship with Ottumwa Regional is set forth in the Asset Purchase Agreement Among Ottumwa Regional Health Center, Inc., Regional Retirement Living, Inc., Regional Enterprises, Inc., RCHP-Ottumwa, Inc., and RegionalCare Hospital Partners, Inc. (the "Asset Purchase Agreement"), which was previously produced at LP-CEG-000036 through LP-CEG-000120. As set out in further detail in our responses to Questions 2 and 3 in the Lifepoint letter, Lifepoint agreed to fund certain capital projects as they are defined in the Asset Purchase Agreement and to make annual routine capital expenditures equal to at least 5 percent of Ottumwa Regional's net revenue.[2] Ottumwa Regional's Board of Directors is responsible for overseeing the development of the annual operating and capital budgets.[3] Since Lifepoint's acquisition of Ottumwa Regional in 2019, Lifepoint has been committed to its investment in Ottumwa Regional and has spent approximately $15 million to finance capital projects, and has exceeded its required investment commitment by $16 million, to permit the hospital to provide needed healthcare services to a rural community.

[1] *See* Managerial and Administrative Support Agreement, Article III.
[2] *See* Asset Purchase Agreement, Section 10.6, 10.7.
[3] *Id.* at 10.7.

Lifepoint also invests in Ottumwa Regional's physician recruitment and development. Indeed, in the last five years, Lifepoint invested in the addition of over 230 employed, affiliated, and telehealth providers to support Ottumwa Regional's core service lines and advanced telemedicine capabilities. In 2023 alone, Lifepoint supported the addition of 78 providers in fields including pediatrics, tele-neurology, tele-radiology, tele-psychiatry, emergency medicine, and sleep medicine.

Lifepoint further has invested in partnerships with leading health systems and providers in Iowa to expand Ottumwa Regional's capabilities and bring new resources to the broader community. For example, Lifepoint has a long-standing relationship with the University of Iowa and together provide radiation oncology services to Ottumwa and the surrounding region. Additionally, Lifepoint has supported Ottumwa Regional's donations of millions of dollars in services to those in need in the community, amounting to approximately $43 million in services over the past five years.

The Limited Liability Company Agreement of RCHP-Ottumwa, LLC (the "LLC Agreement"), previously produced at LP-CEG-000030 through LP-CEG-000035, documents the formation of RCHP-Ottumwa, LLC in accordance with the Delaware Limited Liability Company Act.

6. Please describe and produce all documents that support your answer with respect to how Lifepoint's involvement impacted Ottumwa Regional's authority to:

a. Manage its care delivery;
b. Manage its billing practices;
c. Determine its annual net income goals;
d. Determine its charge-per-patient goals;
e. Determine its staff-to-patient ratios;
f. Determine its charge-to-cost ratios; and
g. Enter into contracts for staffing.

Lifepoint supports care delivery at Ottumwa Regional and our other acute care hospitals through its National Quality Program and through assistance in recruitment and retention to meet national benchmarks. With its national scale, Lifepoint offers its facilities financial stability and security, as well as access to clinical, quality, and operational experts by attracting talent across the country to advance care, improve operations, and support growth. Additionally, as detailed in the Managerial and Administrative Support agreement, previously produced at LP-CEG-000001 through LP-CEG-000029, LifePoint provides consulting services across a wide range of areas, including long-range planning, quality assurance programs, educational programs, and physician recruiting, among other areas.

Lifepoint also provides its facilities with capital to invest in facility improvements, technology and people, and dedicated resources to help recruit providers and employees. Lifepoint has engaged Lifepoint Corporate Services, General Partnership ("LCSGP"), an indirect, wholly owned subsidiary of Lifepoint, through a Managerial and Administrative Support Agreement, previously produced at LP-CEG-000001 through LP-CEG-000029.

In addition, the Quality Committee of the Lifepoint Board of Directors has the authority to monitor and evaluate Lifepoint hospitals' quality of care metrics and patient safety programs, to review and discuss those metrics with Lifepoint senior management, and to receive reports from Lifepoint senior management on the hospital network's safety standard and preventative actions. Ultimately, however, matters requiring the professional medical judgment of a provider are the responsibility of Ottumwa Regional, and Lifepoint has an obligation to respect the medical judgment of the Ottumwa Regional's medical staff and has no right to make medical judgments.

With respect to billing, Ottumwa Regional is responsible for determining the general and fiscal policies at the hospital. Ottumwa Regional's finance team manages day-to-day billing responsibilities, but Lifepoint has policies and procedures to monitor and manage billing practices at the facilities and ensure compliance.

Lifepoint does not set annual net income, charge per patient, or charge-to-cost goals for Ottumwa Regional or for any of its other acute care hospitals.

With respect to hiring, RCHP Ottumwa, LLC is responsible for selecting the hospital Chief Executive Officer after consultation with the Ottumwa Regional Board of Directors, which is comprised of community leaders, the hospital CEO, and members of the Ottumwa Regional medical staff. In addition to its responsibility regarding the selection of the hospital CEO, the Ottumwa Board of Directors oversees the overall quality and efficiency of patient care at Ottumwa Regional and the organization and governance of medical staff. To the extent Ottumwa needs human resources assistance, Lifepoint can provide human resource functions to the hospital.

Lifepoint believes that empowering Ottumwa Regional's management team is critical to successfully identifying and meeting the needs of patients, medical staff, and the community as a whole. In addition to the CEO, Ottumwa Regional's management team includes an associate administrator, a chief financial officer, and a chief nursing officer ("CNO"). The hospital management team has broad authority to conduct the day-to-day operations of Ottumwa Regional. The CEO is responsible for decisions concerning day-to-day general and clinical operations, human resources, and administration of Ottumwa Regional, with oversight by the Ottumwa Regional Board of Directors. The Ottumwa Regional management team more generally is responsible for managing clinical care, developing an annual operating and capital budget for review with the Ottumwa Board of Directors, making staffing decisions and policies, and entering into contracts on behalf of Ottumwa Regional, including staffing contracts.

With respect to contracts, Lifepoint can work with Ottumwa Regional to enter into certain contracts and agreements. For example, pursuant to the Managerial and Administrative Support Agreement referenced above, Lifepoint can engage consultants on behalf of Ottumwa Regional when both Lifepoint and Ottumwa Regional consider it necessary and appropriate. Additionally, subject to applicable legal and regulatory requirements, Lifepoint can negotiate, enter, and terminate contracts for services on behalf of Ottumwa Regional.

14. From 2015 to the present, broken down by year, explain in detail the clinical operations of Ottumwa Regional's intensive care unit (ICU), including but not limited to, the number of ICU beds for which the hospital is licensed and all doctor-to-patient and nurse-to-patient staffing ratios. Were there any sentinel events, any operational, staffing, and/or regulatory issues that caused Ottumwa Regional to reduce the day-to-day clinical operations, reduce capacity, or close the ICU? If so, explain. Produce all documents that support your answer.

Due to location and resource constraints, operating an ICU in a rural area like the one that Ottumwa Regional services presents unique and significant challenges as compared to ICUs in more populated, urban areas. Such challenges include cost, volume, and staffing. For instance, intensivists and pulmonologists, physicians who typically look after ICU patients, are highly compensated, and rural hospitals often lack consistent volume to fully justify the expense. While urban hospitals can reduce their cost and recruit physicians by hiring intensivists or pulmonologists that cover multiple nearby ICUs, rural hospitals, like Ottumwa Regional, lack the ability to implement this cost mitigation strategy given their locations. Rural hospitals also have difficulty achieving the necessary volume to support and recruit these types of physicians. This makes sense; compared to an ICU in a dense urban area that sees a high volume of ICU visits, rural ICUs tend to have far fewer ICU visits. Relatedly, retaining support staff is also a challenge. Since the COVID-19 pandemic, nurses have been in high demand throughout the country, which has placed particular pressure on rural hospitals. For example, many local nurses have quit, becoming travelling nurses instead or have left to pursue potentially more lucrative positions at large urban hospitals that can support such positions.[4]

In response to these challenges, Ottumwa Regional has tried several strategies, including an innovative e-ICU program, to keep its ICU in service so that southeast Iowa residents can access local intensive care when needed. In 2017, Ottumwa Regional secured a grant to launch e-ICU services, where a team of tele-intensivists were available around the clock to provide ICU-level care to ICU patients through the use of advanced camera technology. These intensivists made rounds, or checked on patients, via telemedicine daily and were on-call for any patient needs. As noted below, the grant for e-ICU services ended in 2022, and the cost was too much for Ottumwa Regional to bear on its own.

Since 2015, Ottumwa Regional has maintained 10 ICU beds, with a hospitalist-to-patient[5] ratio of 1:10 and a nurse-to-patient ratio of 1:3. When a patient admitted to the ICU has become severely critical or required a specialist that Ottumwa Regional does not have on staff, Ottumwa Regional has transferred the patient to a hospital in Iowa City or Des Moines, depending on bed availability and need.

---

[4] *Rural Hospitals Losing Hundreds of Staff to High-paid Traveling Nurse Jobs*, NBC News (Sept. 15, 2021) https://www.nbcnews.com/business/business-news/rural-hospitals-losing-hundreds-staff-high-paid-traveling-nurse-jobs-n1279199.

[5] All patients admitted to Ottumwa Regional's medical-surgical or ICU departments are cared for by Ottumwa Regional's contracted hospitalist group, Apogee Medical Management. "Hospitalist" refers to internal medicine physicians or Nurse Practitioners, who are responsible for the care of all inpatients.

In 2015, Ottumwa Regional treated 1,177 patients in the ICU. In 2016, Ottumwa Regional treated 883 patients in the ICU. In 2017, Ottumwa Regional treated 777 patients in the ICU. In 2018, Ottumwa Regional treated 638 patients in the ICU. In 2019, Ottumwa Regional treated 641 patients in the ICU. In 2020, Ottumwa Regional treated 547 patients in the ICU. In 2021, Ottumwa Regional treated 959 patients in the ICU, in large part because of the pandemic. In 2022, Ottumwa Regional treated 783 patients in the ICU. As a consequence of limited staff availability, including a shortage of traveling nurses, Ottumwa Regional's ICU treated 107 patients in 2023.

Several factors contributed to the drop in ICU patients between 2015 and 2023:

- In 2015 following a CMS rule change, Ottumwa Regional no longer admitted to the ICU patients who had undergone angiogram procedures requiring intervention to the ICU, eliminating the requirement for an overnight ICU stay and decreasing ICU volumes.
- In 2017, most cardiovascular procedures changed from in-patient to out-patient procedures, so ICU stays were no longer required, again reducing volumes.
- In 2020, due to Covid-19 pandemic-related staffing challenges and restrictions, Ottumwa Regional treated fewer patients in the ICU.
- In 2022, the grant for e-ICU services ended. As a result, Ottumwa Regional lost its e-ICU provider, and with that, the expertise of having tele-intensivists on call. Coupled with continued staffing challenges, this caused the hospital's ICU volume to decrease in 2022 and 2023, because critical ICU patients who needed a higher level of care than Ottumwa Regional's hospitalists could provide were transferred to Iowa City or Des Moines. Specifically with respect to the continued staffing challenges, in 2022, two RNs left for other jobs, and two others moved to pro re nata or as-needed ("PRN") status because they either took another full time job. In 2023, one LPN left for another job opportunity, three RNs moved to PRN status, and three on PRN status left either because they did not have availability or moved to a bigger city.

16. **From 2015 to the present, broken down by year, provide the exact number of Ottumwa Regional staff who have resigned, been terminated, been laid off, been furloughed, or otherwise left employment for any reason (including any mutual settlement agreement), including any staff primarily employed by a third-party staffing agency. Provide all documents that support your answer.**

Staffing at Ottumwa Regional has been and remains a priority for the hospital. Appropriate staffing ensures both crucial healthcare services are delivered to Ottumwa's rural community and provides much-needed jobs for local residents. This remains a priority despite the healthcare industry-wide staffing challenges noted above. As of January 31, 2024, Ottumwa Regional employed 421 total hospital and lab tech staff and contracted with an additional 271 staff who worked as cardiologists, radiation oncologists, anesthesiologists, hospitalists, ER providers, or RNs, or who worked in the housekeeping, dietary services, or security departments. Ottumwa Regional also directly contracted with a small number of RNs, and Ottumwa Regional's efforts to staff an appropriate number of

hospital and lab employees to provide high-quality patient care are described in further detail above in response to Request 12. To clarify the different employee types, please see the definitions below:

- Employed staff – Can be full-time, part-time, or prn status and are counted in hiring and turnover data.
- Contracted, third party – These are third party companies Lifepoint contracts with to provide services such as dietary, EVS, security, and professional services such as Cardiology, ER, and Hospital Medicine service. These are not counted in hiring or turnover data.
- Travel Agency Staff – These are short term, 13-week contracts with RNs, lab techs, and radiology techs. These are not counted in hiring or turnover data.

The following represents year-by-year information on staffing departures at Ottumwa Regional, broken down by voluntary and involuntary departures. "Voluntary" departures include resignations and retirements of employed staff only. "Involuntary" departures include terminations for cause and layoffs. Travel agency staff are not included in the numbers of employees hired or voluntary/involuntary departures.

- In 2015, 207 hospital and lab staff left employment for any reason.[6] Of those departures, 141 were voluntary and 66 were involuntary. Ottumwa Regional conducted no layoffs or furloughs in 2015. Ottumwa Regional hired 61 hospital employees in 2015.
- In 2016, 98 hospital and lab staff left employment for any reason. Of those, 75 were voluntary and 23 were involuntary. Ottumwa Regional conducted no layoffs or furloughs in 2016. 129 hospital employees were hired in 2016.
- In 2017, 141 hospital and lab staff left employment for any reason. Of those departures, 112 were voluntary and 29 were involuntary. Ottumwa Regional conducted no layoffs or furloughs in 2017. 147 hospital employees were hired in 2017.
- In 2018, 137 hospital and lab staff left employment for any reason. Of those departures, 103 were voluntary and 34 were involuntary. Six of the departures were due to the Home Care facility closure, while three of the departures were due to a reduction in force. 147 hospital employees were hired in 2018.
- In 2019, 151 hospital and lab staff left employment for any reason. Of those departures, 119 were voluntary and 32 were involuntary. One of the departures was due to the Home Care facility closure. 123 hospital employees were hired in 2019.
- In 2020, 117 hospital and lab staff left employment for any reason over the course of the year. Of those departures, 97 were voluntary and 20 were involuntary. Ottumwa Regional conducted no layoffs or furloughs in 2020. In this year, however, due to the

[6] This data point represents solely the number of staff who departed for any reason—including but not necessarily resignation, termination, lay-offs, furlough, and retirement—over the course of any given year. Ottumwa Regional strove to replace the majority of these departing staff over the course of any given year.

COVID-19 pandemic, Ottumwa Regional reduced the working hours for 7 hospital staff. These staff were nevertheless paid sufficient hours to qualify for their benefits. 97 hospital employees were hired in 2020.

- In 2021, 111 hospital and lab staff left employment for any reason. Of those departures, 97 were voluntary and 14 were involuntary. There were 10 position eliminations during this period, but seven of these were moved to R1, a company with which Ottumwa Regional contracts to handle patient registration and billing. Staff were given the opportunity to transition from Ottumwa Regional to R1 if they wanted. 116 hospital employees were hired in 2021.
- In 2022, 149 hospital and lab staff left employment for any reason. Of those departures, 124 were voluntary and 25 were involuntary. Ottumwa Regional conducted no layoffs or furloughs in 2022. 106 hospital employees were hired in 2021.
- In 2023, 144 hospital and lab staff left employment for any reason. Of those departures, 123 were voluntary and 21 were involuntary. Ottumwa Regional conducted no layoffs or furloughs in 2023. 140 hospital employees were hired in 2023.

* * *

Ottumwa Regional welcomes the opportunity to share more about its operations, policies, and procedures. Thank you for the opportunity to engage on these important issues.

[redacted]

September 06, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint" or the "Company").

This submission responds to the set of questions in your email of August 8, 2024.

We have included in this letter information that includes proprietary business information. We request that this information not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Ottumwa Questions

2. Was Lifepoint management aware of any issues related to quality of care; patient safety; drug diversion; and the behavior, competence, and sufficiency of staff at ORHC prior to the death of Mr. Devin Caraccio in October 2022? If yes, what actions was Lifepoint management taking to address them? Please provide all documents, such as board minutes, that support your response, including all communications with Apollo regarding this matter.

Lifepoint was not aware of concerns related to Devin Caraccio's behavior or performance prior to his death in October 2022. As an operator of rural hospitals for 25 years, Lifepoint recognizes that operating rural hospitals, like Ottumwa Regional, come with certain challenges. Consequently, Lifepoint has always prioritized continuous improvements in quality of care, patient safety, drug diversion, and staffing at its hospitals, including at Ottumwa Regional.

When Lifepoint acquired Ottumwa Regional in 2018, Lifepoint understood that Ottumwa Regional needed investments and improvements, including in quality of care, patient safety, drug diversion, and hospital staffing, among other areas. In response, Lifepoint has invested significantly in these areas since acquiring Ottumwa Regional in 2018, and in a period when rural hospitals are struggling

across the country (24 rural hospitals closed across the nation in 2024 alone[1]), Lifepoint's judicious investment has ensured the hospitals like Ottumwa Regional can keep their doors open and continuously improve quality of care and safety.

Lifepoint's investment in Ottumwa Regional--including in quality of care, patient safety, and drug diversion programs--began long before October 2022 and have led to measurable and significant improvements in quality.

A. Quality of Care

Lifepoint has supported improving quality care at Ottumwa Regional since its acquisition in 2018. Lifepoint has supported care delivery at Ottumwa Regional through the National Quality Program, a structured, patient-centered framework for ensuring consistent, high standards of quality and safety across Lifepoint's operations. This program focuses on three core areas: leadership, culture and performance improvement. A Quality Oversight Committee collaborates with local teams to evaluate quality metrics and opportunities for improvement. The Committee also identifies and spreads leading quality and safety practices across all facilities. As part of the National Quality Program, Lifepoint has groups such as Chief Medical Officer and Chief Nursing Executive Councils, a MedSurg Council, and an Infection Prevention Council to build collaboration, accountability, and engagement across clinical teams at its facilities.

As a result of Lifepoint's support and focus on ensuring the highest quality of care for patients in the community, Ottumwa Regional has not had any hospital-acquired condition penalties since 2018 under the Center for Medicare & Medical Services ("CMS") Hospital-Acquired Condition Reduction Program (according to which CMS reduces Medicare payments for hospitals that rank in the worst-performing quartile of all hospitals on measures of hospital-acquired conditions).

B. Patient Safety

Lifepoint has been committed to improving Ottumwa Regional's safety rating since the 2018 acquisition. The hospital's Leapfrog Hospital Safety Grade has risen consistently, from an F in 2019 to a D in 2020 to a C in 2021 to a B in this year's Spring grades.

C. Drug Diversion

In November 2021, Lifepoint launched a comprehensive program to strengthen drug diversion efforts across its facilities, including at Ottumwa Regional. Lifepoint engaged Guidepost in July 2022, to help develop an industry-leading national drug diversion prevention and community engagement program. Today, the program is fully staffed within Lifepoint and is led by four full

[1] Closure of Ohio-based Trumbull Regional Medical Center and Hillside Rehabilitation Hospital (https://www.beckershospitalreview.com/finance/steward-to-close-2-ohio-hospitals.html); closure of Iowa-based MercyOne Primghar (Iowa) Medical Center (https://www.beckershospitalreview.com/finance/mercyone-iowa-hospital-to-close-in-september.html); Closure of Norman Regional Hospital (https://www.normanregional.com/blog/2024/july/norman-regional-hospital-services-moving-july-28/).

time employees, including two former DEA investigative leaders. This program includes several components, including increased oversight at the Lifepoint level (in addition to at the facility level), training programs at the facilities, and audits and tracking to minimize the risk of drug diversion.

First, with respect to oversight, the program entails more rigorous investigations overseen at the Lifepoint level (in addition to at the facility level) with support from a qualified team of professionals—including former DEA investigators—to ensure consistent, efficient, timely, and impartial investigations. Our diversion professionals work with local community partners, state representatives and law enforcement to identify gaps and areas for improvement, as well as opportunities to share resources, information and best practices. The Lifepoint team that oversees the investigation also conducts follow-ups to ensure that remediation is on track at the facilities following an investigation, and ensures that the correct actions are implemented.

Second, our team of professionals has provided in-person trainings at Lifepoint facilities, including at Ottumwa Regional. The education and training programs teach Lifepoint employees, providers, partners, and communities what drug diversion is and how to prevent, recognize and report it. Specifically, one training covers DEA regulations, recognizing the impaired individual, and the impact of drug diversion, and recognizing/reporting tampering and potential drug diversion. A separate training is given to employees with access to controlled substances, focusing on requirements for controlled substance vending, administration, documentation, and wastage, and recordkeeping and reporting requirements related to all medications, including controlled substances.

Third, over the past three years, Lifepoint has invested in and deployed sophisticated tools and technology designed to assist in surveillance, gathering and tracking data and spotting issues and trends. For example, Ottumwa Regional has implemented a diversion prevention surveillance software, which matches controlled substance medications dispensed from automatic dispensing cabinets with documentation in electronic health records, as well as documentation of waste, if applicable, on a patient-specific basis. Routine audits are also completed for clinical areas with manual documentation for medications administered.

Our diversion professionals work with local community partners, state representatives and law enforcement to identify gaps and areas for improvement, as well as opportunities to share resources, information and best practices.

12. Lifepoint's March 4, 2024, response to the Budget Committee notes that in relation to its obligation "to make annual routine capital expenditures in connection with the operation of ORHC equal to at least 5 percent of ORHC's annual net patient revenue," Lifepoint spent $3 million on a linear accelerator and CT stimulation replacement, $1 million on a DaVinci robot, and $2 million on catheterization lab expansion from 2019-2023 (see figure on page 5). Lifepoint's May 12, 2023, response to the budget committee notes that as a result of the 2019 sale-leaseback of ORHC, "Lifepoint was able to invest $300 million in Lifepoint communities across the country" and described the related investments at Ottumwa as "a

new $4.5 million linear accelerator in 2020, … $2 million in a new DaVinci robot, and $4.5 million in expansions and upgrades to the cardiac catheterization lab" (pages 3 and 4).

12a. Please clarify the amount spent on the linear accelerator, the DaVinci robot, and the cardiac catherization lab.

The amount spent on the linear accelerator, the DaVinci robot, and the cardiac catherization lab are as follows:

- Linear Accelerator: $4,506,705.25
- Da Vinci Robot: $1,126,724.75
- Cath Lab: $4,334,388.81

12b. Please itemize the exact amount of the "$300 million" that went to ORHC. Please specify each investment and the accurate dollar amount spent.

As a result of the sale-leaseback transaction (which included hospitals in six markets, of which Ottumwa Regional was one)**,** Lifepoint generated gross proceeds of approximately $700 million, $400 million of which was used to pay down debt and $300 million of which was added as cash to Lifepoint's balance sheet. This allowed Lifepoint to invest more in its hospitals, including Ottumwa Regional.

Lifepoint regularly uses its cash to invest in its facilities, including Ottumwa Regional, and has invested in Ottumwa Regional before and after the sale leaseback transaction. A transaction like the sale-leaseback generates proceeds that bolster Lifepoint's abilities to invest in its facilities, including Ottumwa Regional.

Lifepoint does not account for its expenditures by tying revenue from transactions such as the sales-leaseback to specific investments made in its facilities. Lifepoint cannot specify which revenue from the sales leaseback agreement was directly used for Ottumwa Regional developments. Nor is it possible to provide an exact dollar amount for the portion of the investment at Ottumwa Regional that is attributable to the sale leaseback transaction.

12c. Is it correct to infer that the $300 million was used to fulfill Lifepoint's capital obligations to its facilities under its asset purchase agreements?

As we noted above, Lifepoint does not account for its expenditures by tracing revenue from transactions to specific facility-level investments. Accordingly, it is not possible to specify what portion of the $300 million in proceeds was used to fulfill Lifepoint's capital obligations (versus, for example, used to fund another Lifepoint facility, which permitted additional investment in Ottumwa Regional).

18. Please provide the response rate and results of ORHC's Culture of Safety surveys from 2019 through 2023. Were these results reviewed by the ORHC Board of Directors, Lifepoint management, and the Lifepoint board and included in performance evaluation criteria for senior administrative leadership? If yes, please provide supporting documents.

Enclosed at **LP-CEG-005013** through **LP-CEG-005093** are documents related to Ottumwa Regional's Culture of Safety surveys between 2020 to 2024.

As shown in the Culture of Safety surveys, Ottumwa Regional's Culture of Safety survey results have been improving consistently since 2022. For example, between 2023 to 2024, Ottumwa Regional improved more than five points in several categories, including for "Continuous Improvement", "Values," and "Cares." Additionally, the engagement numbers for Ottumwa Regional have increased significantly, from approximately a 64% response rate in 2023 to an 82% response rate in 2024.

These improvements have been led by the new management team at Ottumwa Regional, including the CEO, the CFO, the Chief Nursing Officer and the Director of Pharmacy, who began their tenure following the incident involving Devin Caraccio. The leadership of William Kiefer, who was appointed interim CEO in November 2022, and permanent CEO in January 2023, has had significant positive impacts at Ottumwa Regional, as reflected in the Culture of Safety survey. Dr. Kiefer is focused on supporting staff and improving staff engagement, and he has introduced regular and open communications among stakeholders, which has correlated with an increase in position responses in the Culture of Safety surveys.

Lifepoint has also continued to invest in Ottumwa Regional's quality of care and safety measures. Over the last several years, in addition to Lifepoint's investments in capital projects and recruitment efforts at Ottumwa, Lifepoint has also funded and supported Ottumwa Regional's development of a Controlled Substance Compliance Program and implementation of a drug diversion prevention surveillance software, which are both aimed at improving the quality of care and safety at Ottumwa Regional. These investments are aimed at ensuring that the Culture of Safety survey scores continue to improve, as they have over the last two years.

21. Have any Lifepoint facilities ever fallen behind on paying their rents, loans, debts, contractors/vendors, payroll, or any other bills or has Lifepoint ever fallen behind in paying the rents, loans, debts, contractors/vendors, payroll, or any other bills for its facilities? If yes, please describe.

Lifepoint facilities have not fallen behind on paying their rents, loans, debts, contractors and vendors, payroll, or other types of bills.

22. Recent events have shown that other hospital operators have faced bankruptcy and other financial issues. In view of these developments, what discussions has Lifepoint had internally and with Apollo concerning its solvency? Please provide all documents that support your response, including all communications with Apollo regarding this matter.

Lifepoint has not had discussions with Apollo regarding its solvency.

24. In light of Lifepoint Health's net income of $283 million in 2020, did Lifepoint consider returning any of the $646 million of government stimulus income that Lifepoint recognized in 2020 to the federal government? Please provide all documents that support your response, including all communications with Apollo regarding this matter.

Like most hospitals across the nation, Lifepoint's facilities received financial support from the federal government through the CARES Act Public Health and Social Services Emergency Fund. As noted in Lifepoint's previous letters, Lifepoint ensured that all funds received from CARES were spent in conformance with applicable guidelines. Prior to receiving the funds, Lifepoint attested to the terms and conditions for obtaining CARES Act Funds, including that the funds would be used for COVID-related care and that Lifepoint would maintain appropriate records and cost documentations of the use of the funds. Lifepoint engaged with advisors and government representatives throughout the process to ensure its uses and tracking of the government funds complied with all applicable rules. Following the receipt of the CARES Act Funds, Lifepoint provided financial data to the United States Department of Health and Human Services ("HHS") to show that the funds were used either to: (1) prevent, prepare for, or respond to COVID-19; or (2) for reimbursement of lost revenues that were attributable to COVID-19.

The $646 million of government stimulus income Lifepoint received was segregated into a COVID-19-specific account. Funds were drawn from that account only when needed to pay for expenses or lost revenue related to COVID-19. Lifepoint also completed provider relief fund audits to ensure that Lifepoint and its subsidiaries complied with all federal regulations regarding COVID funds.

Between 2020 and 2022, Lifepoint repaid the approximately $991 million it received in Medicare Accelerated Advance Payments ("MAAP") months ahead of schedule. The government stimulus income, which was granted to Lifepoint in its capacity as a healthcare provider, did not require repayment or returning.

25. Please provide the annual reports of Lifepoint Health, Inc., prepared in accordance with annual report on form 10-K, for the fiscal years ending in December 31, 2018, December 31, 2019, December 31, 2020, December 31, 2021, and December 31, 2023. Please provide Lifepoint Health, Inc.'s quarterly financial statements starting from Q1 of 2018 through Q2 of 2024, including the capital plan and sources and uses of funds. Please provide ORHC's annual financial reports for 2009-2023, including patient revenue, operating costs, and liabilities.

Enclosed at **LP-CEG-005094** through **LP-CEG-005897** are Lifepoint's form 10-Ks between 2018 to 2023. Enclosed at **LP-CEG-005898** through **LP-CEG-006742** are Lifepoint's quarterly financial statements between Q1 of 2018 to Q2 of 2024.

* * *

Lifepoint welcomes the opportunity to share information about its operations, policies, and procedures. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

WILMERHALE

September 27, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint" or the "Company").

This submission responds to the set of questions in your email of August 8, 2024.

This letter includes proprietary business information. We request that this information not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Lifepoint Questions

1. Please provide scorecards/reports that Lifepoint management uses to assess and benchmark the performance of Ottumwa Regional Health Center (ORHC) for the years 2019 through 2023, including but not limited to measures of quality, safety, patient experience, volume of care, staffing, employee/provider turnover, and employee/provider satisfaction. (We use the term Lifepoint management to refer to any Lifepoint corporate and division-level employees; any Lifepoint Corporate Services, General Partnership employees; any RCHP-Ottumwa, LLC employees; Lifepoint National Quality Program staff, or any other employees of Lifepoint and its affiliates that do not directly work at ORHC but oversee the operations of ORHC in some capacity).

1a. Please provide any documents that support Lifepoint management's review of these scorecards/reports and any associated action plans. Please note who at Lifepoint reviews the scorecards/reports.

Lifepoint and Ottumwa Regional participate in a number of regular updates in order to discuss and improve the performance of Ottumwa Regional in a variety of ways, including quality of care and patient safety.

A. Interactions with Lifepoint's Quality Team

Each month, Ottumwa Regional convenes a local Quality Committee meeting, which discusses areas of improvement for each department at Ottumwa Regional. At this monthly meeting, the Ottumwa Regional leadership team and the departments review data related to operations at Ottumwa Regional. For example, one discussion topic relates to "Serious Safety Event Rate" ("SSER"). Serious Safety Events are defined by the Safety Event Classification as a variation from expected practice followed by death, severe permanent harm, moderate permanent harm, or significant temporary harm. Each Ottumwa Regional Quality Committee meeting contains information on how the SSER has changed over a 12-month period. For example, a February 2023 presentation showed that the SSER went from an average of approximately 0.60 for the 12-month average as of February 2022 to approximately 0.20 for the 12-month average as of January 2023. Data on patient satisfaction, patient quality of care, staffing concerns, employee turnover, and new hires, among other things, are also discussed during these meetings. Based on information on these meetings, the Ottumwa Regional team develops action plans to improve the facility's processes.

Using the information discussed during Ottumwa Regional's monthly Quality Committee meeting, the Ottumwa Regional leadership, including the Chief Executive Officer William Kiefer, participates in monthly telephonic meetings, which are referred to as monthly touchpoints, with Lifepoint's Quality team as part of Lifepoint's National Quality Program. The National Quality Program encourages constant improvement in delivery of care across all Lifepoint facilities, including Ottumwa Regional. The National Quality Program monthly touchpoints discuss what went well at Ottumwa Regional that month, what has been learned, what could be done better, and what items must go to Learning Boards (e.g., what individual departments at Ottumwa Regional are doing to improve patient safety). These touchpoints also allow the National Quality Program to provide feedback to Ottumwa Regional on how to improve patient safety and quality of care, among other things, based on its evaluation of operations at other Lifepoint hospitals.

Enclosed at LP-CEG-006743-LP-CEG-007053 are the monthly National Quality Program touchpoint call materials from September 2020 to December 2023.

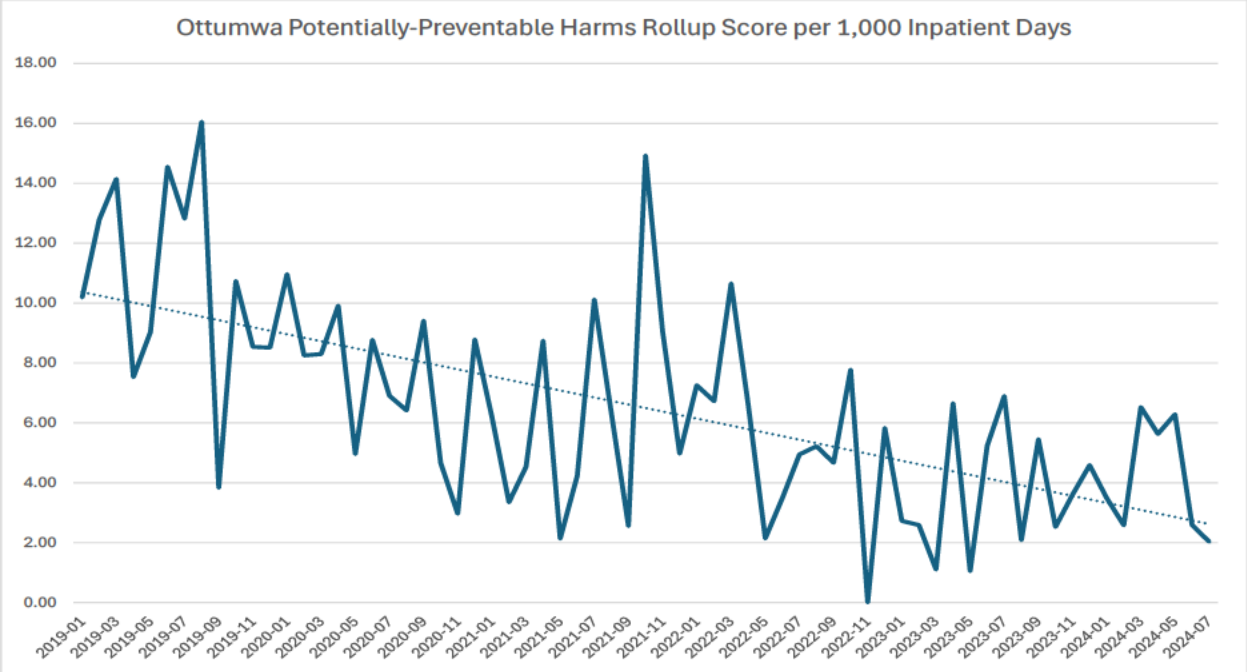
During the monthly touchpoint calls between the Ottumwa Regional leadership team and Lifepoint's Quality team, the Ottumwa Regional leadership team provides high level data on performance at Ottumwa Regional. For example, during the December 2023 touchpoint call, at LP-CEG-007029, Dr. Kiefer, Ottumwa Chief Nursing Officer Ryan Harkness, and Ottumwa Quality Director Jessica Kendrick addressed the National Quality Program Performance Recovery Progress data, which includes information on infection prevention, bedside shift reporting, and leader rounding. The presentation also reflects information about the National Quality Program Status and Ottumwa Regional data from the prior 12 months, including patient satisfaction, self-reported falls, and readmission rates, as well as information about Leapfrog scores and Center for Medicare and Medicaid Services Stars.

The Ottumwa Regional team provides these data points to Lifepoint's Quality team to allow Lifepoint's Quality team to permit (1) feedback on Ottumwa Regional's action plans on improving the quality of care at Ottumwa Regional and (2) advice on areas for additional improvement. For example, in the same December 2023 touchpoint presentation, Ottumwa Regional's leadership acknowledged that it had not met the National Quality Program's Designation Criteria (which requires 75 points for the 12-month period for designation), as Ottumwa Regional currently had 60 points, and listed three top priorities for becoming designated. Those initiatives were (1) recruiting patient representatives for the hospital board, (2) conducting training for the leadership team to increase injury prevention, and (3) ensuring continued rounding as part of the Patient Experience Improvement Plan.

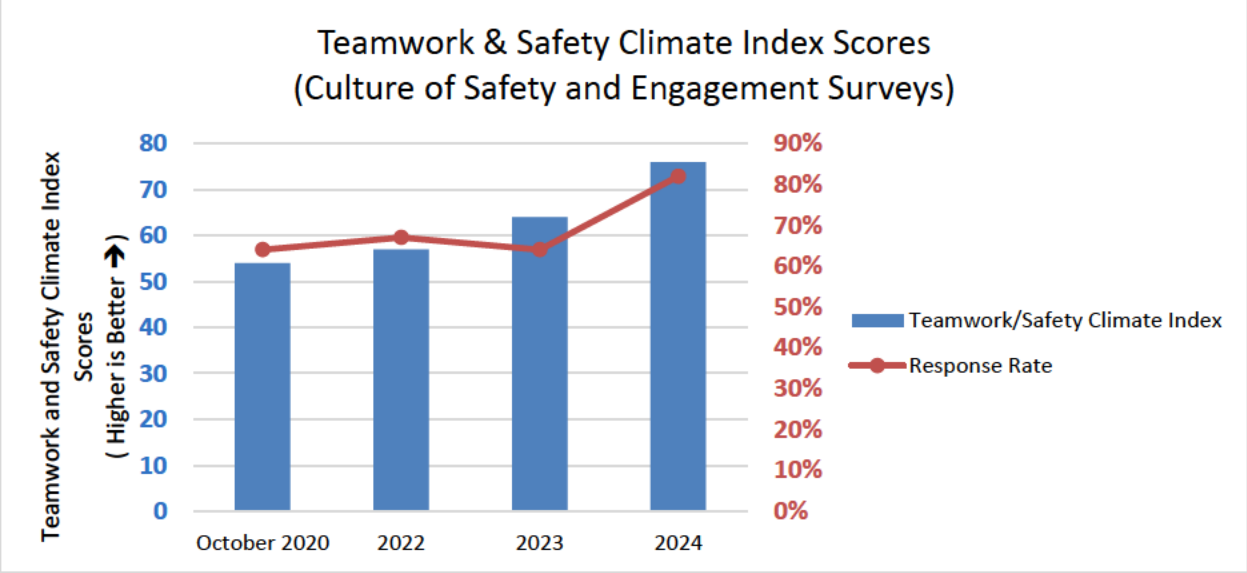
Twice a year, Dr. Kiefer also presents to Lifepoint's President, Chief Nursing Executive, and approximately 20 other subject-matter experts on the progress of Ottumwa Regional's quality journey. During these meetings, the Lifepoint team provides feedback on the presentation and recommends how to ensure continued improvement of quality of care at Ottumwa Regional.

Lifepoint's Quality team, as part of the National Quality Program, also reviews a number of data points on Ottumwa Regional, including annual scorecards for Ottumwa Regional, patient experience, safety, patient volume, culture of survey scores and response rates, and staffed beds, among other factors. Enclosed at LP-CEG-007054 is a spreadsheet with this information from 2019 through 2023, collected by the Lifepoint Quality team. The scorecards consist of information about whether Ottumwa Regional is exceeding its goal in each category (blue), achieving internal targets (green), within 15 percent of achieving target (yellow), or not meeting the goal (red). As you will see in the scorecards, the number of categories that are exceeding the goal has increased significantly between 2019 and 2023.

Additionally, the data shows that Ottumwa Regional's quality of care has improved in a number of categories over the last few years, particularly during Dr. Kiefer's recent tenure. A chart showing potential preventable harm rollup scores per 1,000 inpatients days shows that the rollout score has decreased from an average of 10 in January 2019 to an average of 2 in July 2024 (see chart below).



The Teamwork Safety Climate Index, obtained from the annual Culture of Safety survey has shown similar continued improvement, from 54 in October 2020 to 76 in 2024.



B. Ottumwa Regional's Monthly Operations Reports

Lifepoint representatives, including the Division President, are also present at Ottumwa Regional's Monthly Operations meeting. Enclosed at LP-CEG-007082-LP-CEG-007908 are Ottumwa Regional's Monthly Operation Reports from 2019 through 2023.

The Monthly Operation Reports update Ottumwa Regional's departments, as well as certain Lifepoint leaders, such as the Division President, on the status of various initiatives at Ottumwa Regional. For example, the June 2023 presentation provided information about Ottumwa Regional's efforts on drug diversion, including the actions taken between November 2022 and July 2023 to further implement drug diversion prevention. These presentations also include information from the touchpoint calls between Ottumwa leadership and Lifepoint's Quality team, as well as information on Ottumwa's progress against the National Quality Program's Designation Criteria.

8. Does Lifepoint management monitor the impact on access to health care in rural communities that result from the discontinuation/limitation of services or lack of nurses, providers, or other health care professionals at Lifepoint facilities, including but not limited to the greater Ottumwa community? Please provide all documents that support your response, including all communications with Apollo regarding this matter.

Lifepoint and its facility leaders, including Ottumwa Regional's leadership, regularly use data from publicly available sources, such as hospital associations and other healthcare institutions, to determine the need for services in the communities we serve. Enclosed at LP-CEG-007909-LP-CEG-007912 is Ottumwa Regional's Physician Recruitment Plan, which provides an example of information that is gathered from public sources and included in a presentation to Lifepoint.

17. Please provide the total number of employed and independent active, courtesy, and consulting providers on the medical staff of ORHC from 2015 through 2023 by year as well as the hospital's definitions for these categories. For each year, please provide the total number of added providers, the total number of provider departures, and the percentage of provider care performed by locum tenens providers. Please provide all communication with Apollo regarding this matter.

The chart below provides the total number of added providers, the total number of provider departures, and the percentage of care performed by locum tenens providers from 2015 through 2023. Hospital-level staffing decisions are not discussed with Apollo. Also, enclosed at LP-CEG-007913-LP-CEG-007922 are ORHC medical staff by-laws, which define each of the medical staff privilege statuses.

Additions by Year		Resignations by Year	Locums Tenens	Total Staff
Year	**Staff**	**Staff**	**Number of Locums Tenens**	**Staff**
2015	43	49	1	210
2016	54	36	1	230
2017	97	90	0	244
2018	53	51	1	246
2019	41	66	2	223
2020	37	39	1	223
2021	77	46	0	255
2022	38	84	0	214
2023	87	69	0	235
Grand Total	**528**	**530**		

20. How does ORHC fit in with Lifepoint Health's overall strategy? What are Lifepoint's long-term plans for ORHC and Iowa, including any plans to close, reduce, increase or add services, beds, and facilities? Please include any plans for joint ventures. Please provide all documents that support your response, including all communications with Apollo regarding this matter.

Under Lifepoint's leadership, Ottumwa Regional continues to build on a legacy of more than 125 years of caring for people in southeast Iowa. As one of the largest employers in its region, Ottumwa Regional is the only hospital in Wapello County, with the next closest facility nearly 30 miles away. It is the only facility to offer acute inpatient rehabilitation services for a 75-mile radius, and it is 1 of 2 hospitals in a 50-mile radius to offer both obstetric and psychiatric services. Its 14-bed Behavioral Health Unit offers a full range of highly specialized mental and behavioral health care.

With Lifepoint's assistance, Ottumwa Regional intends to develop its medical staff by hiring additional providers for OB/GYN, Internal Medicine, Orthopedic, and General Surgery. Additionally, Lifepoint has continued to support ongoing recruiting efforts for nurses at Ottumwa Regional. Over the last year, the Ottumwa Regional Chief Nursing Officer, with oversight from Lifepoint, has participated and spoken at Southeastern Community College, Indian Hills Community College, William Penn University, and Ottumwa Job Corps in order to develop relationships with these facilities and their future graduates.

Lifepoint plans to continue investing in and engaging with the Ottumwa community through partnership-building at Ottumwa Regional. To realize its aim to bring additional needed services and expertise to the Ottumwa community, Lifepoint will leverage existing partnerships in the local

community (such as Lifepoint's partnership with the University of Iowa) and look for opportunities for new partnerships.

25. Please provide the annual reports of Lifepoint Health, Inc., prepared in accordance with annual report on form 10-K, for the fiscal years ending in December 31, 2018, December 31, 2019, December 31, 2020, December 31, 2021, and December 31, 2023. Please provide Lifepoint Health, Inc.'s quarterly financial statements starting from Q1 of 2018 through Q2 of 2024, including the capital plan and sources and uses of funds. Please provide ORHC's annual financial reports for 2009-2023, including patient revenue, operating costs, and liabilities.

Enclosed at LP-CEG-007923-LP-CEG-007966 are Ottumwa Regional's Balance Sheets from 2010 to 2023 and Income Statements from 2012 to 2023.

* * *

Lifepoint welcomes the opportunity to share information about its operations, policies, and procedures. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

October 16, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint" or the "Company").

This submission responds to the set of questions in your email of August 8, 2024, and your follow-up questions on September 9, 2024.

We have included in this letter information that includes proprietary business information. We request that this information not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Lifepoint Questions

2. In regard to question #2, you note in your response that "Lifepoint was not aware of concerns related to Devin Caraccio's behavior or performance prior to his death in October 2022." According to the May, 4, 2023, Centers for Medicare and Medicaid Services' survey report for Ottumwa Regional Health Center, "review of interviews conducted from Oct. 18-26, 2022 as part of the hospital's investigation showed various staff to include RN's, Licensed Practical Nurses (LPN)'s, Supervisors, Directors, Pharmacists and Physicians stated NP2 was under investigation for a prior drug diversion and other legal issues, allegedly over sedated patients, worked long hours without going home, slept in the hospital for month-long stretches, took photographs of patients and medications against hospital policy and was reportedly caught having sex in the cardiac rehabilitation room." Are Lifepoint hospitals required to report issues of this nature to Lifepoint? If yes, did ORHC fail to report this information to Lifepoint and how is Lifepoint ensuring that ORHC reports this information to Lifepoint in the future? Please provide any policies that pertain to Lifepoint hospitals reporting of issues related to quality of care; patient safety; drug diversion; and the behavior, competence, and sufficiency of staff to Lifepoint.

Lifepoint is committed to its hospitals and communities and supports its hospitals in handling and responding to difficult circumstances. Lifepoint has policies that require its hospitals to escalate serious concerns promptly to permit Lifepoint to assist the hospitals in ensuring patient safety and quality of care.

Ottumwa Regional's Chain of Command Policy, enclosed at LP-CEG-008113 through LP-CEG-008115, which was in effect at the time of Mr. Caraccio's death, requires that Ottumwa Regional employees and physicians report to their director or manager all department operations and issues, including those related to patient safety, quality of patient care, customer service or facility safety. The Chain of Command Policy lays out how issues should be escalated, including to Lifepoint, based on the severity of the event. Lifepoint was not informed of any prior concerns related to Mr. Caraccio.

Immediately upon learning of the issues related to Mr. Caraccio, Lifepoint invested significant resources to review and remedy the situation, including the replacement of leadership at Ottumwa Regional.

As part of those efforts, Lifepoint assisted Ottumwa Regional with hiring experts to develop enhanced controls and trainings for Ottumwa Regional's staff. With Lifepoint's support, Ottumwa Regional hired external consultants to train the hospital's staff to spot signs of potential drug abuse by employees and potential tampering of drugs at the facility. Ottumwa Regional developed and deployed additional facility security with emphasis on patient safety and controlling drug diversion and issued new procedures, which include requiring the staff to notify both their supervisor and the Director of Pharmacy on any potential signs of tampering and any suspicions of drug abuse.

Moreover, as soon as it learned about the tragic events related to Mr. Caraccio and his death, Lifepoint assisted Ottumwa Regional in implementing enhanced policies and procedures to ensure timely and appropriate reporting of events that require immediate investigation, intervention, and/or quality/safety review to Ottumwa Regional leadership.

Enclosed at LP-CEG-008116 through LP-CEG-008118 is a copy of Ottumwa Regional's Significant Safety, Clinical or Personal Event Policy, which mandates mandatory reporting for a number of safety and serious clinical events.

Lifepoint has also provided additional and enhanced training to Ottumwa Regional staff on how to raise a concern, and issues relating to patient safety that may require reporting. Enclosed at LP-CEG-008119 through LP-CEG-008140 is a presentation from March 2023 from Lifepoint to Ottumwa Regional on patient safety and security updates.

Other information provided to Ottumwa Regional staff about the mandatory requirements for escalation is included in the General Hospital Orientation presentation, which is provided to new employees. The presentation and the materials provided to Ottumwa Regional staff, enclosed at LP-CEG-008141 through LP-CEG-008166 includes information on:

- Your Voice Makes Us Better, at **LP-CEG-008141**;
- See something, say something, at **LP-CEG-008156**;
- Potential Diversion Escalation Map, at **LP-CEG-008157**;
- Code of Conduct section of Ottumwa Regional's Employee Handbook, at **LP-CEG-008160**;
- Reporting Harassment section of the Employee Handbook, at **LP-CEG-008162**; and
- Criminal Conviction Reporting section of the Employee Handbook, at **LP-CEG-008166**.

4. Was Lifepoint management aware of the inadequate "numbers of RN, LPNs, CNA/Techs and sitters to provide supervision, monitoring, and timely 15 minute safety checks to all patients with acute and ongoing mental health issues" prior to the identification of an immediate jeopardy situation by surveyors at ORHC on October 12, 2023? If yes, what actions did Lifepoint management take to address the situation? Please provide all documents that support your response, including all communications with Apollo regarding this matter.

The question appears to recite allegations from a complaint that was filed against Ottumwa Regional with the CMS Kansas City office and that CMS ultimately concluded was unfounded.

The CMS Kansas City office conducted an Emergency Medical Treatment and Labor Act ("EMTALA") investigation in October 2023 after receiving a complaint regarding certain services at Ottumwa Regional. The complaint alleged that Ottumwa Regional had inadequate numbers of registered nurses, licenses practical nurses, and certified nurse administrators / technicians to provide supervision, and that the Ottumwa Regional staff did not provide appropriate medical screening exams ("MSEs") to people presenting in the Emergency Department, including people who had behavioral and mental health issues.

The CMS Kansas City office investigated the complaint and determined that the allegation of inadequate staffing was unsubstantiated. CMS identified certain protocols for safety checks, including in relation to behavioral health patients, that were not being followed. Before the CMS survey, Ottumwa Regional had not identified the specific instances of untimely safety checks noted by the surveyors on October 12, 2023. Neither Lifepoint nor its Board, including the Apollo representatives, was aware that safety check protocols at Ottumwa Regional were not being consistently followed.

In response to the issues identified by the CMS Kansas City office, Ottumwa Regional prepared a corrective action plan. This plan, which was submitted to CMS Kansas City office, is enclosed at LP-CEG-008167 through LP-CEG-008182. Among other things, this plan included ensuring that policies and guidelines were updated to improve the screening process. For example, the ED General Communication Guidelines policy was revised to include notification to the Emergency Department physician when a specimen is unable to be collected or when a patient's condition changes. Ottumwa Regional also provided additional training to staff to ensure they understood the requirements of working in the Emergency Department. For example, staff was trained that, when a

patient's Emergency Department length exceeds 24 hours, an Emergency Department Interdisciplinary Huddle is conducted to determine the plan to move the patient safely to the appropriate level of care or to discharge. Emergency Department staff and providers are now required to receive EMTALA training at least once every 12 months. At the time of the state surveyor's visit, Ottumwa Regional, like other hospitals in the state, was working diligently to manage the shortage of staff in the Emergency Department, which had been caused in part by the COVID-19 pandemic. The materials enclosed at LP-CEG-008183 through LP-CEG-008273, which were also provided to the CMS Kansas City office, evidence the efforts that ORHC management was making to manage these challenges and ensure that staff was appropriately trained to conduct safety checks.

Lifepoint management was informed of the CMS Kansas City Statement of Deficiencies and has provided Ottumwa Regional support in implementing the above-mentioned plan to correct the deficiencies.

5. As noted in the Centers for Medicare and Medicaid Services Inspection Report from October 17, 2023, a patient boarded in the ORHC emergency department from January 12, 2023 to March 24, 2023 (71 days) and was placed in non-violent restraints 46 times and violent restraints/seclusion 151 times. Please provide an explanation for this care, including inpatient bed availability at ORHC during that time and any issues related to the admitting privileges of the hospital's psychiatrists. What actions did Lifepoint management take to ensure the safety of this patient during those 71 days and what actions has Lifepoint taken to prevent similar events from occurring in the future? Please provide all documents that support your response, including all communications with Apollo regarding this matter.

The patient described in the question had been denied care at another facility, required secure sequestration, and could not be discharged safely to any other facility. Ottumwa Regional provided the patient with the only care available to him in his difficult circumstances.

The University of Iowa Hospital discharged the patient from hospice care, but the patient's wife was unable to care for him at home. She consequently brought the patient to the Ottumwa Regional Emergency Department. The patient exhibited violent episodes and could not be returned home due to his family circumstances, including his wife's inability to care for him following discharge. In addition to being intermittently violent, the patient was an elopement risk, meaning that he was at risk of departing the hospital unsupervised and undetected and would not be able to protect himself once outside ORHC. As a result, the medical staff at Ottumwa Regional rightly determined that it was important to treat the patient in the Emergency Department, which is a locked unit subject to close monitoring.

Although Ottumwa Regional determined that the patient did not meet any criteria for admission, there were no discharge or admission options that would ensure both the safety of the patient and that of other patients at the hospital. Ottumwa Regional therefore provided the best care possible to keep all of its patients safe. Lifepoint's case management team worked closely with the Iowa Department of Health and Human Services ("DHHS") to meet the needs of this patient and to

identify the appropriate disposition for this patient. DHHS visited the patient in the Emergency Department multiple times during his stay.

While Ottumwa Regional preferred to house the patient out of the Emergency Department, there was no other safe alternative to ensure the safety of this patient and other Ottumwa Regional patients. Ottumwa Regional could not move him to the Medical Surgical floor because it is not a locked unit (which could put other patients at risk of harm), and his elopement risk was high. The medical director of Ottumwa Regional's Behavioral Health Unit evaluated the patient and deetermined it would not be appropriate to admit him to the unit because his agitation and behavioral symptoms were not from a primary psychiatric disorder, and the patient's severe cognitive deficits would keep him from participating in any portion of the treatment program offered in that unit. Ottumwa Regional worked tirelessly throughout the patient's stay to find an appropriate place of care, but due to his difficult circumstances, every provider solicited by Ottumwa Regional declined to provide care. In the end, the patient stayed in Ottumwa Regional's Emergency Department for 71 days, until Ottumwa Regional staff could find a safe alternative for his discharge.

The circumstances around this patient are unique, and Ottumwa Regional staff were required to adapt to the patient's needs, his family's circumstances, and other facilities' disinclination to take the patient into their facilities. Ottumwa Regional provided the patient with the best care possible given the patient's circumstances and needs.

Lifepoint management was not involved in the day-to-day care of this patient, and the information relating to this patient was not communicated to the Lifepoint Board, including its Apollo representatives. Nor would Lifepoint expect it to be. The treatment of this patient reflected the types of care decisions that Lifepoint's hospitals must make daily across the country. Lifepoint is thankful for the committed care and decision making of its providers.

7. In response to the reduction in critical care and emergency surgical services at ORHC, what actions has Lifepoint management taken to ensure timely and safe transfers of critical patients to other facilities? Please provide all documents that support your response, including all communications with Apollo regarding this matter.

As described above in the responses to Questions 4 and 5, Ottumwa Regional has taken a number of actions, including providing additional training to staff, to ensure timely and safe transfers of patients. Lifepoint is not involved in the day-to-day treatment of any specific patient but provides support to Ottumwa Regional in Ottumwa Regional's improvement of its patient safety and quality of care. Lifepoint's Board, including its Apollo representatives, has not been involved in decisions relating to this topic.

7a. Does Lifepoint/ORHC collect the following data: the number of transfers from ORHC (including from the emergency department and the inpatient units) to other facilities, the receiving units at the receiving facilities, the mode of transportation (e.g., Ottumwa Regional Mobile Intensive Care Services, another ambulance service, air transport), the average time to transfer, and the reason for transfer (i.e., the service that ORHC was not

able to provide or patient request)? If yes, please provide the collected data for 2015-2023 by year. Has this data been previously reviewed by Lifepoint management and Apollo?

Ottumwa Regional uses the data enclosed at LP-CEG-008274 to track transfers to other facilities. Ottumwa Regional began tracking the receiving facility and mode of transportation in 2017. Ottumwa Regional's senior leadership reviews daily reports on transfers.

Lifepoint management discusses and reviews the aggregate transfer information of its facilities as part of its goal of continuously improving the quality of care to the local communities that it serves. The information is not reviewed by the Lifepoint Board, including its Apollo representatives.

7b. Has Lifepoint/ORHC communicated the change in ORHC's capacity to care for critical patients to the greater Ottumwa community?

Ottumwa Regional included a description of the change to ICU services in its annual AHA Survey filings. These filings are filed with the State of Iowa as required by statute and can be obtained by the public from the State.

Over the last two years, Dr. Kiefer and other Ottumwa Regional senior leaders have participated in over 35 community events at which they have discussed hospital operations, provider recruitment, and onboarding activities. During each of these discussions, Dr. Kiefer has invited questions about Ottumwa Regional's operations.

In addition, Dr. Kiefer has met with over 40 local community leaders to discuss Ottumwa Regional's operations. These conversations have facilitated an ongoing dialogue between the hospital leadership and the community. Some of the groups with which Dr. Kiefer has met include the City of Ottumwa City Council, the Wapello County Board of Supervisors, the Ottumwa Rotary Club, the Ottumwa Police Department, and the Ottumwa Fire Department.

Questions Related to Asset Purchase Agreement ("APA")

The 2010 APA governed the sale of Ottumwa Regional from Ottumwa Regional Legacy Foundation, Inc. (the "Ottumwa Regional Legacy Foundation"), Regional Retirement Living, Inc. ("Regional Retirement Living") and Regional Enterprises, Inc. ("Regional Enterprises"), which together acted as sellers in the transactions, to RCHP-Ottumwa, Inc ("RCHP-Ottumwa") and RegionalCare Hospital Partners, Inc. ("RegionalCare"), who together, acted as buyers in the transaction.

The Ottumwa Regional Legacy Foundation was established as a private foundation to oversee both the proceeds from the sale of Ottumwa Regional and the commitments made by RegionalCare and RCHP-Ottumwa in the APA. Today, the Ottumwa Regional Legacy Foundation continues to ensure that the net proceeds from the April 2010 sale of Ottumwa Regional benefit those in the Ottumwa community. The Ottumwa Regional Legacy Foundation is overseen by a Board of

Directors, consisting of 13 members of the Ottumwa community, none of whom are employed by Ottumwa Regional.[1]

Since 2010, Ottumwa Regional has invested heavily in the Ottumwa community, including through capital investments totaling approximately $62 million. The county sold the facility in an effort to retain services in the community and to promote investment at levels that the county could not meet. The sale ensured retention of services, investments in capital, and expansion of the tax base in a community that is among the poorest in the county. To this day, Ottumwa Regional has continued to invest in the community and to expand services through capital investments.

In 2019, when Lifepoint acquired Ottumwa Regional, Lifepoint assumed responsibility for RegionalCare's obligations under the APA. Since Lifepoint's acquisition of Ottumwa Regional, Lifepoint has invested more than $20 million of its own capital in Ottumwa Regional, funding more than $14 million in capital projects and contributing $6 million to address the hospital's losses. On a cumulative basis, Lifepoint has exceeded the capital expenditures investment in Ottumwa Regional required by the APA by more than $1.5 million. A visual of Lifepoint's investment in Ottumwa was previously produced at LP-CEG-005005 through LP-CEG-005006. Lifepoint plans on continue investing in Ottumwa Regional. As of October 2024, Lifepoint expects to invest an additional $16 million in Ottumwa Regional over the next two years, comprised of $6 million in capital projects, and $10 million to address anticipated hospital losses. The amount of Lifepoint's investment has increased since March 2024, when Lifepoint planned to spend $11 million in Ottumwa Regional, reflecting $6 million in capital projects, and $5 million to address anticipated hospital losses.

Lifepoint has a long history of funding care and contributing to the Ottumwa community. The commitments in the APA reflect some but not all of Lifepoint's investments in Ottumwa Regional and the community. Most importantly, Lifepoint's investments in Ottumwa Regional have ensured that Ottumwa Regional could keep its doors open amid the challenges of the COVID-19 pandemic and during a period of nationwide closures of rural hospitals.

Lifepoint has also maintained an active dialogue with the Ottumwa Regional Legacy Foundation, and under William Kiefer's stewardship, Lifepoint has been working with Ottumwa Regional Legacy Foundation to ensure that Lifepoint's continuing investments in Ottumwa Regional match the community's needs. Ottumwa Regional and the Ottumwa Regional Legacy Foundation recognize that the needs of the 2010 Ottumwa community differ significantly from the current 2024 Ottumwa community, and the two parties are in discussions to update the APA to ensure that investment opportunities are focused on the Ottumwa community's current priorities. On September 19, 2024, Dr. Kiefer met with the Ottumwa Regional Legacy Foundation CEO to discuss revisions to the APA to address the community's current needs, and he is meeting with the Foundation again on October 16, 2024, to further discuss these topics, which we anticipate will lead to additional amendments to the APA.

[1] https://www.ottumwalegacy.org/meet-your-foundation/who-we-are/board/.

9. Please provide background on why Lifepoint amended the asset purchase agreement for OHRC to allow for operating/capital leases to be included in the definition of routine capital expenditures and to change the 5% of net operating revenue designated for annual routine capital expenditures to a split of 3.75% for capital expenditures and 1.25% for physician recruitment and retention. Please provide all documents that support your response, including all communications with Apollo regarding this matter.

The January 2021 Board Minutes for Ottumwa Regional, enclosed at LP-CEG-008275 through LP-CEG-008278 indicate that then-CEO Phil Noel reported that Lifepoint was proposing a change to the Asset Purchase Agreement to stipulate that a portion of the 5% RIP would be used for physician recruitment & retention activities.

There were no communications with Apollo on this matter.

9a. Please provide a comprehensive definition of operating/capital leases, including whether this includes any payments to Medical Properties Trust and its affiliates.

Payments to Medical Properties Trust are not included in the definition of operating and capital leases. Operating and capital leases include leases on equipment and generators, as well as additional facilities outside of those covered under the sale-leaseback agreement with Medical Properties Trust. This currently includes an off-site pharmacy dispenser and a business hub associated with Ottumwa Regional.

9b. Was this change also approved by the ORHC Board of Directors? If yes, please provide the meeting minutes.

This change to the APA was approved during the January 2021 Ottumwa Regional Board Meeting. The minutes for the meeting are enclosed at LP-CEG-008275 through LP-CEG-008278.

9c. Was this change communicated to the Ottumwa community?

The Ottumwa Regional Legacy Foundation, which is comprised of local community representatives, agreed to changes to the APA in December 2020, as reflected in the latest version of the executed APA, enclosed at LP-CEG-008279 through LP-CEG-008281. The December 2020 Board Minutes for Ottumwa Regional Legacy Foundation, which documents the Board's approval of the amendment, is enclosed at LP-CEG-008282 through LP-CEG-008283.

9d. Please provide the most current version of the asset purchase agreement between ORHC and RegionalCare/Lifepoint, including any amendments made to the initial agreement.

The executed Asset Purchase Agreement ("APA"), dated April 30, 2010, was previously produced at LP-CEG-000036. The APA was amended pursuant to an agreement between the Ottumwa Regional Legacy Foundation (whose Board approved the amendment in December 2020) and

Ottumwa Regional (whose Board approved the amendment in January 2021). The amendment to the APA is enclosed at LP-CEG-008279 through LP-CEG-008281.[2] The operative agreement is the original agreement, LP-CEG-000036, as amended by the documents at LP-CEG-008279 through LP-CEG-008281.

10. Lifepoint's March 4, 2024, response to the Budget Committee notes that Lifepoint did not fulfill its annual routine capital expenditure obligations to ORHC in 2019 (see figure on Page 5). Please provide the reason, any documents related to this matter, and all communications of this matter to the ORHC Board of Directors, Ottumwa Regional Legacy Foundation, Ottumwa community, and Apollo.

While Ottumwa Regional regularly updated the Ottumwa Regional Legacy Foundation on certain requirements in the APA prior to the COVID-19 pandemic, Ottumwa Regional has not identified any records or communications between Ottumwa Regional and Ottumwa Regional Legacy Foundation on the reason why the routine capital expenditure was lower than 5 percent in 2019. In the past, meetings with the Ottumwa Regional Legacy Foundation were not always documented, although we understand that the then-CEO of Ottumwa Regional met regularly with the Ottumwa Regional Legacy Foundation.

As noted above, Lifepoint has consistently invested in Ottumwa Regional, exceeding on a cumulative basis by more than $1.5 million the capital expenditures investment in Ottumwa Regional required by the APA. Lifepoint has exceeded the investment commitments in the APA every year since 2019, including throughout the COVID-19 pandemic as hospitals struggled to remain open. Lifepoint will continue to invest in Ottumwa Regional and assist with the improvement of its facilities and recruitment of its physicians and medical providers.

11. Please provide the table regarding the required investment percentage (RIP) and total investments toward RIP for OHRC as contained within Lifepoint's March 4, 2024 letter to Senator Whitehouse and Senator Grassley (Question #3, Page #5) for years 2010 through 2018.

Ottumwa Regional's aggregate capital contributions have exceeded its obligations under the APA by more than $1.5 million.

Below is the investment toward the RIP for ORHC for years 2010 to 2023.

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
1.08%	4.07%	7.53%	7.41%	4.66%	3.57%	3.36%	3.92%	2.31%	2.70%	4.20%	12.2%	12.3%	10.3%
$594K	$3.2M	$5.4M	$5.5M	$3.3M	$2.6M	$2.5M	$3M	$1.8M	$2.2M	$2.9M	$9M	$8M	$7M

13. Please provide or describe, if not available in writing, Lifepoint's policy for ensuring it fulfills its commitments to its facilities and the communities supported by its facilities as

[2] In preparing a response to this inquiry, Ottumwa Regional was not able to identify a fully executed copy of the 2021 amendment to the APA and therefore obtained a new fully executed version in September 2024.

outlined in its asset purchase agreements or otherwise. Are independent monitors used with any of Lifepoint's facilities to ensure that Lifepoint is complying with its asset purchase agreements and/or other commitments? Have any parties ever expressed concerns that Lifepoint failed to fulfill its commitments to its facilities and their local communities, including but not limited to those outlined in its asset purchase agreements? What communications does Lifepoint make to Apollo regarding the status of those commitments?

As noted above, the Ottumwa Regional Legacy Foundation is responsible for the oversight of the APA, and Ottumwa Regional's CEO William Kiefer has maintained an engaged and regular dialogue with the Ottumwa Regional Legacy Foundation to ensure that Lifepoint's investments in Ottumwa Regional address the community's needs. Dr. Kiefer handles the relationship with the Foundation and elicits assistance from Lifepoint as necessary.

13a. How often does Lifepoint review the 2010 asset purchase agreement between RegionalCare Hospital Partners and ORHC to ensure that it is fulfilling its commitments? Does Lifepoint meet with Apollo, the ORHC board, the Ottumwa Regional Legacy Foundation, and/or the Ottumwa community to review the status of these commitments? Please provide all documents that support that these discussions were held.

Lifepoint management is available to assist local hospital leaders but does not manage or participate in day-to-day decision-making at individual facilities. Instead, local hospital leadership is responsible for administering hospital-level business and contractual obligations. Accordingly, Lifepoint did not review the APA with its Board (including the Apollo representatives), the Ottumwa Regional board, the Ottumwa Regional Legacy Foundation, or the Ottumwa community.

Ottumwa Regional is currently in the final stages of discussions with the Ottumwa Regional Legacy Foundation regarding revisions to its APA. Certain Lifepoint functions and personnel, including the Finance and Legal teams, have supported Ottumwa Regional in those discussions.

13b. Are there any other documents, aside from the Asset Purchase Agreement, that outline RegionalCare, RCCH, and Lifepoint's commitments to ORHC or the greater Ottumwa community? Please provide those documents.

The APA governs Ottumwa Regional's obligations to the Ottumwa Regional Legacy Foundation. The Managerial and Administrative Support Agreement between Lifepoint Corporate Services, General Partnership and RCHP-Ottumwa, LLC, previously produced at LP-CEG-000001 governs Lifepoint and RCHP-Ottumwa, LLC's operations of Ottumwa Regional.

Lifepoint is committed to meeting the Ottumwa community's evolving needs, including ensuring continued improvements to patient safety and quality of care.

14. Please provide a status update on the following aspects of the asset purchase agreement and provide any documentation to support that applicable discussions were held with the

ORHC board, the Ottumwa Regional Legacy Foundation, and/or the Ottumwa community. Please provide all documents that support your response, including all related communications with Apollo.

14a. Is there a resident rotation program at ORHC? Please provide evidence that supports that Lifepoint, RegionalCare, RCCH, or RCHP-Ottumwa, Inc. worked with Iowa training programs to establish a resident rotation program at the hospital.

Because Ottumwa Regional does not have sufficient teaching physicians/medical staff to support a resident rotation program, Ottumwa Regional is in discussions with the University of Iowa to establish an affiliation program. An affiliation program would allow medical students from the University of Iowa to participate in short term clinical programs at Ottumwa Regional. Ottumwa Regional's goal is for this effort to grow over time into a program that would bring medical students and residents to Ottumwa Regional for clinical rotations and a formal residency program. Ottumwa Regional has prioritized the creation of an affiliation program, which would provide teaching and learning opportunities at Ottumwa Regional.

14b. Does ORHC have an outpatient substance abuse treatment program? If not, please explain the reason.

While Ottumwa Regional does not currently operate an outpatient substance abuse treatment program, Ottumwa Regional and Ottumwa Regional Legacy Foundation are in discussions to establish services of this sort at Ottumwa Regional. As noted above in response to 14a, Ottumwa Regional is exploring potential partnerships with the University of Iowa, including opportunities to advance support for Ottumwa Regional's behavioral health program.

14c. In addition to discontinuing its home healthcare services, discontinuing the e-ICU program, significantly reducing its ICU volume, and limiting its operating room call to cesarean sections, please provide a complete list of services that ORHC has discontinued, limited, reduced, or paused since April 30, 2010, the applicable dates, and the reason.

Ottumwa Regional has prioritized remaining open and available to the local community. As a result, over the last 14 years, Ottumwa Regional occasionally had to make difficult decisions regarding which services to prioritize and which services to reduce in an effort to most effectively address patient needs while remaining open.

Ottumwa Regional discontinued its e-ICU program in the spring of 2022 following the expiration of the grant that funded the service. The hospitalists at Ottumwa Regional recommended discontinuing the e-ICU service due to concerns about patient safety and outcomes. Specifically, intensive care procedures such as central line placement, intubation, ventilator management, and chest tube placement require in-person execution by trained ICU providers. The lack of an on-site ICU-trained provider to perform these critical procedures limited the effectiveness of the e-ICU service. Additionally, the reduced patient census and the resulting challenges in maintaining ICU competencies further contributed to the decision to discontinue the service.

Since discontinuing the e-ICU program, Ottumwa Regional has continued to care for ICU patients as needed, ensuring that it staffs critical care-competent nurses to meet the needs of the Ottumwa community. Despite fluctuations in patient volume, Ottumwa Regional has maintained consistent staffing levels to ensure readiness and the ability to provide high-quality care.

Since April 30, 2010, Ottumwa Regional has also discontinued the following services, all of which occurred before Lifepoint acquired Ottumwa Regional:

- Ottumwa Pediatrics Clinic - June 2010
- Pulmonology - June 30, 2013
- Chemotherapy Services - April 1, 2014
- Home Care - November 1, 2018

Ottumwa Regional does not make decisions regarding closing services lightly. As described in its February 2, 2024 letter, Ottumwa Regional shifted to managed Medicaid in 2016, and subsequent poor reimbursement rates led to the closure of home health care in 2018. Other home care facilities in the Ottumwa community also struggled with funding, and ultimately, many other Iowa home health facilities closed.

14ci. Does ORHC have an active inpatient pediatric unit? If not, please explain when the unit was closed and the reason. If yes, please provide the annual number of admissions to the pediatrics unit from 2015 through 2023.

Yes, Ottumwa Regional has a pediatric inpatient unit that provides a full range of medical and surgical care for infants, children, and adolescents through a 24/7 pediatric call team.

Over the years, Ottumwa Regional has observed pediatric hospitalization trends similar to those seen across the country. There has been a significant decline in the volume of pediatric hospitalizations and emergency department visits, offset by an increase in the severity of cases. This trend has led to a higher transfer rate to ensure that patients receive the appropriate level of care. Maintaining clinical competency under these conditions has become increasingly challenging, especially as the hospital relies more on contract labor, which is a particularly difficult source of pediatric specialties. Despite these challenges, Ottumwa Regional continues to admit and care for pediatric patients through a 24/7 pediatric call team.

14cii. What cancer care services, dialysis services, surgical services are currently being provided at ORHC and what services were provided in 2010? Were there periods of time when these services were not being provided?

In 2010, Ottumwa Regional provided radiation oncology services as well as chemotherapy infusions. The chemotherapy program was discontinued in April 2014, years before Lifepoint acquired the hospital.

Ottumwa Regional has offered dialysis services for many years, but with the loss of its only dialysis nurse in 2023, dialysis services are on hold while Ottumwa Regional works to recruit another dialysis nurse. Ottumwa Regional intends to offer dialysis services again once a dialysis nurse is onboarded to the hospital.

Ottumwa Regional also provides general surgery, orthopedics, urology, gastroenterology, OB/GYN, interventional cardiology, and interventional pain management services.

14ciii. Please provide ORHC's specialist on-call schedule for the first half of 2024, as to understand how many days the hospital did not have specialists on-call (such as cardiologists, gastroenterologists, and general surgeons).

Enclosed at LP-CEG-008284 through LP-CEG-008465 are Ottumwa Regional's specialist on-call schedules for the first half of 2024.

14civ. How many days did ORHC's intensive care unit have staffed beds in 2021, 2022, 2023, and thus far in 2024?

Like other hospitals, Ottumwa Regional staffs its facility according to patient acuity and volume. Thus, the number of staffed beds and the number of staffed hours depends on the number of patients who are admitted into the ICU and the severity of their conditions. The total staffed hours for the ICU are as follows:

- 2020 - 19,663 worked hours, which equates to 13.7 FTEs.
- 2021- 25,028 worked hours, which equates to 24.14 FTEs.
- 2022 - 20,338 worked hours, which equates to 13.25 FTEs.
- 2023 - 6,057 worked hours, which equates to 2.23 FTEs.
- 2024 YTD - 2,591 worked hours, which equates to 1.9 FTEs.

As explained in our response to 14c above, Ottumwa Regional discontinued the e-ICU program in 2022 amid lower patient volumes and challenges in maintaining adequate ICU competencies. This discontinuation in turn contributed to the reduced FTEs for the ICU in 2023 and 2024.

14cv. How many hours was the ORHC's emergency department on diversion in 2021, 2022, 2023, and thus far in 2024?

Please provide the total number of staffed beds in the ORHC in 2009 and the current number of staffed beds broken down by unit type (e.g., emergency department, med-surg, intensive care, pediatrics, behavioral health, acute rehab unit).

Ottumwa Regional operates 911 emergency medical services for Ottumwa and Wapello County. Its emergency department is never on diversion.

Enclosed at LP-CEG-008466 through LP-CEG-008942 is Ottumwa Regional's AHA annual bed-count survey for 2009 to 2023.

* * *

Lifepoint welcomes the opportunity to share information about its operations, policies, and procedures. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

November 08, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint" or the "Company"). This submission responds to the set of questions in your email of August 8, 2024, and your follow-up questions of September 9, 2024, October 4, 2024, and October 28, 2024.

We have included in this letter information that includes proprietary business information. We request that this information not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.[1]

As we have emphasized in our prior letters, rural areas like the one in which Ottumwa Regional is located are difficult places to operate a healthcare facility. Meeting the needs of these communities is complex and demanding, largely due to problems associated with resources, location, limited availability of human capital, and socioeconomic and demographic characteristics. Over the past decade, more than 100 rural hospitals across the nation have closed and another third of rural hospitals are currently at risk of closing because of the serious financial challenges facing healthcare delivery to rural communities.[2] As an example in Iowa, earlier this year, MercyOne Medical Center in northwest Iowa closed as a result of staffing shortages and a decrease in patient volumes leading to unsustainably low utilizations of its facilities.[3]

[1] As indicated in the Monthly Operating Reports, the Biannual Quality Oversight Committee Readouts, and the National Quality Committee Touchpoints, these presentations are Patient Safety Work Product ("PSWP"). As such, these presentations remain privileged and protected from disclosure to any other party. Consistent with the terms of the PSWP Act, we request that you keep these presentations confidential.
[2] *Rural Hospitals at Risk of Closing,* Center for Healthcare Quality & Payment Reform (July 2024), https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.
[3] *Primghar hospital to close, three clinics consolidate*, NWEST IOWA, August 10, 2024, https://www.nwestiowa.com/news/primghar-hospital-to-close-three-clinics-consolidate/article_544eee74-569e-11ef-a791-c30e938461c7.html.

As a result of these closures, the millions of Americans who live in rural communities no longer have access to a local emergency room, inpatient care, and many other hospital services that citizens in suburban and urban communities take for granted. Both to keep hospitals open and to provide quality care by qualified professionals, services have been reduced at rural hospitals across the country. Nationwide, 53 percent of rural hospitals that have remained open have lost services over the past 2 years.[4] This problem is particularly acute in Iowa, where 75 percent of hospitals have lost services over the same period and where 30 percent of hospitals remain at risk of closing.[5]

In the face of these headwinds, Lifepoint has strived to develop meaningful solutions to enhance quality and increase access to care for the communities it serves. Contrary to national trends, Lifepoint has invested in rural communities, including Ottumwa, and is committed to ensuring that Ottumwa Regional, the only hospital in Wapello County, can continue to provide quality healthcare services to a community in need.

The population served by Ottumwa Regional faces a variety of social, economic, and health challenges, and these socioeconomic conditions make it particularly challenging to recruit and retain experienced clinical professionals to relocate and settle in the community. As you are aware, two highly qualified surgeons recently departed Ottumwa Regional. One of these surgeons, [redacted], relocated to Pella Regional Health Center, a suburban facility just outside Des Moines. Unlike the rural community served by Ottumwa Regional, Pella is a suburban facility with access to an urban area, has attractive socioeconomic and demographic characteristics, and offers quality schooling, making it a desirable area for an experienced surgeon to settle with his or her family. We regret [redacted] departure for Pella, and his decision to leave Ottumwa Regional is emblematic of the challenges regularly faced by Ottumwa Regional and other similarly situated facilities. This transition reflects both the systemic pressures on rural healthcare providers and Ottumwa Regional's ongoing efforts to enhance the quality and sustainability of the medical team locally.

Ottumwa Regional has worked diligently to continue to provide quality healthcare despite ongoing operational and environmental challenges. Consequently, Ottumwa Regional has lost an average of about $11 million a year for each of the past five years. Nevertheless, Lifepoint has funded these losses, year over year, and remains committed to Ottumwa Regional and to the broader Wapello County. This commitment is further evidenced by Lifepoint's contributions of approximately $43 million in charity and uncompensated care services over the past five years to the Ottumwa community and investments of more than $15 million in Ottumwa Regional. That commitment—which we have described at length in our prior letters—has allowed Ottumwa Regional to remain open in the face of widespread national closures of rural and regional hospitals and notwithstanding consistent, historical financial losses, which are expected to continue at the same level for the near term.

[4] This includes rural hospitals that had a negative margin (loss) on patient services in the most recent year available (which, depending on the state, was 2022 or 2023).
[5] *Rural Hospitals at Risk of Closing,* Center for Healthcare Quality & Payment Reform (July 2024), https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.

Lifepoint Questions

1. Please provide scorecards/reports that Lifepoint management uses to assess and benchmark the performance of Ottumwa Regional Health Center (ORHC) for the years 2019 through 2023, including but not limited to measures of quality, safety, patient experience, volume of care, staffing, employee/provider turnover, and employee/provider satisfaction. (We use the term Lifepoint management to refer to any Lifepoint corporate and division-level employees; any Lifepoint Corporate Services, General Partnership employees; any RCHP-Ottumwa, LLC employees; Lifepoint National Quality Program staff, or any other employees of Lifepoint and its affiliates that do not directly work at ORHC but oversee the operations of ORHC in some capacity).

1. Supplemental Requests:

Ottumwa Regional's Monthly Operation Reports for April 2019, July 2019, August 2019, Dec 2019, January 2020, Feb 2021, Nov-Dec 2021, Sep 2022, and Mar 2023-Dec 2023.

Quality updates are provided in the Monthly Operation Reports using the previous month's data. Accordingly, some of the documents previously produced were labeled based on the month the data was provided, rather than the month of the presentation. For example, the July 2019 presentation was previously produced at LP-CEG-007141 with the data on quality from June 2019. Additionally, for certain months, the Monthly Operations Report presented data for multiple months. For example, the Monthly Operations Report for February 2020, produced at LP-CEG-007263, provided information on data from December 2019 to February 2020. Similarly, the January 2022 Monthly Operations Report, produced at LP-CEG-007666, provided information on data from November 2021 to January 2022.

Enclosed at LP-CEG-008943 through LP-CEG-009079 are the Monthly Operation Reports for March 2023 to December 2023. Please note that the September 2023 meeting was cancelled, so no Monthly Operation Report was prepared.

We have not identified Monthly Operations Reports for April 2019, August 2019, and February 2021, which typically indicates that the meetings for those months did not occur.

The Monthly National Quality Program touchpoint call materials for some of the months not previously sent and the Quality Oversight Committee presentations.

In the months when there are Quality Oversight Committee presentations, there are no National Quality Program touchpoints. We have not identified any National Quality Program touchpoints or Quality Oversight Committee meetings from October 2020, September 2021 to November 2021, February 2022 to April 2022, June 2022 to September 2022, or December 2022 to January 2023, which may reflect that the meetings were not held in those months. The following presentations were previously produced:

- The March 2021 and April 2021 Quality Oversight Committee presentation, at LP-CEG-007967;
- The October and November 2022 Quality Oversight Committee presentation, at LP-CEG-008008; and
- The September 2023 to November 2023 Quality Oversight Committee presentation, at LP-CEG-008077.

The May 2022 Quality Oversight Committee presentation is enclosed in this production at LP-CEG-009080 through LP-CEG-009112.

1a. Please provide any documents that support Lifepoint management's review of these scorecards/reports and any associated action plans. Please note who at Lifepoint reviews the scorecards/reports.

Lifepoint's response on September 27, 2024, indicated that Dr. Kiefer presents twice a year to Lifepoint's President, Chief Nursing Executive, and approximately 20 other subject-matter experts. We would like to correct this response to indicate that the presentation includes Lifepoint's *Division* President overseeing Ottumwa Regional and not Lifepoint's President. These presentations are the same as the Quality Oversight Committee presentations, which have already been produced in response to Question 1, at LP-CEG-007967 through LP-CEG-008112, and LP-CEG-009080 through LP-CEG-009112.

1a. Supplemental Request: Please provide reports or scorecards on inpatient or outpatient staff, length of boarding, transfer rate, provider resignation numbers, as well as reports or data reviewed by Lifepoint regarding Ottumwa Regional's ambulance service, Level VI trauma center designation, walk-in clinics, and other outpatient services.

a. *Inpatient versus Outpatient Staffing*

Ottumwa Regional tracks worked hours for its inpatient and outpatient staff through an internal online platform. This information is not reviewed by Lifepoint.

Lifepoint further does not receive information on inpatient versus outpatient staffing from Apogee Medical Management ("Apogee") or TeamHealth, as many staff assist with both inpatient and outpatient treatment.

b. *Length of Boarding*

Lifepoint reviews information on the number of boarding or hold hours for all its facilities, including for Ottumwa Regional. Lifepoint defines hold hours as the number of hours a patient is receiving treatment in the Emergency Department for care that would otherwise be provided as inpatient care (typically as a result of lack of staffing or space availability).

Ottumwa Regional's hold hours are provided in the chart below. As a result of the staffing shortages exacerbated by COVID-19, Ottumwa Regional's hold hours have increased during the 2019 to 2023 period. Lifepoint and Ottumwa Regional are committed to hiring additional staff and are working to decrease hold hours.

Year	2019	2020	2021	2022	2023
Total Hold Hours	2,564.2	4,321.8	4,656.8	4,597.8	7,581.5

c. Transfer Rates

Transfer rates for rural Emergency Departments are typically higher than those for urban Emergency Departments, because rural hospitals are usually unable to employ medical specialists and therefore services are more limited than in larger, more urban, settings. Centrally located urban hospitals are more likely to maintain the advanced resources necessary to care for patients who have complex or uncommon conditions; rural facilities such as Ottumwa Regional often do not have the resources or patient volumes to support such services. Ottumwa Regional's transfer rate for patients who visited the Emergency Department remained between 4 percent to 5.6 percent from 2019 to 2023, with a high of 5.6 percent in 2020, during the height of the COVID-19 pandemic. This is less than the national average: approximately 6.2% of visits to rural Emergency Departments result in transfer.[6]

d. *Provider Resignation Numbers*

Ottumwa Regional is committed to hiring quality staff members to ensure that the Ottumwa community receives the highest level of care. Even as resignations have increased over the last few years (especially between 2020 and 2022, during the COVID-19 global pandemic), Ottumwa Regional has made it a priority to continue recruiting and hiring providers to replace the ones who leave. A chart detailing the total resignations, excluding retirements, versus the total appointments for providers between 2015 to 2023 are as follows:

Year	2015	2016	2017	2018	2019	2020	2021	2022	2023
Resignations	49	36	90	51	66	39	46	84	69
Appointments	43	54	97	53	41	37	77	39	87

e. Ambulance Service

As previously discussed in our January 17, 2024 letter, Ottumwa Regional provides emergency medical services ("EMS") to the Ottumwa community, which are more typically provided by local municipalities or regional authorities. Ottumwa Regional is the 911 medical service provider for the

[6] Association of Rural and Critical Access Hospital Status With Patient Outcomes After Emergency Department Visits Among Medicare Beneficiaries, JAMA Network Open (November 1, 2021).

city of Ottumwa, as well as for the broader Wapello County. Between 2019 and 2023, Ottumwa Regional's ambulance fleet made close to 25,000 EMS runs in response to 911 calls. The majority of Ottumwa Regional's EMS runs are in response to 911 calls (close to 90% of total EMS runs each year), but Ottumwa Regional's ambulance fleet is also utilized for medical transport, interfacility transport, and public assistance.

We are not aware of any scorecards or reports shared with Lifepoint regarding Ottumwa Regional's ambulance service.

f. Trauma Level Designation

Ottumwa Regional is designated as a Level IV trauma center, which is the lowest level designation that the State of Iowa has for trauma centers.[2] As a Level IV trauma center, Ottumwa Regional is required to use its resources to stabilize and treat a trauma patient. After the patient is stabilized, if the patient requires additional resources or specialties that Ottumwa Regional does not offer, Ottumwa Regional will transfer the patient to another facility.

We are not aware of any scorecards or reports shared with Lifepoint regarding Ottumwa Regional's trauma level designation.

g. Walk-In Clinic and Other Outpatient Services

Ottumwa Regional has invested in its walk-in clinic to provide the necessary care for the community it serves. The walk-in clinic, which opened in 2013, initially served 3,317 patients in its inaugural year. Ottumwa Regional closely monitors the volume in its walk-in clinic to ensure that the needs of the community are met, and devotes significant resources and efforts into recruiting staff to support the walk-in clinic. A chart detailing the number of patients treated in the walk-in clinic is below:

Year	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Patients	3,317	7,750	8,321	9,358	11,354	13,901	16,747	14,972	20,011	21,503	19,574

Ottumwa Regional also provides critical outpatient services including lab visits, radiology, wound care, and outpatient surgery. A chart detailing the total number of patients who received these outpatient services between 2019 to 2023 is below:

Year	**2019**	**2020**	**2021**	**2022**	**2023**
Lab	82,509	79,296	72,457	62,430	54,126
Radiology	12,060	10,228	11,441	10,817	10,842
Wound Care	3,881	3,943	4,434	3,766	3,212
Surgery	5,557	4,605	5,285	3,766	3,212
Total	104,007	98,072	93,617	80,779	71,392

Information regarding the patient volume at Ottumwa Regional's walk-in clinic and other outpatient services is communicated at a high level to Lifepoint.

1b. Please provide all scorecards/reports that Lifepoint provides to Apollo directly or through Apollo representatives to the Lifepoint board (hereto forth referred to as "Apollo") that pertain to ORHC's performance.

Lifepoint does not provide monthly or yearly scorecards of individual hospitals to the Lifepoint Board of Directors, which includes Apollo representatives. Lifepoint periodically provides aggregate and select information on its hospitals to the Board, including through the Quality Committee.

2. Supplemental Requests: Was Lifepoint management aware of issues related to the sufficiency of staff at Ottumwa prior to the death of Mr. Devin Caraccio in October 2022? Specifically, the CMS report showed Caraccio worked every night from August 1 through September 5, 36 days straight as night hospitalist. Please provide all documents, such as board minutes, that support your response, including all communications with Apollo regarding this matter.

As discussed below in Question 3, Lifepoint receives monthly reports from Apogee, which provide information on the staffing volumes. Lifepoint reviews the daily encounter metric (which contains all of the individuals that are treated by Apogee hospitalists) provided in the Apogee reports to determine whether hospitalists are able to keep up with the demands of the hospital. For example, hospitalists often see an average of 16 to 18 patients a day. Lifepoint reviews the daily encounters per facility to ensure that there are enough hospitalists to cover daily encounters and still stay within the 16 to 18 patients average, which Lifepoint uses as a reference point when assessing the optimal level to provide sufficient care to patients at its facilities

This information is not provided to the Lifepoint Board, of which Apollo has members.

3. Does Lifepoint management review the contracts that its facilities enter with contractors or review the performance of contractors, including but not limited to ORHC's contract with TEAMHealth/Southeastern Emergency Physicians, LLC for emergency medicine providers and Apogee Medical Management for hospitalists? If yes, has Lifepoint management ever identified concerns regarding the sufficiency of the services negotiated under these contracts or the performance of the contractors? If yes, what actions has Lifepoint management taken in response? Please provide all documents that support your response, including all communications with Apollo regarding this matter.

The contracts with TeamHealth and Apogee respectively are structured differently:

- Lifepoint has a Master Agreement with TeamHealth, previously produced at LP-CEG-002265, which governs the overall relationship between Lifepoint and TeamHealth with certain decisions, such as the lines of service for which TeamHealth will provide services, made at the facility level.

- By contrast, Lifepoint does not have a contractual relationship with Apogee. Lifepoint and Apogee instead jointly developed a template contract, and Lifepoint facilities use that form agreement to enter into individual contracts between the contracting facility and Apogee.

Lifepoint partners with TeamHealth and Apogee to advance clinical, quality, patient safety, and operational opportunities. When appropriate, TeamHealth and/or Apogee may identify for Lifepoint system level processes to improve a hospital's performance. In these cases, Lifepoint will assist in preparing an action plan and receive periodic updates on the progress of implementing the action plan.

Lifepoint meets with TeamHealth and Apogee on a quarterly basis to discuss how they are performing from an operational, financial, and quality perspective. Lifepoint National Quality Program and Quality Oversight Committee meetings also include discussion of services provided by TeamHealth and Apogee.

As we have emphasized, recruiting quality medical staff to rural Iowa is a challenge. In 2023, Ottumwa Regional leadership began escalating to Lifepoint concerns about the quality and performance of the TeamHealth providers working in Ottumwa Regional's Emergency Department. As a result, Lifepoint and Ottumwa Regional leadership developed an action plan, which included a meeting with TeamHealth leadership in which Ottumwa Regional requested from TeamHealth a new supervisory structure for the facility as well as a revamped approach to Emergency Department provider staffing. Lifepoint and Ottumwa Regional leadership meet twice a month to ensure progress on this TeamHealth action plan, and the quality of the TeamHealth staff at Ottumwa Regional has been continuously improving.

3a. On October 24, 2022, RCHP-Ottumwa, LLC and Apogee Medical Management, Inc. amended their Professional Services Agreement to increase the monthly guarantee amount for physicians and to establish a monthly guarantee amount for advanced practitioners. Please provide background on the reason for this amendment. Please provide all documents that support your response, including all communications with Apollo regarding this matter.

The Professional Services Agreement with Apogee was amended to remain in line with market-based provider rates. COVID-19 had a significant effect on the healthcare staffing landscape, and there has been a shift toward a preference for locum tenens positions which offer greater control and flexibility for the physician on their scheduling and work/life balance. As a result, recruitment and employment costs have risen for hospitals across the country, including Ottumwa Regional.

3b. As described in the Schedule E of the Professional Services Agreement between Apogee Medical Management and RCHP-Ottumwa (signed July 31, 2014), please provide the amount of the pro rata performance payouts or penalties that Apogee received from ORHC for 2019 through 2023 and the scorecards used to evaluate Apogee's performance for this

purpose and please note whether these scorecards were reviewed by Lifepoint management and Apollo.

We have not identified any pro rata performance payouts or penalties applied to Apogee in connection with Ottumwa Regional for the years 2019 through 2023. Apogee provides monthly reports regarding their staffing and billing metrics to Lifepoint. Enclosed at LP-CEG-009113 is the report Apogee provided in October 2024 for all Lifepoint facilities with whom it contracts, including Ottumwa Regional. The report provides information about the prior 12 month rolling average of various metrics including compensation ranges, coverage model, full-time employees provided to the respective facilities, daily encounters, and collections per encounter, among other things. The report also provides the subsidy amount the facilities (including Ottumwa Regional) provided to Apogee. This subsidy number is calculated based on several factors, including patients' ability to pay and compensation level of the Apogee employees. For example, Ottumwa Regional's subsidy amount is higher than other Lifepoint facilities because of the high compensation required in the area to attract hospitalists and the low reimbursement rates given the high volume of patients without insurance or covered by state insurance.

These Apogee reports are reviewed during Ottumwa Regional's Monthly Operating Call with Apogee leadership. Ottumwa Regional leadership periodically provides aggregate information from these reports to Lifepoint's Quality Team during the monthly touchpoints. These reports are not shared with the Lifepoint Board, of which Apollo has members.

3c. As described in Schedule 1.A and 1.B of the professional services agreement between Southeastern Emergency Physicians and RCHP-Ottumwa (signed July 2, 2019), please provide the ED Physician Scorecard for ORHC for 2019 through 2023 and please note whether these scorecards were reviewed by Lifepoint management and Apollo.

TeamHealth provides Lifepoint with monthly reports of metrics on its budgeted and actual spend and hours. This provides information on the number of hours budgeted for MD versus Advanced Practice Provider, the number of expected patients in the Emergency Department versus the number of actual patients served in the Emergency Department, among other things. An example of these metrics is available at LP-CEG-009114.

These reports are not shared with the Lifepoint Board or Apollo.

6. What role, if any, did Lifepoint/RCCH play in the decision to discontinue home healthcare services (2018), discontinue the e-ICU program (2022), significantly reduce ICU volume (from 783 in 2022 to 107 in 2023), and limit operating room call to cesarean sections (2023) at ORHC? What actions, if any, has Lifepoint management taken to restore these services? Please provide all documents that support your response, including all communications with Apollo regarding these matters.
6. Supplemental Request: In other responses there was an explanation about cutting services, but they are interested in understanding who makes the final decision. Is it Lifepoint? Apollo? If not Lifepoint or Apollo directly, do Lifepoint or Apollo set financial targets for the hospital that requires the hospital to cut service lines? Are they informed

when service lines are cut? Any documentation about their role in the elimination of services?

Decisions about discontinuation of services are made at the facility level, in consultation with the medical staff and local governing board, and Ottumwa Regional leadership regularly deliberates about which services it can provide safely, efficiently and successfully to the local community. The considerations in making such decisions include community need, volumes and availability of clinical staff to serve the community. Ottumwa Regional leadership provides regular updates on these issues to Lifepoint management, including the Division President, and in the rare event that a service line is closed, such closure is made in consultation with Lifepoint Division leadership.

Lifepoint's Board of Directors, of which Apollo has members, is not involved in decisions relating to the discontinuation of services at Lifepoint facilities.

6. Supplemental Request: In other responses there was an explanation about cutting services, but they are interested in understanding who makes the final decision. Is it Lifepoint? Apollo? If not Lifepoint or Apollo directly, do Lifepoint or Apollo set financial targets for the hospital that requires the hospital to cut service lines? Are they informed when service lines are cut? Any documentation about their role in the elimination of services?
6a. Please explain how Lifepoint has the resources to build and acquire new facilities and invest in Forward Health/Lifepoint Forward ventures/25m Health, but not the resources to ensure the maintenance of services at its existing facilities.

Lifepoint invests significant resources to ensure that its facilities, including Ottumwa Regional, provide the best possible quality of care to their communities. Consistent with that goal, Lifepoint Division leadership, in conjunction with hospital leadership, routinely analyzes the efficacy of its initiatives to ensure its programs address the needs of the community. Since acquisition, Lifepoint has invested more than $20 million in Ottumwa Regional.

As described below in response to Question 23(a), Lifepoint's investments in Lifepoint Forward, Forward Health Ventures, and 25m Health also further Lifepoint's efforts to prioritize quality of care through innovation and investments in technology. The vision for Forward Health is to support the development of technologies and solutions to enhance the quality of care provided in Lifepoint communities and other rural communities across the country. Its investments are for the purpose of enhancing care and capabilities. Examples are included in response to Question 23(a).

8. Please provide all communications with Apollo regarding "impact on access to health care in rural communities that result from the discontinuation/limitation of services or lack of nurses, providers, or other health care professionals at Lifepoint facilities." Is that shared with Apollo? How is this information relayed back to Apollo and are they providing recommendations or directives to Lifepoint or Apollo?

Lifepoint monitors the challenges in the communities that it serves, including the Ottumwa Regional community, and assists its facilities with providing critical services. The Lifepoint Board, of which

Apollo has members, is informed about challenges that Lifepoint facilities face in the aggregate but typically does not discuss the discontinuation or limitation of services for individual facilities.

14. Supplemental Request: Please provide more information on any partnerships between Ottumwa Regional and University of Iowa, such as the partnerships for medical student rotations and operations of an outpatient substance use clinic.

Dr. Kiefer has been in discussions with the University of Iowa to develop a partnership that will increase cooperation between Ottumwa Regional and the University of Iowa while providing additional resources to Ottumwa Regional and the community. The University of Iowa is a current and important partner to Ottumwa Regional and that partnership is a demonstration of how services and access to services can be expanded in rural communities across the country through expansion of partnerships. The discussions remain ongoing and focused on expansion of care and expertise in Ottumwa, Iowa.

15. Based on the ORHC Community Impact Reports from 2019-2023, we estimated an approximately 37% decrease in employees at ORHC from 2019 to 2023. Please provide the number of ORHC employees for years 2010 through 2018. Has Lifepoint examined the impact of this decrease on the local economy? Please provide all documents that support your response, including all communications with Apollo regarding this matter.

Please see below the total number of providers for Ottumwa Regional.

2015	2016	2017	2018	2019	2020	2021	2022	2023
210	230	244	246	223	223	255	214	235

The number of providers at Ottumwa Regional has remained relatively consistent throughout Lifepoint's ownership of Ottumwa Regional, with the exception of the immediate aftermath of COVID-19, when there was a global shortage of physicians and nurses. Lifepoint has supported, and continues to support, Ottumwa Regional's recruitment of additional physicians.

16. Based on numbers we reviewed from ORHC's March 4, 2024, response to the budget committee (page 8) and the ORHC 2023 Community Impact Report, we estimated the annual hospital employee turnover rate at ORHC for 2023 to be 35% (144/415). Please note if this is correct and provide the ORHC employee turnover rates for 2015-2023. Please provide all communication with Apollo regarding this matter.

The turnover rate for hospital and lab staff, excluding contract and clinic employees, for 2015 to 2023 are as follows:

- 2015: 39.89%
- 2016: 15.09%
- 2017: 20.83%
- 2018: 20.16%

- 2019: 22.67%
- 2020: 22.14%
- 2021: 23.74%
- 2022: 37.25%
- 2023: 42.28%

Between 2020 to 2023, staff turnover increased as a result of the COVID-19 pandemic and nationwide staffing shortages. During the pandemic, Ottumwa Regional, like facilities around the world, had difficulties with attracting and retaining full-time, permanent medical staff. Ottumwa Regional faced additional challenges in staff retention following the incident with Devin Caraccio in late 2022, which added to existing challenges in recruiting staff.

Dr. Kiefer and his leadership team have been focused on bringing local talent back into the organization. They have implemented wage adjustments across nearly all job titles, including RNs, LPNs, paramedics, lab, radiology, and central sterile technicians. Indeed, to attract local clinical talent and improve retention, Ottumwa Regional has recently further increased compensation for RNs with at least eight years of experience, in alignment with national market rates.

18. Please provide comments from the Culture of Safety surveys. Specifically, the 672 comments received during the June 2022 survey, the 645 comments received during the May 2023 survey, and the 386 comments received during the February 2024 survey.

Enclosed at LP-CEG-009115 through LP-CEG-009117are comments received through Ottumwa Regional's Culture of Safety survey. Additionally, enclosed at LP-CEG-009118 are Ottumwa Regional's action plans from 2022 to 2024, which provide information on Ottumwa Regional's action items in response to certain areas identified in the Culture of Safety surveys.

19. What goals and objectives has Lifepoint used to evaluate the ORHC CEO's performance and thereby determine the CEO's compensation level? Since 2019, please describe how the ORHC CEO performed on these goals and objectives and thereby the CEO's associated compensation, including bonuses and any benefits excess of base salary. Please also note any golden parachutes or retirement bonuses provided. Please provide all documents that support your response, including all communications with Apollo regarding this matter.

19. Supplemental Request: Have the goals for the ORHC CEO changed over time. What role does Apollo play? Please provide all documents that support your response, including all communications with Apollo regarding this matter

Lifepoint evaluates all employees in conjunction with Lifepoint's five values, which are: (1) Champion Patient Care; (2) Do the Right Thing; (3) Embrace Individuality; (4) Act with Kindness; and (5) Make a Difference Together. All employees are also evaluated against the Leapfrog performance factors, which includes ensuring that there are ongoing strategies to eliminate unsafe practices. Lifepoint also has specific metrics that are used to evaluate leadership through a "9 Box"

process, including facility CEOs. The practice of evaluating facility leadership with Lifepoint's values has been consistent throughout Lifepoint's oversight of Ottumwa Regional.

Ottumwa Regional's former CEO was separated from Ottumwa Regional on November 3, 2022; he received six months of compensation in severance.

Dr. Kiefer's compensation is based on his progress against individual and company performance targets, as detailed in his offer letter, previously produced at **LP-CEG-002259**.
As detailed in the Ottumwa Regional Chief Executive Officer job description, previously produced at **LP-CEG-002262**, the Ottumwa Regional CEO is expected to provide "leadership and direction for the overall operation of the hospital." This includes, among other things:

- Coordinating the activities of senior executives, and working with senior executives to develop short and long range objectives, policies, and procedures.
- Ensuring the policies are uniformly understood and consistently interpreted and administered;
- Establishing the organization hierarchy and delegating limits of authority to subordinates executives; and
- Analyzing operating results of the hospital and its principal components relative to established objectives and ensuring that appropriate steps are taken to correct unsatisfactory conditions.

As discussed in our January 17, 2024 letter, since joining Ottumwa Regional, Dr. Kiefer has stabilized the hospital's operations and has initiated a number of enhancements to patient safety and care, including implementation of new customer service standards and accompanying training for staff, new equipment, facility repairs and upgrades, and new technology.

Following his appointment as CEO of Ottumwa Regional, Dr. Kiefer set out to ensure that the tragic events that led to the death of Devin Caraccio do not recur. Dr. Kiefer has focused on patient safety throughout his tenure at Ottumwa Regional. Among other things, he has overseen the installation of 100 cameras to increase overall safety for patients and staff and to prevent drug diversion. Under his leadership, Ottumwa Regional also began participating in the Billion Pill Pledge initiative to decrease opioids use following surgery and has begun serving as a drug disposal location for the Ottumwa community, where individuals can dispose of any unused or unwanted medication.

Additionally, Dr. Kiefer has focused on supporting staff and improving staff engagement by introducing regular and open communications among stakeholders, including executive rounding, department meetings, five all-staff town hall meetings over the last year, and a CEO newsletter. Dr. Kiefer has focused on improving patient care as well. For example, to enhance patient and family experiences, he has trained staff on the new customer service standards, strengthened Ottumwa Regional's quality of care committee by adding front line staff as well as a community patient representative to the meeting, and focused on adding new equipment, such as anesthesia carts and a

DaVinci robot, to the hospital. He has also overseen pay increases for EMTs and paramedics to stabilize 911 services for Ottumwa and Wapello County, as well as market salary increases for RNs, LPNs, and a variety of other roles at Ottumwa Regional.

Dr. Kiefer has continued to connect with the local Ottumwa community. He participates in regular discussions with other leaders in the Ottumwa community (such as through his position as a director on the Board of the Greater Ottumwa Partners in Progress ("GOPIP"), a combined chamber of commerce and economic development organization).

His regular coordination and interactions with hospital staff, patients, and local communities allows him to provide strong leadership and direction to Ottumwa Regional and to ensure that Ottumwa Regional is meeting the needs of the Ottumwa community.

Apollo is not involved in compensation decisions for leadership at Lifepoint facilities.

22. What discussions has Lifepoint had internally concerning its solvency? Please provide all documents that support your response.

Lifepoint, similar to every organization, regularly monitors its financial health, both at the local hospital level and in terms of the overall health of all its facilities. Lifepoint has not had any internal discussions about its solvency, which is not in question.

23. Please provide the full list of investments that Lifepoint and its subsidiaries have made in any other companies or projects not directly related to the operation of Lifepoint health care facilities. Please provide the date and amount of the investment, the terms of the investments, any returns made on the investments, Apollo's relationship to the companies receiving the investment, and how ORHC has benefitted from the investment. Please provide all documents that support your response, including all communications with Apollo regarding this matter.

Lifepoint has made only one investment in a healthcare company unrelated to the operations of its existing facilities. *See* LP-CEG-005611.

23a. What is Lifepoint Forward, Forward Health Ventures, and 25m Health?

Lifepoint Forward embodies Lifepoint's approach to cultivating ideas and investing in technology-based solutions to improve quality, access and outcomes win the communities Lifepoint services, while lowering costs. Through the Lifepoint Forward strategy, Lifepoint partners with organizations that are innovating in the healthcare ecosystem, builds companies and solutions to address new opportunities and areas of unmet market need, and buys capabilities that will add value to the organization, the communities Lifepoint serves, and the broader healthcare system. For example, through its partnership with Eon, a leading data science company, Lifepoint launched the "Healthy Lung Program," which leverages Eon's technology to identify abnormal lung findings on X-ray, CT scans, and MRI reports that may be ordered for patients for clinical reasons other than the concern of potential lung cancer. This program has been piloted at three Lifepoint facilities to explore its

effectiveness, with the goal of expanding it to all Lifepoint hospitals in the future. Lifepoint knows that innovation begins in the communities that Lifepoint serves. For this reason, Lifepoint engages with each of its facility teams across the country to understand their specific challenges, and strategically evaluates and implements solutions that meet their needs today and positions its network for the future.

Forward Health Ventures LP and its subsidiaries are affiliates of Lifepoint and invest directly or indirectly in certain digital and innovative health assets, including certain of those in use at Lifepoint's facilities. For example, Forward Health Ventures LP has invested in telemedicine companies focused on offering inpatient and outpatient specialties for virtual care consultations.

Through its subsidiaries, Forward Health Ventures has also invested in 25m Health, Lifepoint's in-house innovation incubator. 25m Health was created in partnership with venture studio 25madison and focuses on building promising healthcare businesses that can address key challenges across Lifepoint's network and more broadly within the healthcare industry. 25m Health has supported the launch and growth of more than a dozen health technology innovators in areas ranging from case management software to women's digital health. Examples of such businesses include Kouper Health, a discharge case management software for hospitals initially piloted at a Lifepoint facility in Dallas, and Midi Health, a female-founded and -led company focused on revolutionizing healthcare for women 40 years of age and older.

25. Please provide ORHC's annual financial reports for 2009-2023, including patient revenue, operating costs, and liabilities." If the annual financial reports are different documents than the "annual operating plans setting forth growth strategies through the expansion of current services, implementation of new services and the recruitment and retention of physicians in each community, as well as plans to improve operating efficiencies and reduce costs" described on LP-CEG-005619, please provide the annual operating plans as well.

25. Supplemental Requests:

Does Apollo play any role in developing these action plans or does Apollo set certain targets that guide the development of these plans?

Ottumwa Regional leadership, in partnership with Lifepoint Division leadership, not Apollo, creates the hospital's strategic growth plans. These plans identify areas for the hospital to improve service quality, expand market share, and enhance operational efficiency across key service lines. As noted above, Lifepoint has invested more than $20 million in Ottumwa Regional to assist hospital leadership in executing these goals. For example, in 2020 Ottumwa Regional determined that it should strengthen its primary care service by adding an additional physician. Ottumwa Regional met this goal the next year, when it added a physician and increased its visits per provider by 16 percent.

Please provide Page 2 for the 2021 income statement (LP-CEG-007964), the 2022 income statement, and the final 2023 income statement.

The previous 2022 income statement inadvertently was titled 2023 income statement (at LP-CEG-00007965). The document at LP-CEG-0007965 is the income statement for 2022, not 2023, which is why the numbers are different than those at LP-CEG-0007965. Enclosed at LP-CEG-009119 is a copy of the updated 2022 income statement, which contains the same numbers, but has the proper 2022 header.

Additionally, enclosed at LP-CEG-009120 is the 2021 income statement, which contains the additional information requested by the Staff.

Please provide clarification on the following line items of the income statements.

A. What is included in the contract services line item and why did it increase from $4.75 million in 2018 to $14.5 million in 2023?

Across all of the markets in which Lifepoint operates, contract services have increased significantly in recent years. Given the financial challenges of operating in a rural community like Ottumwa, and the limited availability of skilled personnel, Lifepoint has begun outsourcing certain services that were previously performed in-house, including, for example, account receivable collections or other non-clinical, backend operations and services.

Additionally, several categories of expenses that typically would be considered contract services were not recorded as such in the income statements before 2019. This included, for example, expenses associated with inpatient rehabilitation services, housekeeping, dietary services, and the pharmacy department.

B. What is included in the interest expense line item and why did it increase from increased from $121,494 in 2018 to $6.4 million in 2023?

The interest expense line item increased between 2018 and 2023 as a consequence of rent expense. Lifepoint remains ultimately and fully responsible for funding its facilities' rent obligations, including at Ottumwa Regional, which it does consistently.

C. Which line item includes the rent payments to Medical Properties Trust?

Rent payments to Medical Properties Trust are captured in the interest expense line item.

D. What is included in other receivables line item and why did it increase from $764,652 in 2022 to $7,423,190 in 2023?

The other receivables line item increased between 2022 and 2023 in connection with the Iowa Directed Payment Program that went into effect in July 2023 and required managed Medicaid companies to pay healthcare providers certain rates. As result of this program, Ottumwa Regional was due an additional $6.9 million in 2023.

E. What contributes to the increase in total non-current liabilities line item from about $2 million in 2018 to about $93 million in 2022 and $118 million in 2023?

There are several factors that contributed to the increase in total non-current liabilities between 2018 and 2023, including debt incurred in connection with capital expenditure investments as well as debt repayable to Lifepoint.

The debt includes debt incurred to expand service line offerings in the community, including but not limited to, a new cardiac catheterization laboratory, a new automated pharmacy management system for safer distribution of medication to ensure that the right medication gets to the right patient, a new robotic surgical system to increase the efficiency and reduce the invasiveness for a wide spectrum of surgical procedures, a new linear accelerator, and a new computed tomography (CT) machine.

As we have noted, Ottumwa Regional has been operating at a cumulative net loss of $53 million since 2019. As a result, Lifepoint has had to invest additional capital in Ottumwa Regional to fund the hospital's ongoing cash operating deficits to keep it open despite its poor financial performance. These investments are recognized as debt repayable to Lifepoint. Ottumwa Regional's debt to Lifepoint will continue to increase until Ottumwa Regional operates at a profit and is able to repay Lifepoint.

26. Please provide a breakout of any dividends or distributions from Regional Care/Lifepoint to Apollo or the Apollo Funds and any fees Lifepoint has paid to Apollo and any of its affiliates. Please provide all documents that support your response.

As we have previously explained, Lifepoint has never paid Apollo or any Apollo affiliate any dividends.

Certain of Lifepoint's employees and directors hold capital units and/or profits interest units in Lifepoint's indirect parent, DSB Parent, L.P. (DSB Parent). DSB Parent is a wholly owned Apollo subsidiary, which is authorized to issue Lifepoint stock to employees, executives, consultants, and directors of Lifepoint. When these employees or directors leave Lifepoint, DSB Parent may repurchase their equity. To fund such repurchases, Lifepoint makes distributions of cash to DSB Parent. These amounts are reflected in "distributions to parent" in the Lifepoint financial statements. The most significant payments occurred in 2021, when Apollo sold its Lifepoint investment to a new Apollo fund, which triggered an accelerated vesting event for holders of equity in DSB Parent. Because Lifepoint, a private company, must compete for senior and executive talent at market rates, the profit units structure provides a method of compensation comparable to compensation structures common among public companies.

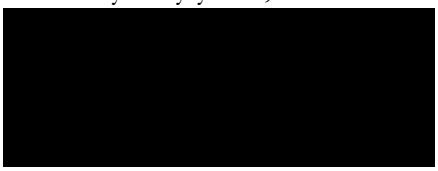
As described in the Management Agreement section of Lifepoint's Annual Report, Lifepoint and an affiliate of Apollo are parties to a Management Consulting Agreement, pursuant to which Lifepoint pays Apollo a quarterly management fee of approximately $2.3 million in exchange for advisory services.

In addition, Lifepoint compensates Apollo at market rates for assistance in connection with financial transactions. See, e.g., 2021 Annual 10-K Report, LP-CEG-005565.

* * *

Lifepoint welcomes the opportunity to share information about its operations, policies, and procedures. Thank you for the opportunity to engage on these important issues.

Very truly yours,



WILMERHALE

November 22, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint" or the "Company"). This submission responds to your follow-up questions of November 8, 2024, and provides additional information about Lifepoint's response to the Devin Caraccio incident and continuing efforts to enhance the Company's risk management program and strengthen its drug diversion program, as discussed on our November 6, 2024, call.

We have included in this letter information that includes proprietary business information. We request that this information not be disclosed publicly or to any third party, and to the extent you intend to disclose this information, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

As we have stated in our prior letters, Lifepoint and Ottumwa Regional took immediate and significant steps in response to the Devin Caraccio incident at Ottumwa Regional, at both the local and enterprise-wide levels.

At the local level, Lifepoint supported remediation in several ways, including through financial support to keep Ottumwa Regional open during this challenging time, capital investments to improve the facility and strengthen security, enhancements to the drug diversion program by expanding the role of Guidepost, and support for employees and the affected community. We discussed these efforts in our April 21, 2023 letter.

Lifepoint has also taken a number of steps at the enterprise level over the past few years to strengthen its oversight and compliance programs and help prevent future incidents like those that affected Ottumwa Regional. These changes include (1) developing a more comprehensive Enterprise Risk Management program to facilitate identification and mitigation of risks across Lifepoint facilities; (2) strengthening Lifepoint's drug diversion program, including through investment in a dedicated diversion prevention team, new policies, and increased technology use; (3) implementing policies designed to prevent misconduct, including a new Chaperone Policy, and providing training to ensure employee adoption; (4) investing in a dedicated safety and security team staffed by trained individuals with significant expertise and accountability for patient and employee

safety across the enterprise, and (5) promoting messaging across Lifepoint facilities emphasizing the importance of a speaking up culture.

Enterprise Risk Management Program

Over the past few years, Lifepoint has enhanced its Enterprise Risk Management ("ERM") program to prioritize earlier identification of risk factors that merit Lifepoint intervention. The ERM program was already in progress before the Devin Caraccio incident, and Lifepoint has continued to strengthen the program in the years since.

The ERM program focuses on identifying and evaluating potential risks that exist at Lifepoint facilities and developing and implementing plans to mitigate those risks to improve operations at the facilities. As part of the process, Lifepoint has enhanced and expanded systemwide reporting and monitoring by regularly reviewing trends at its facilities, with a focus on recurring risks and trends; Lifepoint then leverages this data to target efforts to work with facilities to detect and mitigate risks.

Drug Diversion Program

Lifepoint has invested in the creation of a drug diversion prevention department staffed with a team of professionals, many former DEA investigators, to assist the organization with training, policy creation, technology deployment and risk avoidance activities across the enterprise. Central to this team's work has been the implementation of several policies and procedures across the Lifepoint facilities to strengthen its drug diversion prevention program, particularly with respect to the detection of drug diversion instances at early stages, including the Lifepoint Health Controlled Substance Waste Policy (effective in Q1 2024), enclosed at **LP-CEG-009121 through LP-CEG-009129**, the Drug Diversion Surveillance Software Policy and Procedure (effective in May 2023 and modified in November 2024), enclosed at **LP-CEG-009130 through LP-CEG-009134**, and the Storage Handling Procedure for Patient Owned Medications Brought Into the Facility Guidance (effective June 2024), enclosed at **LP-CEG-009135 through LP-CEG-009151**.

Lifepoint developed trainings for these policies to ensure that employees at its facilities are aware of the new requirements. In early 2024, Lifepoint issued a training titled, "It's On Us: Recognizing and Reporting Potential Substance Misuse, Abuse, Drug Diversion and Resources for Employees and Managers" across its facilities to increase awareness of these topics so that Lifepoint employees can detect these types of issues early. Lifepoint also created an online training for the Controlled Substance Waste Policy in January 2024 to provide guidance regarding the handling of medical waste and reporting expectations for any potential problems. This training is now required to be completed annually by all employees, and it is a critical required training during the onboarding process for all new employees.

Lifepoint has also leveraged technology to strengthen and monitor the effectiveness of its drug diversion program. Lifepoint has purchased anti-drug diversion software that has audit and reconciliation capabilities, enabling a hospital to efficiently triage, review, and resolve medication documentation variances. This drug diversion software will be operational at all Lifepoint acute care

facilities by December 2024 and its data will be used by Lifepoint to monitor each facility's drug diversion remediation efforts.

Finally, Lifepoint has established the Diversion Prevention and Community Engagement Team to help implement and oversee the drug diversion program at the local level. Among other things, the Diversion Prevention and Community Engagement Team has informed local Lifepoint facility employees that any instance of potential drug diversion or suspicious activity related to medication management should be reported to the Diversion Prevention and Community Engagement Team immediately for further investigation. The Diversion Prevention Teams also conducts onsite visits at Lifepoint facilities to evaluate facilities' compliance with federal and state regulations, enterprise policies, and ongoing process improvements around drug diversion prevention.

Since January 2024, Lifepoint has also mandated that all facilities conduct a monthly multidisciplinary meeting to ensure communication across hospital operations about controlled substance discrepancies, reviews, trend analysis, and diversion investigations. The required attendees include the facility's CEO, CFO, CNO, ACNO, CMO, DOP Compliance, HR, Security, and Nursing. Further details about this initiative were included in Lifepoint's September 6, 2024 response.

Chaperone Policy and Associated Trainings

Following the Devin Caraccio incident, Lifepoint implemented the Chaperone Policy in May 2023, enclosed at **LP-CEG-009152 through LP-CEG-009156**.

The Chaperone Policy requires an additional healthcare employee to be present to serve as a chaperone during any intimate medical examination or treatment of certain patients, including minors and patients who are unresponsive or sedated (and thus lack decision-making capacity), among others (except during a life-threatening emergency). The chaperone's role is to remain with the patient for the entire examination, to provide emotional support, comfort, safety, and security and to facilitate communication (such as in instances where a language barrier may exist). Patients who are not required to have a chaperone may also request one if they prefer to have another individual present during their examinations.

Lifepoint also provided training on the Chaperone Policy and required all employees to receive training on the Chaperone Policy by September 2023. Lifepoint also directed its marketing department to develop signage educating patients about the policy. An example of signage explaining the policy to patients is enclosed at **LP-CEG-009157**.

Safety and Security Team

In January 2024, Lifepoint established the Safety and Security Team to oversee physical safety and security across its facilities. The team consists of the Assistant Vice President of Safety and Security and three regional directors. Among other things, the Safety and Security Team assists facilities with the management of their video surveillance and access area designations. The Safety and Security Team also conducts assessments to identify potential gaps in facilities' safety and security practices,

and works with the facilities to improve their safety and security programs. These efforts include reviewing and conducting trainings at facilities to ensure employees and staff are aware of the most effective way to protect the wellbeing of patients, employees, and staff.

Lifepoint plans to continue investing in the development of the Safety and Security Team, including expanding the team with additional resources.

Messaging on the Importance of Compliance with Lifepoint Policies

Finally, Lifepoint has strengthened messaging to all its employees regarding the expectation that individuals speak up when they detect any potentially suspicious behavior. These efforts include rolling out an enterprise wide "See Something, Say Something" messaging campaign to promote the culture of speaking openly at all Lifepoint facilities and encouraging individuals to report any instances in which a patient or staff's safety may be at risk. Leaders at Lifepoint headquarters and facilities have reinforced the tone at the top by including information about the See Something, Say Something campaign in their townhalls, management meetings, and other updates to set out clear expectations that individuals must report potential violations of Lifepoint policies immediately.

Furthermore, Lifepoint trainings, including the enterprise-wide Code of Conduct training, have also emphasized the importance of speaking up.

* * *

Lifepoint has a strong and demonstrated commitment to quality, to patient safety, to continuous maturation of our approaches, and to continued investment in the communities we serve. Lifepoint welcomes this opportunity to share information about its operations, policies, and procedures. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

December 11, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint" or the "Company"). This submission responds to the follow-up questions in your email of November 25, 2024.

We have included in this letter information that includes proprietary business information. We request that this information not be disclosed publicly or to any third party. To the extent you intend to disclose this information publicly or to another third party, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

The Asset Purchase Agreement

Enclosed at **LP-CEG-009158** through **LP-CEG-009165** is the executed Second Amendment to the Asset Purchase Agreement ("Second Amended APA"), which amends Section 10.7 of the previous Asset Purchase Agreement (the "APA), previously produced at LP-CEG-000036 (the original APA dated April 30, 2010) and LP-CEG-008279 (First Amendment to the Asset Purchase Agreement).

Among other things, the Ottumwa Regional Legacy Foundation and Ottumwa Regional agreed to amend the provisions of the APA governing capital projects, physician recruitment and development, residency and hospitalist programs, and outpatient substance abuse program. These amendments were agreed to following conversations between Ottumwa Regional Legacy Foundation and Ottumwa Regional to determine how best to adapt Ottumwa Regional's commitments under the APA to the current needs and conditions of the Wapello County community.

Consistent with the recent discussions concerning how to amend the APA, Ottumwa Regional plans to continue engaging with Ottumwa Regional Legacy Foundation to discuss the ways to best satisfy Ottumwa Regional's obligations under the Second Amended APA.

Ottumwa Regional's Enhancements

Rural hospitals are at risk of closing in almost every state.[1] In the majority of states, over 25 percent of rural hospitals are at risk of closing, and in 10 states, more than half the rural hospitals are at risk.[2] Twenty-eight hospitals in Iowa (about 30 percent of the total number of hospitals in the state) are at risk for closing – 9 of those are at risk for immediate closing. At the same time that private insurance reimbursement fails to reimburse the actual cost of providing services to patients, high inflation has increased the costs of supplies and labor, further exacerbating these challenges.[3] As we have emphasized in our prior letters and in line with this national trend, Ottumwa Regional and its surrounding community have experienced the full range of challenges facing rural hospitals, which has resulted in the hospital's expenses exceeding the hospital's revenue year after year. Lifepoint and Ottumwa Regional have nevertheless remained committed to keeping Ottumwa Regional's doors open, continuing to provide critical services such as obstetrics and gynecology notwithstanding that more than half of the rural hospitals in the United States have ceased labor and delivery services.[4] In Iowa alone, seventy hospitals (about 75 percent of Iowa's total number of hospitals) experienced losses on services.

Lifepoint has consistently supported Ottumwa Regional in its efforts to maintain and expand its services, including by recruiting and hiring additional providers for Ottumwa Regional and improving Ottumwa Regional's current services. As detailed in the Second Amended APA, Ottumwa Regional is actively recruiting general surgeons, an obstetrician/gynecologist, and primary care providers. The organization hired two new certified nurse midwives in 2024 who are already in practice and an orthopedic surgeon who is scheduled to begin providing care in Ottumwa in February of 2025.

Ottumwa Regional is in the process of establishing an outpatient behavioral health service line for the treatment of adult behavioral health needs and substance use disorders to complement its inpatient adult behavioral health unit. Ottumwa Regional has identified space within the hospital to provide these services and is considering potential behavioral health providers with which to contract. Currently, the unit expects to begin providing services around the first or second quarter of 2025.

Additionally, as we have described in past letters, Ottumwa Regional invested in implementing proactive measures to strengthen its drug diversion prevention program and security protocols following the Devin Caraccio incident to prevent any occurrences in the future. These measures include:

---

[1] Rural Hospitals at Risk of Closing, Center for Healthcare Quality & Payment Reform (July 2024), https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf, enclosed at **LP-CEG-009166** through **LP-CEG-009168**.
[2] *Id*.
[3] *Id*.
[4] Addressing the Crisis in Rural Maternity Care (July 2024), https://chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf, enclosed at **LP-CEG-009169** through **LP-CEG-009172**.

- **Medication Security Enhancements**. Ottumwa Regional has purchased new lockboxes for IV drip medications, implemented additional verification, including fingerprint authentication, in automated medication dispensing cabinets, and tightened controls over key distribution and returns.
- **Pharmacy Oversight.** Ottumwa Regional implemented pharmacy software with artificial intelligence integration, which monitors utilization and any abnormal activity with clinical staff and flags concerns for further investigation by pharmacy personnel.
- **Access Control Improvements.** Ottumwa Regional invested in overhauling its proximity access system, and limited facility entry points to a "need-for-access" basis.
- **Staff and Provider Training.** As previously noted, Ottumwa Regional conducted extensive training for staff and providers on safety topics, including training on identifying and reporting unexpected or suspicious activities, education on drug diversion detection and reporting, and training on safeguarding vulnerable patients, including recognizing those with compromised self-advocacy due to age, medical frailty, medications, or restraints.
- **Monitoring and Surveillance Enhancements**. Ottumwa Regional installed two cameras in every medication room to monitor narcotic removal and waste processes continuously and replaced sharps containers with impenetrable, best-in-class models to eliminate opportunities for diversion.
- **Drug Diversion Team and Monitoring.** Ottumwa Regional has established a multidisciplinary drug diversion team that meets regularly to review any drug-related concerns and implemented a random drug screening process for staff and providers, where individuals are randomly selected monthly to provide a urine sample.

Furthermore, Ottumwa Regional also has invested in strengthening communication. In addition to the check-ins between Lifepoint and Apogee described in our November 8, 2024 letter, Ottumwa Regional participates in monthly meetings with Apogee's regional leadership and biweekly meetings with Apogee's local medical director. These meetings allow Ottumwa Regional to raise concerns and identify areas for potential opportunities to enhance care delivery and patient outcomes.

Ottumwa Regional's Income Statement

The Staff suggests that financial income loss should be measured solely by reference to EBITDA. However, that approach runs contrary to accounting principles, which recognize that interest, taxes, depreciation, and amortization must be taken into account to adequately account for the actual costs and consequences of operating the facility.

Furthermore, the Staff raised a specific question about the interest expense line item of the company's income statement. The interest expense line item predominantly include the interest in relation to rent payments under the sale leaseback agreement, financing leases on facilities rented by Ottumwa Regional (such as Ottumwa Regional's clinic buildings).

Finally, the Staff asked about the increase in the non-current liabilities line item of the balance sheet. As explained in our November 8, 2024 letter, since 2019, Lifepoint has invested significant capital in Ottumwa Regional to fund the hospitals' ongoing cash operating deficits to keep it open despite poor financial performance. These investments have funded Ottumwa Regional's operating losses and investments exceeding the RIP. With these investments, Ottumwa Regional has been able to make significant improvements and expand services.

Ottumwa Regional Community Leader Update

As we discussed over email, Ottumwa Regional will provide the Wapello county community with an update about the state of Ottumwa Regional on December 12, 2024. Enclosed at **LP-CEG-009173** through **LP-CEG-009201** is a copy of the slide deck that will be used during the presentation.

* * *

Lifepoint welcomes the opportunity to share information about its operations, policies, and procedures. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

WILMERHALE

December 18, 2024

[redacted]

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Lifepoint Health Inc. ("Lifepoint" or the "Company"). Over the course of the past 18 months, we have submitted 21 letters responding to over 100 questions, and produced nearly 10,000 pages of documents, including detailed data on the quality of care at Ottumwa Regional Health Center ("Ottumwa Regional), and Lifepoint's investments in the hospital.

In these letters, we have described at length Lifepoint's commitment to patient care at Ottumwa Regional and its work to meet that commitment, including through partnerships with vendors like Apogee Medical Management ("Apogee") and TeamHealth. As we have noted, Ottumwa Regional and Lifepoint are in regular contact with Apogee and TeamHealth on topics involving patient quality and operational efficiency. Specifically, Ottumwa Regional leadership holds regular meetings with Apogee and TeamHealth to discuss their performance and identify any issues that need to be addressed or improved, and to agree to corrective action plans where needed. Lifepoint meets with TeamHealth and Apogee on a quarterly basis to discuss how they are performing from an operational, financial, and quality perspective, and similarly assists on corrective action plans as necessary. Additionally, TeamHealth and Apogee have dedicated representatives who are responsible for responding to concerns raised by Lifepoint facilities, and Lifepoint and Ottumwa Regional interact with and rely on those representatives to address and resolve any immediate concerns related to patient safety and quality of care that implicate either TeamHealth or Apogee. Our responses have also addressed the extensive remediation efforts undertaken across Ottumwa Regional and Lifepoint following the Devin Caraccio incident.

More broadly, our letters have described to you the efforts at Ottumwa Regional to promote patient quality and ensure that they are meeting the needs of the community. These responses have included extensive discussion of efforts to maintain and expand services, and to recruit and retain physicians and nursing staff, including through compensation adjustments, other incentives, and local partnerships. As you know, last week Dr. William Kiefer presented to the Wapello county community about the work that has been undertaken at Ottumwa Regional. We provided you the

deck he planned to use and are enclosing with this letter the final deck that was presented, at **LP-CEG-009202** through **LP-CEG-009230** along with an article published in the Ottumwa Courier on December 13, 2024, about the progress that has been made at Ottumwa Regional, at **LP-CEG-009231** through **LP-CEG-009234**.

* * *

We have included in this letter information that includes proprietary business information. We request that this information not be disclosed publicly or to any third party. To the extent you intend to disclose this information publicly or to another third party, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Lifepoint welcomes the opportunity to share information about its operations, policies, and procedures. Thank you for the opportunity to engage on these important issues.

Very truly yours,

[redacted]

WILMERHALE

[redacted]

December 24, 2024

The Honorable Sheldon Whitehouse
Hart Senate Office Building, Rm. 530
Washington, DC 20510

The Honorable Charles E. Grassley
135 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Whitehouse and Ranking Member Grassley:

We appreciate the continued opportunity to share information with you about Ottumwa Regional Health Center ("Ottumwa Regional") and Lifepoint Health Inc. ("Lifepoint" or the "Company").

As we noted in our submission from December 18, 2024, we have voluntarily provided to the Budget Committee staff with extensive material concerning not only Ottumwa Regional, but Lifepoint more generally. Our submissions have addressed the staff's questions regarding Ottumwa Regional's patient care, its quality of care, and its drug diversion programs, as well as Ottumwa Regional's operations and financial results. We have also provided detailed information on Lifepoint's investments in and oversight of Ottumwa Regional, as well as investments that Lifepoint and Ottumwa Regional have made in the Wapello County community more broadly.

On November 8, 2024, we produced at LP-CEG-009113 the monthly report provided by Apogee for October 2024 which includes information about the prior 12 month rolling average of various metrics for all Lifepoint facilities with which it contracts, including Ottumwa Regional. In response to your most recent request on December 20, 2024, we have identified recent examples of reports relating to the topics you noted, including the most recent Emergency Department scorecard for Ottumwa Regional, enclosed at **LP-CEG-009235**, the Ottumwa Regional and TeamHealth action tracker, enclosed at **LP-CEG-009236**, and Ottumwa Regional's 2025 Strategic Plan **LP-CEG-009237** through **LP-CEG-009284**.

* * *

We have included in this letter information that includes proprietary business information. We request that this information not be disclosed publicly or to any third party. To the extent you intend to disclose this information publicly or to another third party, we request that your staff notify us in advance to allow us to discuss the matter and to take appropriate steps to safeguard confidential business information.

Lifepoint welcomes the opportunity to share information about its operations, policies, and procedures. We appreciate the Committee's attention to these important issues.

Very truly yours,

[redacted]

Medical Properties Trust

March 31, 2023

Senator Charles E. Grassley, Ranking Member
[redacted]
Committee on the Budget
624 Dirksen Senate Office Building
Washington, DC 20510

VIA EMAIL

Dear Senator Grassley:

We appreciate the opportunity to respond to your letter of March 17, 2023, requesting information with respect to our company's connection to Ottumwa Regional Health Center. We join you in deploring the horrific acts that occurred at the facility as described in your letter, and applaud your leadership and advocacy on behalf of patients of rural hospitals in Iowa and throughout the United States. As described in further detail below, Medical Properties Trust, Inc. ("MPT") is the owner of the real estate assets comprising Ottumwa Regional Health Center but plays no role of any kind in its healthcare operations.

For over 20 years, MPT has served as a trusted and committed resource for hospital capital because we understand how vital hospitals are in supporting a community's health. As a qualified real estate investment trust ("REIT), our primary business is to acquire and develop hospital real estate, which we then lease to healthcare operating companies under long-term net leases. MPT has tenant relationships with more than 50 healthcare operators involving more than 400 facilities around the world.

As noted in your letter, MPT acquired the real estate assets of Ottumwa Regional Health Center in December 2019 from Lifepoint Health, Inc. ("Lifepoint"), as part of a portfolio of acute care hospitals located in six U.S. states. MPT paid approximately $57.0 million for the Ottumwa assets, which were leased to Lifepoint under a master lease agreement with an initial term of 20 years. Based on our prior experience, we considered Lifepoint to be a proven healthcare operator, with expertise in operating hospitals in mid-sized markets. Lifepoint is the sole community healthcare provider in many of the non-urban communities it serves, including Ottumwa.

Medical Properties Trust, Inc.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242

Phone: 205.969.3755
Fax: 205.969.3756

medicalpropertiestrust.com

Pursuant to the terms of the master lease and the laws and regulations applicable to REITs, we have no operational role of any kind at any of the facilities leased to Lifepoint, including Ottumwa. As with the vast majority of our tenants, our lease with Lifepoint as operator of the Ottumwa Regional facility is "triple-net," meaning that Lifepoint is responsible for all ongoing operating expenses of the facility, including the costs of repairs and maintenance, property taxes and property, casualty, general liability and other insurance coverages. The capital we provide through the master lease structure essentially serves as real estate financing that allows the operator to strengthen its operations and better address patient needs, but it does not give MPT any role in hospital operations. Decisions regarding care delivery, billing practices, revenue and charge per patient goals, staff-to-patient ratios, charge-to-cost ratios, contracts for staffing, and other contracts are made solely by the operator.

Set out in the following pages please find MPT's responses to the specific questions addressed to us in your letter. Please feel free to contact the undersigned with respect to any of the matters addressed in this letter or otherwise.

Very truly yours,

Edward K. Aldag, Jr.,
Chairman, President and Chief Executive Officer

Responses

1. *Describe your company's financial or operational relationship with Ottumwa Regional Health Center and provide the exact dollar amount your company has invested in Ottumwa Regional. Please answer in timeline form and include any agreements or contracts between your company and Ottumwa Regional.*

   Response: As noted above, MPT acquired the real estate assets (only) of Ottumwa Regional Health Center on December 17, 2019, as part of our acquisition of a portfolio of acute care hospitals in six U.S. states from Lifepoint. MPT paid $57,028,731 for the Ottumwa real estate, which was (and remains) leased to Lifepoint under a master lease agreement with an initial term of 20 years. Aggregate annual lease payments to MPT under the lease are currently approximately $4.5 million. This rent level is fixed for the term of the lease, subject only to adjustments for inflation, which provides assurance to the hospital operator that market forces, unpredictable changes in interest rates and periodic disruptions in credit markets will not unexpectedly increase the hospital's costs.

2. *If your company no longer has a financial or operational relationship with Ottumwa Regional, explain the reasons for which your company withdrew its investment, including the date you exited and your return on investment.*

   Response: As noted above, MPT remains the landlord of the operator of Ottumwa Regional.

3. *While invested in Ottumwa Regional Center or any related entity that has an interest in Ottumwa Regional, please describe your company's authority to:*

   a. *Manage its care delivery;*
   b. *Manage its billing practices;*
   c. *Determine its annual net income goals;*
   d. *Determine its charge per patient goals;*
   e. *Determine its staff-to-patient ratios;*
   f. *Determine its charge-to-cost ratios;*
   g. *Enter into contracts for staffing; and*
   h. *Enter into any contracts on behalf of Ottumwa Regional.*

   Response: MPT does not have an operational role at Ottumwa Regional Center of any kind and does not have any authority whatsoever with respect to any of the matters listed above.

4. *Does your company have plans to invest capital in Ottumwa Regional? If so, please describe them. If not, why not?*

   Response: As a REIT, our investment in Ottumwa is limited to its real estate assets, and any further investment in property or improvements would be in collaboration with the operator We are not aware at this time of plans by the operator for major capital improvements to the real estate. However, at the operator's request, MPT would consider funding any such improvements.

5. *How was your company involved in the 2019 sale-leaseback?*

   Response: As noted above, MPT and its affiliates acquired the real estate assets of acute care hospitals in six U.S. states operated by Lifepoint in the 2019 sale-leaseback transaction, including Ottumwa Regional Center. We leased the real estate of Ottumwa to affiliates of Lifepoint under a long-term master lease agreement.

6. *Explain in detail the reasons for the 2019 sale-leaseback of Ottumwa Regional. What were the terms of the 2019 sale-leaseback transaction? How did you sell this to the local communities and hospitals? Please provide all records.*

   Response: (Our response to this question is necessarily limited to reasons for the transactions from MPT's perspective.) MPT is a publicly-traded REIT formed in 2003 for the primary purpose of acquiring and developing healthcare facilities. Our strategy is to lease the facilities that we acquire or develop to experienced healthcare operators pursuant to long-term triple-net leases. Based on our prior experience with hospital real estate leased to Lifepoint and its predecessors, we concluded that Lifepoint was a proven hospital operator with expertise in operating hospitals in mid-sized markets, and was often the sole community healthcare provider in many of the non-urban communities it serves, including Ottumwa.

   The reasons for the Ottumwa Regional sale-leaseback transaction from MPT's perspective were thus in the ordinary course for a public REIT. We invested approximately $57.0 million of capital to acquire the real estate assets of a community-critical hospital in exchange for a long-term lease with an experienced and reputable operator at commercially reasonable rates and terms.

   We would be happy to provide further information with respect to the 2019 sale-leaseback transaction as may be helpful, in addition to information about sale leaseback transactions in our industry more generally.

7. *To what extent does your company contractually shield itself from liability for activities that occur at the hospitals you invest in, operate, or manage?*

Response: As noted above, MPT does not operate or manage hospitals or other healthcare facilities (nor is it permitted to do so under applicable REIT tax rules, absent special circumstances). Accordingly, we have no involvement whatsoever in the day-to-day operational activities of any hospitals which are our tenants. Our leases with operators are triple-net, meaning that the lessees are responsible for all ongoing operating expenses of the facility, including the costs of repairs and maintenance, property taxes and property, casualty, general liability and other insurance coverages. Our leases consequently require lessees to indemnify us for any liabilities arising from activities that occur at the hospital.

8. *What happens if one of the medical facilities that are subject to a sale-leaseback is unable to pay rent?*

Response: From our perspective as the owner of hospital real estate, the last thing we want is for a hospital to cease operating. Because our own revenues are largely dependent on the ability of our tenants to pay us rent under their leases, our underwriting is primarily focused on ensuring that hospitals within our portfolio remain financially sound and continue to serve their communities for the full long-term duration of our leases. Accordingly, on the rare occasions when one of our hospital operators was unable to timely pay their operating expenses, we attempt to work collaboratively with the operator to address the problem.

In this regard we note that in our experience a hospital's rent expense under a sale-leaseback transaction is virtually never the determinate cause of the hospital's financial weakness or curtailment of any particular service. This is because rent is only one operating expense line item among many others on a hospital's operating statement, including more substantial expenses such as supplies, pharmaceuticals, professional services, etc.

9. *Describe in detail your company's expertise regarding rural or non-urban hospitals. Please include the full name and curriculum vitae of every person your company relies on for rural or non-urban hospital advice.*

Response: As noted in the Responses to Question 3 and 7, MPT does not have an operational role at the hospitals that are its tenants.

10. *How much money did your company receive in COVID-19 stimulus aid, including CARES Act dollars and grants? Provide an explanation as to why your company needed federal stimulus aid. Describe in detail how these funds were allocated.*

    Response: MPT was fortunate to be able to provide sustainable levels of compensation to its employees and their families during the extreme financial stresses caused by the COVID-19 pandemic. Although certain provisions of the CARES Act and other stimulus were available to us, we elected not to apply for them and we received no such support.

11. *Explain your company's role in the decision to hire William Kiefer as CEO of Ottumwa Regional.*

    Response: As noted above, MPT does not have, and did not have, any role or decision-making authority with respect to personnel decisions or any other operational matters at Ottumwa Regional.

12. *Explain your company's relationship with William Kiefer, including any prior positions he held with your company or a related company.*

    Response: MPT does not have currently and has not had in the past, any relationship with William Kiefer.

WARBURG PINCUS

Warburg Pincus LLC
450 Lexington Avenue
New York, NY 10017-3911

212-878-0600 tel
212-878-9351 fax

www.warburgpincus.com

CONFIDENTIAL TREATMENT REQUESTED

April 7, 2023

VIA ELECTRONIC TRANSMISSION

The Honorable Charles E. Grassley
United States Senate
Hart Senate Office Building
Washington, D.C. 20510

Re: March 17, 2023 Letter to Warburg Pincus LLC

Dear Senator Grassley,

On behalf of Warburg Pincus LLC ("Warburg Pincus" or "our" or "we" or the "Firm"), I write in response to your letter dated March 17, 2023 (the "Letter") in which you requested information regarded investments made by funds managed by Warburg Pincus in the Ottumwa Regional Health Center in Ottumwa, Iowa, and specifically about the events that occurred at that facility in 2021 and 2022.

Funds managed by Warburg Pincus have made investments in a wide array of industries including investments in hospitals and other segments of the healthcare industry. Currently, no fund managed by Warburg Pincus holds any investments in US based hospitals.

Since its founding in 1966, Warburg Pincus has predominantly pursued a strategy of growth investing at scale, with the vast majority of the investments made in growth stage or early-stage companies. Over the years, funds managed by Warburg Pincus have successfully invested in growth companies as well as companies at other stages of development, from building early stage and start-up companies, to providing capital to meet the needs of existing businesses and, to a lesser extent, to investing in later-stage transactions and special situations, typically in circumstances in which growth is a key aspect of the investment thesis. The firm's early-stage and growth investing approach is thesis-driven, pursuing extensively researched themes and ideas. The firm also prefers to invest with accomplished management teams who are investing in the transactions alongside the firm. As evidence of the firm's successful focus on growth investing, the firm's portfolio investments have completed over 170 initial public offerings.

Warburg Pincus aims to build lasting companies that will perform well in growing industries—the goal in every investment is to create a larger, thriving business by making long-term investments and creating value. Warburg Pincus believes that this approach positions the investors in the funds it manages, which include pension funds

that benefit multiple categories of public and private employees, to receive attractive risk-adjusted long-term returns over the course of economic and capital markets cycles.

In 2009, funds managed by Warburg Pincus partnered with Martin Rash to form RegionalCare Hospital Partners Holdings, Inc. ("RCHP") a start-up based in Brentwood, Tennessee. Mr. Rash is an accomplished hospital industry executive and had previously been the CEO of another hospital company that had been sold to LifePoint Hospitals in 2005. Province Healthcare Company. Mr. Rash was supported by a team of senior executives that had a deep experience acquiring and operating hospitals as well as in the healthcare industry more broadly.

As you noted in your Letter, Ottumwa Regional Health Center ("Ottumwa Regional") was acquired by RCHP in 2010. As noted via email on March 20, 2023, RHCP was then sold to Apollo Global Management ("Apollo") in December of 2015. Since the 2015 sale of RHCP by funds managed by Warburg Pincus, Warburg Pincus has had no relationship with RCHP, Ottumwa Regional, or LifePoint Health.

As discussed on the April 4 phone call, Warburg Pincus is limited in its ability to respond the Letter. Warburg Pincus sold its investment in RHCP to Apollo in 2015 and has maintained no relationship with RHCP or Ottumwa Regional since that date. The Warburg Pincus partner who oversaw the investment in RHCP left the Firm approximately six years ago. Pursuant to our compliance policies, which are consistent with the recordkeeping rules set forth in the Investment Advisers Act of 1940, we retain records for 7 years and some of the records associated with the Warburg Pincus Investment in RCHP are beyond this recordkeeping requirement. Therefore, there is no complete set of documentation regarding our RHCP investment.[1] Given these constraints and Warburg's lack of involvement with Ottumwa Regional and RCHP since 2015, the information we are able to provide is incomplete and would effectively rely on publicly available information rather than our own records. Below are the responses from Warburg Pincus given these constraints.

1. **Describe your company's financial or operational relationship with Ottumwa Regional Health Center and provide the exact dollar amount your company has invested in Ottumwa Regional. Please answer in timeline form and include any agreements or contracts between your company and Ottumwa Regional.**

[1] Warburg Pincus is a SEC regulated investment advisor. Pursuant to federal regulation, books and records of investment advisers are required to be kept for a minimum period of five years after exiting the investment. *See* 17 CFR § 275.204-2.

Warburg Pincus has no current financial or operational relationship with Ottumwa Regional Health Center. From 2009-2015, funds managed by Warburg Pincus invested $265 million in RCHP out of a $300 million line of equity established in July 2009. These capital investments were used in part to help the hospitals described below (including Ottumwa Regional Health Center) pay down existing debt, expand clinical services, invest in advanced care treatments and fund other working capital needs. The table below shows a timeline of the investment in RCHP.

Date	Event
July 6, 2009	Warburg Pincus invested $5.0 million in RCHP to commence operations
April 30, 2010	Warburg Pincus invested $100 million in RCHP to finance their acquisition of Ottumwa Regional
June 30, 2010	Warburg Pincus invested $160 million in RCHP to finance their acquisition of Coffee Health Group, a two-hospital system in Florence, Alabama
December 1, 2010	RCHP acquired Clinton Memorial Hospital
November 4, 2011	RCHP acquired Essent Healthcare, Inc.
April 30, 2013	RCHP acquired Sierra Vista Regional Health Center
January 16, 2015	RCHP acquired Community Medical Center
December 3, 2015	Warburg Pincus sold RCHP to Apollo

2. If your company no longer has a financial or operational relationship with Ottumwa Regional, explain the reasons for which your company withdrew its investment, including the date you exited and your return on investment.

Warburg Pincus regularly exits investments for a variety of reasons. On December 3, 2015, Warburg Pincus exited its investment in RCHP by selling its shares in RCHP to Apollo. As previously mentioned, Warburg Pincus made a total investment of $265 million in RCHP. The sale of shares to Apollo was the only liquidity event associated with the Warburg Pincus investment in RCHP. In connection with the sale, Warburg Pincus received total proceeds of approximately $259.7 million, slightly less than the money it invested resulting in a slightly negative rate of return.

3. While invested in Ottumwa Regional or any related entity that has an interest in Ottumwa Regional, please describe your company's authority to:

a. Manage its care delivery;

b. Manage its billing practices;
c. Determine its annual net income goals
d. Determine its charge per patient goals;
e. Determine its staff-to-patient ratios;
f. Determine its charge-to-cost ratios;
g. Enter into contracts for staffing; and
h. Enter into any contracts on behalf of Ottumwa Regional.

From 2010-2015, the period after RHCP acquired Ottumwa Regional and before the sale of RHCP to Apollo, Warburg Pincus did not make operational decisions for Ottumwa Regional or any other hospital facilities operated by RHCP. The RCHP management team were responsible for care delivery, billing practices, staffing, annual planning, and all other aspects of patient care.

4. Does your company have plans to invest capital in Ottumwa Regional? If so, please them. If not, why not?

Warburg Pincus has no plans to invest capital in Ottumwa because there is no current relationship between Warburg Pincus and Ottumwa Regional and there has been no relationship between Warburg Pincus and Ottumwa Regional since 2015 when funds managed by Warburg Pincus sold RHCP, which included Ottumwa Regional.

5. How was your company involved in the 2019 sale-leaseback?

Warburg Pincus was not involved in the 2019 sale-leaseback because there has been no relationship between Warburg Pincus and Ottumwa Regional since 2015 when funds managed by Warburg Pincus sold RHCP, a sale which included Ottumwa Regional.

6. Explain in detail the reasons for the 2019 sale-leaseback of Ottumwa Regional. What were the terms of the 2019 sale-leaseback transaction? How did you sell this to the local communities and hospitals? Please provide all records.

Warburg Pincus has no knowledge of the reasons for the 2019 sale-leaseback of Ottumwa Regional or its terms, and has no records related to the sale-leaseback. Warburg Pincus was not involved in the 2019 sale-leaseback of Ottumwa Regional because there has been no relationship between Warburg Pincus and Ottumwa Regional since 2015 when funds managed by Warburg Pincus sold RHCP, a sale which included Ottumwa Regional.

7. To what extent does your company contractually shield itself from liability for activities that occur at the hospitals you invest in, operate, or manage?

Warburg Pincus does not have any current investments in hospitals and does not operate or manage any hospitals. To the extent this question is seeking information about how Warburg makes investments, there is no pre-determined formula and instead investments are structured and made after significant diligence based on the individual circumstances around the investment.

8. What happens if one of the medical facilities that are subject to a sale-leaseback is unable to pay rent?

Warburg Pincus does not currently have any investment in medical facilities and has no knowledge of the implications for medical facilities that are subject to sale-leasebacks and are unable pay rent. Warburg Pincus was not involved in the 2019 sale-leaseback of Ottumwa Regional because there has been no relationship between Warburg Pincus and Ottumwa Regional since 2015 when funds managed by Warburg Pincus sold RHCP, a sale which included Ottumwa Regional.

9. Describe in detail your company's expertise regarding rural or non-urban hospitals. Please include the full name and curriculum vitae of every person your company relies on for rural or non-urban hospital advice.

Warburg Pincus is active in a variety of sectors including healthcare generally, however there are no current investments in any US-based hospitals. When making investments, Warburg Pincus will often partner with and engage consultants and advisors with specific industry expertise on an investment-by-investment basis. In 2009, when Warburg Pincus initially invested in RCHP, we partnered with Martin S. Rash who was the chairman and CEO of RCHP. To the best of our knowledge and based on a review of publicly available information, Mr. Rash is currently a member of the board of directors of LifePoint Health and the former chairman and CEO of RCCH HealthCare Partners and Province Healthcare.[2] Mr. Rash is also a past chairman of the Federation of American Hospitals (FAH) and the Nashville Health Care Council.[3] To the best of our knowledge, Warburg Pincus has not had a relationship with Rash, RHCP, or LifePoint Health since the 2015 sale of RCHP.

[2] Warburg Pincus does not maintain records or curriculum vitae regarding Rash's expertise, however his parts of his background and experience are included based on a review of public information from the following sources: https://www.uvpeye.com/leadership-team/martin-s-rash/ and https://www.linkedin.com/in/marty-rash-7a125288/.

[3] *Id.*

10. How much money did your company receive in COVID-19 stimulus aid, including CARES Act dollars and grants? Provide an explanation as to why your company needed federal stimulus aid. Describe in detail how these funds were allocated.

Warburg Pincus did not receive COVID-19 stimulus aid.

11. Explain your company's role in the decision to hire William Kiefer as CEO of Ottumwa Regional.

Warburg Pincus has no knowledge regarding the decision to hire William Kiefer as CEO of Ottumwa Regional. There has been no relationship between Warburg Pincus and Ottumwa Regional since 2015 when funds managed by Warburg Pincus sold RHCP, a sale which included Ottumwa Regional.

12. Explain your company's relationship with William Kiefer, including any prior positions he held with your company or a related company.

To the best of our knowledge, Warburg Pincus has no relationship with William Kiefer nor has Mr. Kiefer held any positions with Warburg Pincus or a related company.

We hope the information we have provided herein with respect to Warburg Pincus's investment in RHCP investment, which we fully exited in 2015, is helpful to your review.

****

The information and data included in this response contains sensitive information—including confidential and proprietary information— and we request that such information be treated accordingly and that it not be released to any third parties. Production of this information and data is not intended to constitute a waiver of the attorney-client, attorney work product, or any other applicable rights or privileged in this or any other forum, and Warburg Pincus expressly reserves its rights in this regard.

Sincerely,

[redacted]

Managing Director, Head of Global Public Policy and Political Risk
Warburg Pincus LLC

MANAGERIAL AND ADMINISTRATIVE SUPPORT AGREEMENT

THIS MANAGERIAL AND ADMINISTRATIVE SUPPORT AGREEMENT (this "Agreement") is entered into with an effective date of January 1, 2019, by and between LifePoint Corporate Services, General Partnership (the "Manager"), and RCHP-Ottumwa, LLC (the "Company"), which presently owns and operates Ottumwa Regional Health Center (the "Hospital").

W I T N E S S E T H:

WHEREAS, Company and Manager are each wholly owned indirect subsidiaries of LifePoint Health, Inc., a Delaware corporation ("Parent");

WHEREAS, Manager, through its executives, other personnel, and/or personnel of its affiliates, possesses certain experience and expertise in the developmental, operational and administrative aspects of businesses like that of the Hospital;

WHEREAS, Company desires to retain Manager for the purpose of rendering management, administration, consulting and purchasing services and support, and all other reasonably necessary management support needed for the operation of the Hospital on the basis hereinafter set forth, subject to the policies established by Company, which policies shall be consistent with applicable state and federal law;

WHEREAS, Manager shall provide those management services that are set forth in more detail in this Agreement (the "Management Services") for the account of, and as an agent of, Company. All such management services shall be rendered using Manager's commercially reasonable efforts and subject to the control of Company, which (as between Manager and Company) shall have the final authority in all matters relating to the Hospital's operations;

WHEREAS, Manager also provides the Management Services to other subsidiaries of Parent, each of which operate and function as separate legal entities;

WHEREAS, significant economies of scale could be achieved by coordinating the Management Services between Company and the other subsidiaries; and

WHEREAS, Company and Manager wish to set forth the terms and conditions for the rendering of the Management Services to the Hospital.

NOW, THEREFORE, in consideration of the foregoing, of the mutual premises contained herein and of other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto, intending legally to be bound, hereby agree as follows.

ARTICLE I. ENGAGEMENT OF MANAGEMENT SERVICES

Company hereby engages Manager, and Manager agrees to provide the Management Services upon those terms and conditions hereinafter set forth. The Hospital and the businesses conducted at the Hospital shall be collectively referred to herein as the "Business." Manager shall discharge its duties pursuant to this Agreement as a manager in good faith and in a manner Manager reasonably believes to be in the best interests of the Business.

ARTICLE II. RETENTION OF CONTROL

2.1. Company shall retain all jurisdictional powers incident to ownership and operation of the Hospital, to determine the general and fiscal policies thereof, and to maintain full and complete control of the administration and operations of the Hospital. The powers retained by Company shall include, without limiting the foregoing: (a) appointing members to the medical staff, (b) making decisions regarding the admission of patients; (c) establishing all policies and procedures for the provision of healthcare at the Hospital; (d) selecting the administrative staff and all other staff of the Business; (e) determining the salary, benefits and other compensation for all staff and other employees; and (f) establishing and appointing members of the advisory boards of the Hospital. Company shall be and shall remain the owner and holder of all licenses, contracts, certificates and accreditations and shall be the "provider of services" within the meaning of any third-party contracts for services. It shall be the sole responsibility of Company to ensure that the Hospital complies with all pertinent provisions of federal, state and local statutes, rules and regulations. All matters requiring the professional medical judgment of a provider shall remain the responsibility of the Hospital's medical staff and other health professionals. Manager shall have no responsibility or right whatsoever to make any medical judgments, and at all times shall respect the medical judgment of the Hospital's medical staff.

2.2. Company shall conduct all of its relationships with providers, including the Hospital's medical staff and other healthcare professionals, in full compliance with all applicable laws and regulations. Company covenants and agrees that prior to admitting a new member to the medical staff, contracting with a health professional, or entering into a new agreement with a contractor, Company will conduct appropriate credentialing of those providers consistent with then applicable laws and rules.

ARTICLE III. MANAGEMENT SERVICES

Subject to the provisions of Article II, the financial resources of Company, and where applicable under the terms of this Agreement, subject to the direction and prior approval of Company, Manager or its affiliates will render the following Management Services to the Hospital:

A. Providing consulting services in such areas as: long-range planning, management planning, quality assurance programs, risk management, materials management, management development, facilities development and productivity improvement programs, service utilization analysis, systems development, supply and charge systems, manpower utilization and control systems, technical skills training, new product evaluation and educational programs for clinical staff, physician recruiting, compliance and medical staff development;

B. Providing consulting services in connection with assisting the Hospital in maintaining the accreditation of the Hospital with the proper agencies, to include, but not limited to, The Joint Commission and consulting services in connection with implementing the Hospital's quality plan;

C. Arranging for the purchase by Company, at Company's expense, of hazard, liability, professional and other necessary insurance coverage for the Hospital; provided, however, that the medical staff members and other health professionals practicing in the Hospital shall obtain their own malpractice insurance;

D. Employing and/or supervising, directing, leasing and discharging on behalf of Company, at Company's expense, all non-physician personnel performing services at the Hospital as set forth in Article VI;

E. Providing consulting services in such areas as professional recruitment, performance appraisal systems, personnel education and training, procurement of employee benefits and the design of compensation packages;

F. Providing advisory services and other assistance with the creation of reimbursement files, categorizations for submission of reimbursement forms to the appropriate agencies, electronic transfer of data communications and funds and monitoring and coordination of issues related to reimbursement; provided that if legal action is required in connection with such matters, the cost of such action is not included in the Management Fee (as hereinafter defined) and will be paid by Company;

G. Negotiating fee payment methods, including Medicare and Medicaid reimbursement, with third-party payors and state and federal agencies and determining and setting patient charges for services provided by the Hospital;

H. Providing consulting services, at Company's expense, such as legal consultation and document preparation related to acquisitions, real estate purchases, real estate sales, managed care contracts, hospital-based physician contracts, outside service contracts, medical office building issues, maintenance contracts, physician recruitment and employment issues and patient confidentiality issues; provided that the Management Fee includes Manager's consulting services, but does not include the cost of third-party consultation services (which costs will be paid by Company) and arranging for all necessary and desirable repairs and maintenance at Company's expense of the physical plant, furnishings and equipment of the Hospital;

I. Providing standard formats for all charts, invoices and other forms used in the operation of the Hospital;

J. Providing various operational guidelines, including, but not limited to, protocols and medical guidelines;

K. Providing for the purchase or lease by Company, at Company's expense, of all supplies and equipment used in the operation of the Hospital, and providing assistance in evaluating capital and operational expenditures in connection with the Hospital;

L. Subject to any applicable legal and regulatory requirements, negotiating, entering into, terminating and administering on behalf of the Hospital and in the name of the Hospital, contracts for services;

M. Information systems management, including arranging for use of third-party software and services with respect to information technology for clinical systems, programming interfaces between software products, help desk and software support; provided that the costs of any third-party software is not included in the Management Fee and will be paid by Company;

N. Providing administrative advisory services for the overall benefit of the Hospital's healthcare operations, such as establishing and maintaining group purchasing arrangements of Manager or its affiliates through Healthtrust Purchasing Group, LP or otherwise, and identifying and maintaining quality vendor relationships;

O. Providing human resources functions; and

P. Directing the day-to-day operations of the Hospital to ensure that the Hospital's operations are conducted in a business-like manner and in accordance with the decisions of the Company.

ARTICLE IV. ACCOUNTING AND BOOKKEEPING SERVICES

Manager agrees that Manager or its affiliates shall review, direct and supervise the following accounting and bookkeeping services for Company in the operation of the Hospital:

A. Implementing and administering policies and procedures for the management and control of purchases, accounts payable, cash disbursements and all business related transactions;

B. Implementing and administering policies and procedures for the management and control of patient billing, claims filing, accounts receivable, credit collection and receivables activities and all necessary patient account transactions;

C. Cooperating in the preparation of periodic financial statements, including those as required by Company's organizational documents (if any), and cooperating in periodic audits of the Hospital by state and/or federal agencies;

D. Assisting in the implementation and administration by Company of an annual capital and operating budget for the Hospital and recommending rates for patient and other hospital charges permitting the Hospital to fulfill its internal budget guidelines;

E. Implementing and administering procedures for the reporting of patient claims and utilization services in accordance with payor requirements and negotiating fees with third-party payors (including health maintenance organizations) on behalf of the Hospital;

F. Implementing and managing accounting systems and data processing systems that are required to perform the functions necessary to efficiently and effectively operate the Hospital, including, without limitation, such accounting systems as are necessary and appropriate to enable the Hospital to allocate its costs and revenues to designated cost centers, and in connection therewith, providing and maintaining all equipment necessary to provide those services set forth above;

G. Collecting and receiving for the Hospital and depositing in the bank accounts for the Hospital as directed by Company all funds generated from the operation of the Hospital and supervising the disbursement of such funds for the operation of the Hospital; provided that nothing herein shall prohibit Manager from utilizing third party collection agents in fulfilling such obligation; and

H. Preparing or providing for the preparation, at Company's expense, of payroll and supervising preparation of Company's tax returns and the K-1 of the member of Company.

ARTICLE V. OTHER MANAGEMENT SERVICES

At the request of Company, Manager may provide additional services to Company which are not included in this Agreement and for which a separate fee will be negotiated and separate terms and conditions agreed ("Other Services").

ARTICLE VI. EMPLOYEES

During the term of this Agreement, Manager will make available to Company the services of certain employees of Manager and its affiliates (the "Employees"). Such Employees shall include the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer and Chief Nursing Officer (collectively, the "Key Personnel"). Manager shall have the right to reassign or terminate the

employment of an Employee and to hire such additional individuals as Employees as Manager determines is reasonably necessary from time to time to fulfill Manager's obligations under this Agreement. Manager shall have the right to control and direct the Employees as to the performance of duties and as to the means by which such duties are performed. Nothing herein is intended to affect Manager's or its affiliate's status as an employer of each Employee or Manager's control over each such individual during the term of this Agreement. Notwithstanding any other provision of this Agreement to the contrary, including Article XV hereof, Manager and its respective officers, directors, agents and employees shall be held harmless and indemnified by Company for claims, demands, losses or liabilities incurred or arising out of or relating to the continued employment of the Employees during the term of the Agreement.

ARTICLE VII. SPECIAL CONSULTANTS

Manager shall engage, for and on behalf of Company, such consultant(s) as Company and Manager may consider reasonably necessary and appropriate. Such consultant(s) may include any services outside of the services covered under this management agreement. Company shall bear the fees and expenses incurred for the services of such consultants.

ARTICLE VIII. LEGAL ACTIONS

Manager shall advise and assist Company in instituting or defending, as the case may be, in the name of Company and/or Manager, all actions arising out of the operation of the Hospital and any and all legal actions or proceedings relating to the Hospital and operations therefrom to which either Company or Manager is a named or threatened party. Manager also shall assist Company in taking such actions as are necessary to protest, arbitrate or litigate to a final decision in any appropriate court or forum any violation, penalty, sanction, order, rule or regulation affecting the Hospital. Manager has access to a staff of attorneys who may be consulted by Company on legal issues relating to the Hospital as reasonably necessary. The consulting services of such staff are included in the Management Fee. It is not intended that the in-house legal staff handle all of Company's legal matters and Manager, in consultation with Company, shall determine when engaging outside legal counsel, rather than in-house legal staff, would be desirable for a specific issue or matter. The in-house legal staff will, upon request, assist Company in selecting and overseeing the work of outside counsel. The costs of outside counsel incurred for special projects approved in the operating budget or otherwise approved by the Company are not included in the Management Fee and will be charged to Company. In general, litigation is not covered by the Management Fee.

ARTICLE IX. TERM

Subject to the terms of Article X and Section 16.3, the term of this Agreement (the "Term") shall commence as of the date hereof and shall continue in full force and effect until the date that an entity directly or indirectly owned or controlled by LifePoint Hospitals, Inc., ceases directly or indirectly to be a member of Company.

ARTICLE X. DEFAULT AND TERMINATION

10.1. It shall be an event of default ("Event of Default") hereunder:

10.1.1. If Company shall fail to make or cause to be made any payment to Manager required to be made hereunder, or shall fail to make any payment pursuant to any other agreement between the parties, and such failure shall continue for thirty (30) days after notice thereof shall have been given to Company.

10.1.2. If Manager shall fail in any material respect to make available to Company any material portion of the Management Services required by this Agreement, and such failure shall not be cured: (i) within thirty (30) days after notice thereof by Company to Manager if such failure is capable of cure within such period; or (ii) within a reasonable period of time for cure if such failure cannot reasonably be cured within such thirty (30)-day period, provided Manager commences its curative actions within such thirty (30)-day period and proceeds diligently to cure thereafter (in which event, Manager shall have a reasonable time beyond such thirty (30)-day period to complete its cure of the alleged basis for Company's election to terminate).

10.1.3. If either Company or Manager applies for or consents to the appointment of a receiver, trustee or liquidator of such party or of all or a substantial part of its assets, file a voluntary petition in bankruptcy, make a general assignment for the benefit of creditors, file a petition or an answer seeking reorganization or arrangements with creditors or to take advantage of any insolvency law, or if an order, judgment or decree shall be entered by any court of competent jurisdiction, on the application of a creditor, adjudicating such party bankrupt or insolvent, and such order, judgment or decree shall be entered by any court of competent jurisdiction, on the application of a creditor, adjudicating such party bankrupt or insolvent, and such order, judgment or decree shall continue unstayed and in effect for any period of ninety (90) consecutive days.

10.1.4. If any Event of Default by Company listed in Section 10.1.1 above shall occur and be continuing, or if any Event of Default by Manager listed in Section 10.1.2 above shall occur and be continuing, the non-defaulting party may forthwith terminate this Agreement, and neither party shall have any further obligations whatever under this Agreement, except those provided under the provisions of Articles XI, XIII and XIV hereof. If any Event of Default by Company or Manager listed in Section 10.1.3 shall occur, the term of this Agreement shall terminate, at the option of the non-defaulting party, upon written notice to the bankrupt party.

10.2. Upon termination hereof, Manager's obligations to perform services hereunder shall completely cease; provided, however, that Company and Manager shall perform such matters as are necessary to wind up their activities under this Agreement in an orderly manner. In the event of termination of this Agreement, Manager also shall turn over to Company as soon as possible any and all information related to Company's receivables, ledgers and other business records which are then in Manager's possession, and shall provide an accounting of Net Revenues (as hereinafter defined) upon which the Management Fee has been calculated up to the date of termination. Manager shall be entitled upon termination of this Agreement to receive payment of all amounts theretofore unpaid which have been earned and are due to Manager through the date of termination.

ARTICLE XI. MANAGEMENT FEES

11.1. The aggregate amount of costs incurred by the Manager for the Management Services (the "Allocable Costs") shall be allocated among the Company and the other subsidiaries of the Parent who engage Manager to provide Management Services (each a "Managed Company" and, collectively, the "Managed Companies"), which allocation shall be computed in accordance with the provisions of this Article XI.

11.1(a). Allocable Costs shall be classified into the following categories: (i) strategic management services; and (ii) corporate support services.

The strategic management services category will include both the direct and indirect costs within various departments of Manager's cost accounting system. Such strategic management

services will be marked up at a percentage to be determined annually based on a transfer pricing study performed by an independent consulting firm.

The corporate support services category will include both the direct and indirect costs captured within various departments of Manager's cost accounting system. Such corporate support services will receive no additional mark-up.

11.1(b). Allocable Costs shall not include: (i) costs relating to Other Services which have been incurred separately at the specific request of a Managed Company; (ii) costs incurred by the Manager by virtue of a shareholder or equity owner relationship and which do not provide any benefit to a Managed Company.

11.2. The following cost allocation key shall be applied for the purpose of allocating to Managed Companies their share of the aggregate Allocable Costs as calculated in Section 11.1 above, which Manager has incurred for rendering the Management Services included in this Agreement:

11.2(a). The share of each of the Managed Companies in the Allocable Costs for the annual period from January 1 to December 31 of each year that the Agreement is in force (the "Accounting Period") shall be determined by reference to Net Revenues (as defined below) of the Company and the aggregate Net Revenues of the Managed Companies. "Net Revenues" shall mean all revenues billed as fees or other charges arising out of the operation of the Hospital, reduced for contractual adjustments, third-party discounts, charity adjustments, and other uncollectible amounts (but not bad debts), the proceeds of claims under casualty insurance policies (but including the proceeds of claims under business interruption insurance policies), condemnation awards and similar claims of a capital nature."

11.2(b). The share of costs allocated to each Managed Company shall be computed by multiplying the Allocable Costs as calculated in Section 11.1 by a fraction, the numerator of which shall be the budgeted Net Revenue relating to the Company and the denominator of which shall be the aggregate budgeted Net Revenue relating to the Managed Companies (the "Management Fee").

11.2(c). Management Fees shall be calculated based on budgeted Net Revenues for the Accounting Period; provided, however, on a quarterly basis, Manager will perform a reconciliation between budgeted and actual results and make any necessary true up adjustments to the Management Fees charged to each Managed Company.

11.4. If any of the Management Services costs are subject to VAT or similar levies, these amounts shall be paid by the Company.

11.5. The Management Fee shall be paid monthly no later than the fifteenth (15^{th}) day of the month following the month in which the fee was earned or expense incurred, as applicable.

11.6. Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, Manager and any of its affiliates providing services with a value or cost of $10,000 or more over a twelve (12)-month period shall make available to the Secretary the contract, books, documents and records that are necessary to verify the nature and extent of the cost of providing such services. Such inspection shall be available up to four years after the rendering of such services. The parties agree that any applicable attorney-client, account-client or other legal privilege shall not be deemed waived by virtue of this Agreement.

ARTICLE XII. NO PARTNERSHIP

Manager and Company affirmatively state that they do not have the intention to form a joint venture or partnership for tax or any other purposes, nor have they done so. If, however, a joint venture or partnership is found to exist for federal income tax purposes: (i) capital accounts will be maintained for Manager and Company on a tax accounting basis; (ii) net income will be allocated to Manager in the amount of the payments due Manager pursuant to Article XI hereof; (iii) all remaining net taxable income or loss will be allocated to Company; and (iv) upon termination, distributions will be in accordance with Manager's and Company's capital account balances.

ARTICLE XIII. OWNERSHIP OF INFORMATION; CONFIDENTIALITY

13.1. Systems Ownership. Manager retains all ownership and other rights in all systems, manuals, computer software, materials and other information, in whatever form, provided by it in the performance of its obligations hereunder (collectively referred to as the "Systems") and nothing contained in this Agreement shall be construed as a license or transfer of such Systems or any portion thereof, either during the term of this Agreement or thereafter. Upon the termination or expiration of this Agreement, Manager shall retain all of the Systems.

13.2. Systems Confidentiality. Company acknowledges that Manager has invested a significant amount of its resources in developing and maintaining the Systems and that the value to Manager of the Systems may be diminished or destroyed if Company discloses the Systems or any portion thereof to a third-party. Accordingly, Company shall maintain the confidentiality of the Systems. Company shall not duplicate or permit the duplication of any portion of the Systems and shall not permit access to the Systems by Company's personnel or any third-party other than on a strict need-to-know basis and in the ordinary course of business. Company shall take at least those steps that it would take to protect its own confidential information. The provisions of this Article XIV shall survive any termination or expiration of this Agreement.

ARTICLE XIV. INDEMNIFICATION

14.1. Indemnification by Company. Company agrees to indemnify and hold harmless Manager, its affiliates, members, partners or shareholders, and their respective members, shareholders, directors, governors, officers, employees and agents (collectively, a "Manager Indemnified Party") from and against any and all losses, claims, damages, liabilities, costs and expenses (including reasonable attorneys' fees and expenses related to the defense of any claims) (a "Loss"), which is caused by Company, which may be asserted against any of Manager Indemnified Parties in connection with this Agreement, including without limitation matters relating to: (i) alleged or actual failure by Company to perform any of its duties; (ii) any pending or threatened malpractice or other tort claims asserted against Manager relating to the Hospital; (iii) any action against Manager brought by any medical staff members or former employees, or for matters occurring before the beginning of the Term; (iv) any act or omission by any medical staff member, or employee, or other personnel who were under the supervision of a member of the medical staff as a result of providing medical services to such medical staff member's patient; and (v) any violation of any requirement applicable to the Hospital under any federal, state or local environmental, hazardous waste or similar law or regulation in connection with the services provided pursuant to this Agreement; provided that such Loss has not been caused by the negligence or willful misconduct of Manager Indemnified Party seeking indemnification pursuant to this Agreement.

14.2. Indemnification by Manager. Manager agrees to indemnify and hold harmless Company, its affiliates, members, partners or shareholders, and their respective members, shareholders, directors, governors, officers, employees and agents (collectively, a "Subsidiary Indemnified Party") from and

against any Loss, which is caused by Manager, which may be asserted against a Subsidiary Indemnified Party in connection with this Agreement, including without limitation matters related to: (i) the failure by Manager to perform its duties hereunder, or (ii) the negligence or willful misconduct of Manager in connection with the performance by Manager of its duties hereunder; provided that such Loss has not been caused by the negligence or willful misconduct of Company Indemnified Party seeking indemnification pursuant to this Agreement.

14.3. Sole Remedy. This Article XIV shall constitute the sole remedy of the parties hereto with respect to any Loss resulting from a third-party claim.

ARTICLE XV. MISCELLANEOUS

15.1. Business Associate. Manager acknowledges that the services it provides hereunder may make it a business associate of the Hospital. Manager agrees to execute a HIPAA business associate agreement, in substantially the form attached hereto as Exhibit A, separately outlining its obligations as a business associate with respect to the privacy and security of individually identifiable health information it may acquire in the course of its duties hereunder.

15.2. Referral Disclaimer. The amounts to be paid hereunder represent the fair market value of the services to be provided as established by arms length negotiations by the parties and have not been determined in any manner that takes into account the volume or value of any potential referrals between the parties. No amount paid hereunder is intended to be, nor shall it be construed to be, an inducement or payment for referral of patients by any party to any other party. In addition, the amounts charged hereunder do not include any discount, rebate, kickback or other reduction in charges, and the amount charged is not intended to be, nor shall it be construed to be, an inducement or payment for referral of patients by any party to any other party. Further, it is agreed that none of the parties shall refer or attempt to influence the referrals of any patients to any particular program.

15.3. Material Change in Law. In the event any material change in any federal or state law or regulation creates a significant likelihood of sanction or penalty based on the terms of this Agreement or would prohibit either party from billing for or receiving payment for any services provided by the parties, then upon request of either party, the parties hereto shall enter into good faith negotiations to renegotiate the affected provision or provisions of the Agreement to remedy such term or condition. In the event the parties are unable to reach agreement on the affected provision or provisions, so as to bring such provision or provisions into compliance with the law or regulation within thirty (30) days of the initial request for renegotiation, this Agreement shall terminate upon fifteen (15) days written notice or the effective date of such change (whichever is earlier). Each party hereto expressly recognizes that upon request for renegotiation, each party has a duty and obligation to the other only to renegotiate the affected term(s) in good faith.

15.4. Notices. All notices given pursuant to this Agreement shall be in writing and shall be deemed effective: (i) on the date the United States certified mail return receipt is signed by the recipient; (ii) on the date of receipt if sent by an overnight courier that verifies receipt by the recipient; or (iii) on the date of receipt by facsimile or other electronic means. For purposes of this notice, the addresses of the parties shall be as set forth below:

If to Manager:	with a copy to:
LifePoint Corporate Services, General Partnership 330 Seven Springs Way Brentwood, TN 37027 Attn: General Counsel	LifePoint Health, Inc. 330 Seven Springs Way Brentwood, TN 37027 Attn: General Counsel
If to Company:	with a copy to:
RCHP-Ottumwa, LLC 330 Seven Springs Way Brentwood, TN 37027 Attn: President	LifePoint Health, Inc. 330 Seven Springs Way Brentwood, TN 37027 Attn: General Counsel

or to such other address, and to the attention of such other person or officer as any party may designate by giving at least (thirty) 30 days notice to the other party.

15.5. Section Captions. Section and other captions contained in this Agreement are for reference purposes only and are in no way intended to describe, interpret, define or limit the scope, extent or intent of this Agreement or any provision hereof.

15.6. Assignment. Manager shall not assign this Agreement without the prior written consent of Company, provided, however, Manager shall have the right to assign this Agreement without prior written consent of Company if such assignment is to an affiliate of Manager. Company shall not assign this Agreement without the prior written consent of Manager. Subject to the foregoing, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and permitted assigns. This Agreement is intended solely for the benefit of the parties hereto and is not intended to, and shall not, create any enforceable third-party beneficiary rights.

15.7. Severability. Every provision of this Agreement is intended to be severable. If any term or provision of this Agreement is illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity of the remainder of this Agreement.

15.8. Amendment. No changes in, additions or amendments to this Agreement shall be effective unless and until made in writing and signed by all parties hereto.

15.9. Counterpart Execution. This Agreement may be executed in one or more counterparts all of which together shall constitute one and the same Agreement.

15.10. Integrated Agreement. This Agreement constitutes the entire understanding and agreement among the parties hereto with respect to the subject matter hereof, and there are no agreements, understandings, restrictions, representations or warranties among the parties other than those set forth herein or herein provided for.

15.11. Governing Law and Venue. This Agreement shall be construed and enforced in accordance with the laws of the State of Delaware without regard to its principles of conflicts of laws.

15.12. Waiver. Failure by any party to enforce any of the provisions hereof for any length of time shall not be deemed a waiver of its rights set forth in this Agreement. Such a waiver may be made only by an instrument in writing signed by the party sought to be charged with the waiver. No waiver of any condition or covenant of this Agreement shall be deemed to imply or constitute a further waiver of the same or any other condition or covenant, and nothing contained in this Agreement shall be construed to be a waiver on the part of the parties of any right or remedy at law or in equity or otherwise.

15.13. Gender and Number. Whenever the context of this Agreement requires, the gender of all words herein shall include the masculine, feminine and neuter, and the number of all words herein shall include the singular and plural.

15.14. Force Majeure. Neither party shall be liable for any failure, inability or delay to perform hereunder, if such failure, inability or delay is due to any cause beyond the reasonable control of the party so failing, and due diligence is used in curing such cause and in resuming performance.

15.15. Insurance. During the Term, Manager shall maintain, at its own expense, through self-insurance or through insurance contracts, appropriate workers' compensation coverage for Manager's employed personnel provided under this Agreement, and professional, casualty, directors and officers, and comprehensive general liability insurance covering Manager and Manager's personnel. Upon Company's request, Manager will provide Company with a certificate evidencing Manager's insurance coverage.

15.16. Power of Attorney. Company hereby appoints Manager as its attorney-in-fact with full power on its behalf and its name, or in the name of the Hospital to prosecute or defend any litigation or proceeding before any governmental agency arising out of the operation of the Hospital, after consulting with Company and after receiving Company's approval of the selection of counsel and the position to be taken in any adversarial situation affecting the Hospital.

[Signature page follows]

IN WITNESS WHEREOF, the parties have executed this Agreement by and through their duly authorized representatives effective as of the date and year first above written.

RCHP-OTTUMWA, LLC

DocuSigned by:
By: Christopher J Monte
3BFC8188B7424E0...
Name: Christopher J. Monte
Title: Vice President

LIFEPOINT CORPORATE SERVICES, GENERAL PARTNERSHIP

DocuSigned by:
By: J. Michael Grooms
3B7B7B859781474...
Name: J. Michael Grooms
Title: President

Exhibit A

HIPAA Business Associate Agreement

[See Attached]

HIPAA BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "Agreement") is made by and among _____(herein referred to as "Covered Entity") and _____ (hereinafter individually and collectively referred to as "Business Associate"). Covered Entity and Business Associate shall be collectively referred to herein as the "Parties".

WHEREAS, Covered Entity is entering into a business relationship with Business Associate that is memorialized in that certain Managerial and Administrative Support Agreement, as may be amended from time to time (the "Underlying Agreement") pursuant to which Business Associate may be considered a "business associate" of Covered Entity as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including all pertinent regulations (45 CFR Parts 160 and 164) issued by the U.S. Department of Health and Human Services as either have been amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (collectively "HIPAA Law");

WHEREAS, the nature of the prospective contractual relationship between Covered Entity and Business Associate may involve the exchange of Protected Health Information ("PHI") as that term is defined under HIPAA Law; and

For good and lawful consideration as set forth in the Underlying Agreement, Covered Entity and Business Associate enter into this agreement for the purpose of ensuring compliance with the requirements of the HIPAA Law and relevant state law.

NOW THEREFORE, the premises having been considered and with acknowledgment of the mutual promises and of other good and valuable consideration herein contained, the Parties, intending to be legally bound, hereby agree as follows:

I. DEFINITIONS. Terms not defined below shall have the meaning set forth in the HIPAA Law.

A. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

B. Breach. "Breach" shall have the same meaning as the term "breach" in 45 CFR §164.402.

C. Designated Record Set. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR §164.501.

D. Electronic Protected Health Information, EPHI or Electronic PHI. "Electronic Protected Health Information", "EPHI" or "Electronic PHI" shall have the same meaning as the term "electronic protected health information" in 45 CFR §160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

E. Encrypted or Encryption. Any encryption requirements set forth in this Agreement must meet the U.S. Department of Health and Human Services Guidance Specifying the Technologies and Methodologies that Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of HITECH Act.

F. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E, as amended by the HITECH Act and as may otherwise be amended from time to time.

G. Protected Health Information or PHI. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR §160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. As used in this Agreement, Protected Health Information shall also include Electronic PHI.

H. Required by Law. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR §164.103.

I. Secretary. "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or his or her designee.

J. Security Incident. "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR §164.304.

K. Security Rule. The "Security Rule" shall mean the regulations found at 45 CFR Part 160 and Part 164, Subparts A and C, as amended by the HITECH Act and as may otherwise be amended from time to time.

L. State Privacy and Security Laws. "State Privacy and Security Laws" shall mean all applicable state laws relating to privacy, security, data breach and confidentiality of the information provided to Business Associate under this Agreement.

M. Subcontractor. "Subcontractor" shall have the same meaning as the term "subcontractor" in 45 CFR § 160.103.

N. Unsecured Protected Health Information. "Unsecured Protected Health Information" or "Unsecured PHI" shall have the same meaning as the term "unsecured protected health information" in 45 CFR §164.402.

II. APPLICABILITY

A. This Agreement applies to all agreements and relationships between Covered Entity and Business Associate, whether written or verbal, pursuant to which Covered Entity provides or will provide any Protected Health Information to Business Associate in any form whatsoever (the "Underlying Agreement"). As of the Effective Date, this Agreement shall automatically amend and be incorporated as part of the Underlying Agreement, whether or not specifically referenced therein. Should there be any conflict between the language of this Agreement and the Underlying Agreement (either previous or subsequent to the date of this Agreement), the language and provisions of this Agreement shall control and prevail unless the Parties specifically refer in a subsequent written agreement to this Agreement by its title and date and specifically state that the provisions of the later written agreement shall control over this Agreement.

III. USE OR DISCLOSURE OF PHI BY BUSINESS ASSOCIATE.

A. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on

behalf of, Covered Entity as specified in the Underlying Agreement, provided that such use or disclosure would not violate the Privacy Rule, if done by Covered Entity.

B. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of Business Associate or to carry its legal responsibilities. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

C. Business Associate shall only use and disclose PHI if such use or disclosure complies with each applicable requirement of 45 CFR §164.504(e).

D. Business Associate shall use reasonable efforts to limit uses, disclosures, and requests for PHI to the minimum necessary to accomplish the intended purposes of such use, disclosure or request, in accordance with the minimum necessary standards at 45 CFR § 164.502(b) and in any guidance issued by the Secretary.

IV. DUTIES OF BUSINESS ASSOCIATE RELATIVE TO PHI.

A. Business Associate shall not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

B. Business Associate shall be directly responsible for full compliance with the relevant requirements of the Privacy Rule to the same extent as Covered Entity.

C. Business Associate shall comply with the applicable provisions of the Security Rule directing the implementation of Administrative, Physical and Technical Safeguards for Electronic Protected Health Information and the development and enforcement of related policies, procedures, and documentation standards (including but not limited to designation of a security official), and shall enter into written agreements with any Subcontractors that create, receive, maintain, or transmit Electronic Protected Health Information on behalf of Business Associate pursuant to which the Subcontractors shall agree to comply with the applicable requirements of the Security Rule. Business Associate shall implement safeguards and policies, procedures, and documentation consistent with the requirements of 45 C.F.R. §§ 164.306, 164.308, 164.310, 164.312, 164.314 and 164.316. Any hard drives on any computers or laptops that are used to access, receive, send, or maintain Covered Entities' Electronic Protected Health Information must be Encrypted and all communications must be Encrypted if sending Electronic Protected Health Information over an open network. Mobile devices or external or removable media, including, without limitation backup tapes, used for sending, receiving, or storing Electronic Protected Health Information must be Encrypted and password protected.

D. In the event of an unauthorized use or disclosure of PHI or a Breach of Unsecured PHI, Business Associate shall mitigate, to the extent practicable, any harmful effects of said disclosure that are known to it.

E. Business Associate agrees to enter into a written agreement with any Subcontractor that creates, receives, maintains, or transmits PHI on behalf of Business Associate, which complies with the requirements of 45 C.F.R. § 164.504(e)(2) through (e)(4), and pursuant

to which the Subcontractor agrees to the same restrictions and conditions that apply to Business Associate with respect to such PHI.

F. To the extent applicable, Business Associate shall provide access to Protected Health Information in a Designated Record Set at reasonable times, at the request of Covered Entity or, as directed by Covered Entity, to an Individual (or Individual's designee) in order to meet the requirements under 45 CFR §164.524. Business Associate shall notify Covered Entity within five (5) days of receipt of any request for access by an Individual. Covered Entity shall determine whether to grant or deny any access requested by the Individual. The information shall be provided in the form or format requested, if it is readily producible in such form or format, or in summary, if the Individual has agreed in advance to accept the information in summary form. If the Individual requests an electronic copy of his or her PHI maintained in a Designated Record Set electronically, Business Associate shall provide the Individual (or Individual's designee) with access to the information in the electronic form and format requested by the Individual, if it is readily producible in such form or format, or, if not, in a machine readable electronic form and format agreed to by the Individual. No fee for copying or providing access to the PHI may be charged.

G. If Business Associate maintains a Designated Record Set on behalf of Covered Entity, Business Associate shall amend the PHI maintained by Business Associate as directed by Covered Entity within five (5) days of such request. Business Associate shall notify Covered Entity within five (5) days of receipt of any request for amendment by an Individual. Covered Entity shall determine whether to grant or deny any access or amendment requested by the Individual. Business Associate shall have a process in place for requests for amendments and for appending such requests to the Designated Record Set, as requested by Covered Entity. No fee for copying or amending the PHI may be charged.

H. Business Associate shall, upon request with reasonable notice and at no charge, provide Covered Entity access to its premises for a review and demonstration of its internal practices and procedures for safeguarding PHI. The fact that Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's premises, systems, policies and procedures does not relieve Business Associate of its responsibility to comply with this Agreement, nor does Covered Entity's: (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of Covered Entity's enforcement rights under this Agreement.

I. Business Associate agrees to document and make available such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528 and Section 13405(c) of the HITECH Act, and any implementing regulations. Should an Individual make a request to Covered Entity for an accounting of disclosures of his or her PHI pursuant to 45 C.F.R. §164.528, Business Associate agrees to promptly provide Covered Entity with information in a format and manner sufficient to respond to the Individual's request. No fee for providing the accounting of disclosures of PHI may be charged. This Section shall survive termination of the Agreement.

J. If an Individual requests Business Associate to restrict the use or disclosure of PHI, Business Associate will forward the request to Covered Entity within five (5) days of Business Associate's receipt of the request. Covered Entity will be responsible for making all determinations regarding the grant or denial of a Individual's request for restrictions, and Business Associate will make no such determinations. Business Associate will restrict the use or disclosure of PHI consistent with Covered Entity's instructions, and shall further comply with any

Individual's request for restrictions on PHI disclosures that Covered Entity or Business Associate is required by law to honor, including without limitation, requested restrictions on payment or health care operations-related disclosures to health plans when the Individual (or other person on behalf of the Individual) has paid the Individual's health care provider in full, unless otherwise required by law. No fee for providing the restriction of PHI may be charged.

K. Business Associate shall make its internal practices, books, records, and any other material requested by the Secretary relating to the use, disclosure, and safeguarding of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for the purpose of determining compliance with the Privacy Rule. The aforementioned information shall be made available to the Secretary in the manner and place as designated by the Secretary or the Secretary's duly appointed delegate. Under this Agreement, Business Associate shall comply and cooperate with any request for documents or other information from the Secretary directed to Covered Entity that seeks documents or other information held by Business Associate. Notwithstanding this provision, no attorney-client, accountant-client or other legal privilege will be deemed waived by Business Associate or Covered Entity as a result of this Section. Except to the extent prohibited by law, Business Associate agrees to notify Covered Entity immediately upon receipt by Business Associate of any and all requests by or on behalf of any and all government authorities served upon Business Associate relating to this Section or Protected Health Information.

L. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 42 C.F.R. §164.502(j)(1).

M. Business Associate may not de-identify any Protected Health Information without the express prior written consent of the Covered Entity, and if such consent is given, Business Associate must comply with the requirements set forth at 45 C.F.R. § 164.514 for de-identifying PHI. Business Associate shall not sell any Protected Health Information without the express prior written consent of Covered Entity. Business Associate shall not transmit, to any Individual for whom Business Associate has Protected Health Information, any communication about a product or service that encourages the recipient of the communication to purchase or use that product or service in violation of any of the marketing prohibitions set forth in the HIPAA Law. Business Associate shall not use or disclose Protected Health Information for fundraising purposes as prohibited under the HIPAA Law.

N. Covered Entity shall have the right, at its expense, during Business Associate's normal business hours, to evaluate, test, and review Business Associate's HIPAA-HITECH policies and procedures, facilities, books, records and systems which contain Covered Entity's PHI and EPHI in order to ensure compliance with the terms and conditions of this Agreement and the HIPAA Law. Covered Entity shall have the right to conduct such audit by use of its own employees or by use of outside consultants and auditors. Business Associate agrees to cooperate with Covered Entity, and to otherwise provide any reasonable assistance to Covered Entity necessary for Covered Entity to carry out any audit as permitted herein, at no additional cost to Covered Entity. Upon Covered Entities' written request, Business Associate agrees to provide an annual written attestation of its compliance to the HIPAA Law in the form and format requested by Covered Entity in order to obtain satisfactory assurances in accordance with the HIPAA Law that Business Associate will appropriately safeguard the information with which it is entrusted. Covered Entity shall protect the confidentiality of all confidential and proprietary information of Business Associate to which Covered Entity or its agents have access during the course of such audit. The fact that Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Business Associate of its responsibility to comply with this Agreement, nor does Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Business Associate or

require Business Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of Covered Entity's enforcement rights under this Agreement. Notwithstanding the foregoing, Covered Entity assumes no obligation to perform any inspection or audit of Business Associate's practices or policies, and assumes no liability for any violation or breach caused by Business Associate, whether an audit is performed or not.

O. To the extent Business Associate is to carry out any covered entity obligation of Covered Entity under the Privacy Rule, Business Associate shall agree to comply with the same Privacy Rule requirements that apply to Covered Entity in the performance of such obligation.

V. REPORTING

A. Privacy Breach. Business Associate will report to Covered Entity any use or disclosure of Covered Entity's PHI that is not permitted by this Agreement or the Underlying Agreement within two (2) business days of discovery of the unauthorized use or disclosure. In addition, Business Associate will report to Covered Entity following discovery and without unreasonable delay, but in no event later than two (2) days following discovery of any suspected or actual Breach of Unsecured Protected Health Information or any actual or suspected disclosure or inappropriate access of Covered Entity's information which is subject to State Privacy and Security Laws. Business Associate shall cooperate with Covered Entity in investigating the potential or actual breach, disclosure or inappropriate access and in meeting Covered Entity's obligations under the HITECH Act and any other state or federal privacy or security breach notification laws, including, without limitation, assisting the Covered Entity with performing a risk assessment as set forth in 45 C.F.R. §164.402(2) and providing any information and documentation related to such risk assessment to the Covered Entity promptly upon request. Any such report shall contain at a minimum the information set forth on Exhibit A attached hereto and incorporated by reference. Since time is of the essence under the HITECH Act and State Privacy and Security Laws, in addition to providing the report in accordance with the notice provisions contained in Section XI.B below, a copy of the report shall be faxed to the Privacy Officer at (615) 695-8426 or to such other person as Covered Entity shall request in writing of Business Associate. To the extent any Breach of Unsecured Protected Health Information or unauthorized acquisition or access to information subject to State Privacy and Security Laws is attributable to either: (i) a breach of the obligations under this Agreement by Business Associate or (ii) a violation of the HIPAA Law or State Privacy and Security Laws by Business Associate, Business Associate shall bear (a) the costs incurred by Covered Entity in complying with its legal obligations relating to such breach or violation, and (b) in addition to other damages for which Business Associate may be liable for under this Agreement, the following expenses incurred by Covered Entity in responding to such breach: (1) the cost of preparing and distributing notifications to affected Individuals, (2) the cost of providing notice to government agencies, credit bureaus, and/or other required entities, (3) the cost of providing affected Individuals with credit monitoring services for a specific period not to exceed twenty-four (24) months, or longer if required by law, to the extent the incident could lead to a compromise of the data subject's credit or credit standing, (4) call center support for such affected Individuals for a specific period not to exceed thirty (30) days from the date the breach notification is sent to such affected Individuals and (5) the cost of any other measures required under applicable law.

B. Security Incident. Business Associate agrees to report to Covered Entity any Security Incident affecting Electronic Protected Health Information of Covered Entity within two (2) business days of becoming aware of the Security Incident. Business Associate shall mitigate, to the extent practicable, any harmful effect known to Business Associate of a Security Incident.

VI. TERM AND TERMINATION.

A. Term. The Term of this Agreement shall be effective as of the date the Underlying Agreement is effective (the "Effective Date"), and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy the Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section VI. Notwithstanding anything to the contrary contained in this Agreement, Business Associate shall not destroy any Protected Health Information without the prior written consent of Covered Entity.

B. Termination for Cause. Upon Covered Entity's knowledge of a breach by Business Associate, Business Associate's violation of the HIPAA Laws or a Breach of Unsecured Protected Health Information by Business Associate or any Subcontractor of Business Associate, Covered Entity shall, within its sole discretion, either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, terminate this Agreement; or

2. Immediately terminate this Agreement.

C. Effect of Termination.

1. Except as provided in paragraph C(2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy (at Covered Entity's sole discretion) all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity within five (5) days of the effective date of the termination. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall not retain any copies of the Protected Health Information. Business Associate will be responsible for recovering any PHI from such agents or subcontractors at no cost to Covered Entity. Any information that is in electronic format shall be provided to Covered Entity at no additional charge. The format to be provided should be one that is commonly used for export (i.e. comma delimited, text file, Word, Excel or Access database) that is agreeable to Covered Entity.

2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. If such written notification that return or destruction of Protected Health Information is infeasible and agreed to by Covered Entity, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

3. Should Business Associate make a disclosure of PHI in violation of this Agreement, Covered Entity shall have the right to immediately terminate any contract, other than this Agreement, then in force between the Parties, including the Underlying Agreement.

VII. REMEDIES IN EVENT OF BREACH, DISCLAIMER AND INDEMNIFICATION.

A. Business Associate hereby recognizes that irreparable harm may result to Covered Entity, and to the business of Covered Entity, in the event of breach by Business Associate of any of the covenants and assurances contained in this Agreement. As such, in the event of breach of any of the covenants and assurances contained in Sections III, IV or V above, Covered Entity shall be entitled to enjoin and restrain Business Associate from any continued violation of Sections III, IV or V.

B. PHI IS PROVIDED TO BUSINESS ASSOCIATE SOLELY ON AN "AS IS" BASIS. COVERED ENTITY DISCLAIMS ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY, NON-INFRINGEMENT AND FITNESS FOR A PARTICULAR PURPOSE. As between Covered Entity and Business Associate, any PHI disclosed, delivered or provided to Business Associate in connection with the Agreement, shall be deemed to be the exclusive property of Covered Entity. In no event shall Business Associate or its subcontractors claim any rights with respect to such PHI. Without prior written consent from an authorized officer of Covered Entity, neither Business Associate nor its agents or subcontractors shall transfer or export any PHI provided by Covered Entity outside the United States or store any PHI provided by Covered Entity in a hosted/cloud computing environment. Additionally, Business Associate shall not use, authorize to use or disclose the PHI for the purpose of developing information or statistical compilations for use by third parties or other division or subsidiary of Business Associate or for any commercial exploitation.

C. Business Associate will indemnify, defend and hold Covered Entity and its officers, directors, employees, agents, affiliates, successors and assigns harmless, from and against any and all losses, liabilities, damages, costs, penalties, fines and expenses (including reasonably attorneys' fees and costs) arising out of or related to either: (i) the Business Associate's breach of its obligations under this Agreement and/or (ii) any third-party claim based upon any breach of this Agreement, violation of HIPAA Laws or State Privacy and Security Laws by Business Associate or by its employees, agents or subcontractors ("Claim"). If Business Associate assumes the defense of a Claim, Covered Entity shall have the right, at its expense, to participate in the defense of such Claim, and Business Associate shall not take any final action with respect to such Claim without the prior written consent of Covered Entity. This Section shall survive termination of this Agreement and any Claim is without regard to any limitation or exclusion of damages or liability provisions otherwise set forth in the Agreement or the Underlying Agreement.

VIII. MODIFICATION. This Agreement may only be modified through a writing signed by the Parties. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the HIPAA Law.

IX. INTERPRETATION OF THIS CONTRACT IN RELATION TO OTHER CONTRACTS BETWEEN THE PARTIES. Should there be any conflict between the language of this contract and any other contract entered into between the Parties (either previous or subsequent to the date of this Agreement), the language and provisions of this Agreement shall control and prevail unless the Parties specifically refer in a subsequent written agreement to this Agreement by its title and date and specifically state that the provisions of the later written agreement shall control over this Agreement.

X. COMPLIANCE WITH STATE LAW. Business Associate shall comply with State Privacy and Security Laws. If the HIPAA Law and the law of the State in which Covered Entity is located conflict regarding the degree of protection provided for Protected Health Information, Business Associate shall comply with the more restrictive protection requirement.

XI. MISCELLANEOUS.

A. Ambiguity. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the HIPAA Law.

B. Notice to Covered Entity. Any notice required under this Agreement to be given Covered Entity shall be made in writing to Facility, with a copy to LifePoint Hospitals, 103 Powell Court, Brentwood, TN 37027, Attention: Compliance, Privacy Officer.

C. Notice to Business Associate. Any notice required under this Agreement to be given Business Associate shall be made in writing to Contractor.

IN WITNESS WHEREOF and acknowledging acceptance and agreement of the foregoing, the Parties affix their signatures hereto.

COVERED ENTITY:	BUSINESS ASSOCIATE:
[ENTITY NAME]	**[ENTITY NAME]**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

EXHIBIT A1

FORM OF NOTIFICATION TO COVERED ENTITY OF

BREACH OF UNSECURED PHI AND STATE LAW

Date completed: _____

This notification is made pursuant to the Business Associate Agreement between _____ _____ (Covered Entity), and _____ (Business Associate).

Business Associate hereby notifies Covered Entity that there has been an actual or potential breach of unsecured (unencrypted) protected health information (PHI) or information subject to State Privacy and Security Laws that Business Associate (or its agents or subcontractors) has used or has had access to under the terms of the Business Associate Agreement.

I. Characteristics of the Breach

Date of the breach:_____ Date the breach was discovered:_____

Description of the breach: _____

_____

_____

_____

_____

_____

_____

How was the breach discovered? _____

Number of individuals affected by the breach: _____

Are over 500 individuals affected by the breach?

Yes __ No ___

Have you been able to identify all individuals affected by the breach?

Yes __ No ___

If yes, for how many of the affected individuals do you have current addresses? _____

Does the information disclosed in the breach identify, or can reasonably be used to identify, specific patients?

Yes __ No ___

If no, please explain why the information does not identify, or cannot reasonably be used to identify, specific patients: _____

_____

Does the information disclosed in the breach contain any sensitive information or other information that can be used in a manner that would be adverse or cause financial or reputational harm to the individual?

Yes __ No ___

If no, explain why the information cannot be used in an adverse or harmful manner to the individual:_____

_____

_____

_____

Was all of the patient(s') information compromised or only portions?

Yes __ No ___

If only portions of the information, explain which portions of the information were compromised: _____

_____

_____

Indicate type of breach:

___	Theft	___	Unauthorized Access	___	Unknown
___	Loss	___	Hacking/IT Incident	___	Other: _____
___	Improper Disposal	___	Phishing		_____
					_____
					_____

Location of breached information:

___	Laptop	___	Portable Media/Device	___	Other: _____
___	Desktop Computer	___	EMR		_____
___	Email	___	Paper		_____
					_____

Description of types of unsecured PHI or other data involved in the breach:

___	Demographic (full or partial name)	___	Account number	___	ICD-9-CM or CPT-codes
___	Social security number	___	Disability Code	___	Driver's license, insurance card, or other form of identification
___	Date of birth	___	Financial (billing info, credit card # or check/bank account number)	___	Other:_____ _____ _____ _____ _____
___	Home address	___	Clinical (any mention of diagnosis, procedure, or treatment provided)		

Are the patient(s) or the patient(s') family members aware of the incident?

Yes __ No ___

If yes, describe _____

_____

_____

II. Description of Safeguards

Safeguards that were in place prior to the breach:

___	Firewalls	___	Encrypted wireless	___	Secure browser
___	Packet Filtering	___	Logic access control	___	Biometrics
___	Intrusion detection	___	Anti-virus software (list product name):_____	___	Strong authentication
___	Other:_____	___	Physical security: _____		
_____		_____			
_____		_____			

Was the data encrypted in compliance with the encryption standards set forth in the U.S. Department of Health and Human Services Guidance Specifying the Technologies and Methodologies that Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of HITECH Act?

Yes __ No ___

If yes, please identify the method of encryption: _____

_____

_____

If no, please identify any other methods of securing the information (for example, password protected file): _____

_____

III. The Recipient

Can you determine whether the PHI was actually acquired or viewed by the unintended recipient?

Yes __ No ___

If yes, please explain how and provide any information regarding the information viewed, length of time viewed, whether it was e-mailed or saved to another device and who viewed the information: _____

_____

_____

Did the breach involve a good faith, unintentional acquisition, access or use of PHI by the entity's employee/workforce member? (For example, a billing employee receives and opens an e-mail containing PHI about a patient which a nurse mistakenly sent to the billing employee. The billing employee notices that he is not the intended recipient, alerts the nurse of the misdirected e-mail, and then deletes it.)

Yes __ No ___

If yes, please explain: _____

_____

_____

Did the breach involve an inadvertent disclosure to another authorized person within the entity or Organized Health Care Arrangement in which the entity participates? (For example – A physician who has authority to use or disclose PHI at a hospital by virtue of participating in an organized health care arrangement with the hospital is similarly situated to a nurse or billing employee at the hospital.)

Yes __ No ___

If yes, please explain: _____

_____

_____

Did the breach involve a recipient who could not reasonably have retained or remembered the data? (For example – A covered entity, due to a lack of reasonable safeguards, sends a number of explanations of benefits (EOBs) to the wrong individuals. A few of the EOBs are returned by the post office, unopened, as undeliverable.)

Yes __ No ___

If yes, please explain: _____

_____

Was the unauthorized person who received the PHI or to whom the disclosure was made covered by HIPAA and/or a licensed healthcare provider?

Yes __ No ___

If yes, please identify the licensed healthcare provider, the type of license and any state confidentiality regulations which require the licensed provider to maintain the confidentiality of the information: _____
_____

_____

Can any of the information be used by an unauthorized recipient to further the recipient's own interests?

Yes __ No ___

If no, explain why none of the information cannot be used by an unauthorized recipient to further the recipient's own interests? _____

_____

_____

IV. Addressing the Breach

Description of what Business Associate is doing to investigate the breach: _____

_____

_____

_____

_____

_____

Has law enforcement been notified?:

Yes __ No ___

If so, describe _____

_____

Did law enforcement ask for patient notification delay (based on hindering an investigation or causing harm to national security)

Yes __ No ___

If yes, please provide documentation of the police request and deadline for notifications:_____

_____

_____

Was satisfactory assurance obtained from the recipient of PHI indicating that PHI will not be further used or disclosed?

Yes __ No ___

If yes, please attach and explain: _____

_____

Has the information been returned or properly destroyed? (If destroyed – need to obtain satisfactory assurance that the information was destroyed.)

Yes __ No ___

If yes, please attach the assurances and explain the circumstances:_____

_____

Description of what Business Associate is doing to mitigate harm to the individual(s): _____

_____

_____

Description of what Business Associate is doing to protect against any further breaches: _____

_____

_____

Contact information to ask questions and obtain additional information:

Name: _____

Title: _____

Address: _____

_____

Email Address: _____

Phone Number: _____

ASSET PURCHASE AGREEMENT

AMONG

OTTUMWA REGIONAL HEALTH CENTER, INCORPORATED,

REGIONAL RETIREMENT LIVING, INC.,

REGIONAL ENTERPRISES, INC.,

RCHP-OTTUMWA, INC.

AND

REGIONALCARE HOSPITAL PARTNERS, INC.

April 30, 2010

Table of Contents

Page

Table of Contents
(continued)

Page

Table of Contents
(continued)

Page

Table of Contents
(continued)

Page

Page

ASSET PURCHASE AGREEMENT

This **ASSET PURCHASE AGREEMENT** (the "**Agreement**") is made and entered into this 30th day of April, 2010, by and among **OTTUMWA REGIONAL HEALTH CENTER, INCORPORATED**, an Iowa non-profit, non-stock corporation ("**ORHC**"), **REGIONAL RETIREMENT LIVING, INC.**, an Iowa non-profit, non-stock corporation ("**RRL**"), **REGIONAL ENTERPRISES, INC.**, an Iowa corporation ("**RE**" and, collectively, with ORHC and RRL, the "**Sellers**"), **RCHP-OTTUMWA, INC.**, a Delaware corporation ("**Buyer**"), and **REGIONALCARE HOSPITAL PARTNERS, INC.**, a Delaware corporation ("**RCHP**"). ORHC, RRL, RE, Buyer and RCHP may be referred to individually as a "**Party**" and, collectively, as the "**Parties.**"

RECITALS

WHEREAS, the Sellers own and operate Ottumwa Regional Health Center, currently licensed as a 217-bed general acute care hospital located in Ottumwa, Iowa (the "**Hospital**"), and own or lease and operate the other healthcare facilities or operations listed on Exhibit A-1 (collectively, with the Hospital, the "**Seller Facilities**");

WHEREAS, ORHC is the sole corporate member of RRL and the sole shareholder of RE;

WHEREAS, ORHC holds the following limited liability and/or limited partnership interests: (i) a forty percent (40%) interest (which shall be increased to eighty percent (80%) effective as of the Closing Date pursuant to ORHC's purchase of an additional forty percent (40%) interest) in Collaborative Laboratory Services, L.L.C., an Iowa limited liability company ("**CLS**"); and (ii) a fifty percent (50%) interest in Southeast Iowa Radiation Oncology L.L.C., an Iowa limited liability company ("**SIROC**") (together CLS and SIROC are referred to herein as the "**Joint Ventures**", and together the Sellers and the Joint Ventures are sometimes hereinafter referred to as the "**Seller Parties**");

WHEREAS, the Joint Ventures operate the healthcare facilities or operations listed on Exhibit A-2 (collectively, the "**Joint Venture Facilities**");

WHEREAS, the Parties desire to enter into this Agreement to provide for the sale by the Sellers to Buyer of: (i) substantially all of the assets, real and personal, tangible and intangible, constituting the Seller Facilities; and (ii) ORHC's interests in the Joint Ventures; and

WHEREAS, RCHP is a party to this Agreement for purposes of making certain representations and warranties and covenants, as well as guaranteeing the obligations of Buyer as set forth herein.

NOW, THEREFORE, in consideration of the mutual covenants set forth herein and other good and valuable consideration, the adequacy and receipt of which hereby are acknowledged, the Parties, intending to be legally bound, agree as follows:

AGREEMENT

ARTICLE I

DEFINITIONS

"**401(a) Plan**" means the 401(a) Ottumwa Regional Health Center Retirement Income Plan.

"**403(b) Plan**" means the Ottumwa Regional Health Center Internal Revenue Code Section 403(b) Tax Deferred Annuity Plan.

"**Actual Closing Net Working Capital Statement**" has the meaning set forth in Section 2.6(b).

"**ADA**" means the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.*

"**Affiliate**" means, as to the entity in question, any person or entity that directly or indirectly controls, is controlled by or is under common control with the entity in question.

"**Agents**" has the meaning set forth in Section 13.17.

"**Agreement**" has the meaning set forth in the Preamble.

"**AHLA**" has the meaning set forth in Section 13.14(b).

"**ALTA**" means the American Land Title Association.

"**Alta Vista Site**" means the Real Property, improvements, tangible personal property, and the equipment and machinery located at 312 E. Alta Vista Avenue, Ottumwa, Iowa, commonly known as Alta Vista.

"**Application**" has the meaning set forth in Section 4.7.

"**Assets**" has the meaning set forth in Section 2.1.

"**Assignment and Assumption Agreements**" has the meaning set forth in Section 3.2(c).

"**Assumed Contracts**" has the meaning set forth in Section 2.1(k).

"**Assumed Liabilities**" has the meaning set forth in Section 2.3.

"**Assumed Sick Leave**" has the meaning set forth in Section 10.1(b).

"**Audit Firm**" has the meaning set forth in Section 2.6(c).

"**Balance Sheet Date**" has the meaning set forth in Section 4.4(a).

"**Baseline Net Working Capital**" has the meaning set forth in Section 2.5(a).

"**Benefit Plans**" has the meaning set forth in Section 4.13(a).

"**Bills of Sale**" has the meaning set forth in Section 3.2(b).

"**Board of Directors**" has the meaning set forth in Section 10.3(a).

"**Bond Trustee**" means: (i) with respect to the ORHC Bonds, Wells Fargo Bank, National Association; and (ii) with respect to the RRL Bonds, U.S. Bank National Association.

"**Bonds**" means the ORHC Bonds and the RRL Bonds.

"**Business**" has the meaning set forth in Section 2.1(a).

"**Buyer**" has the meaning set forth in the Preamble.

"**Buyer Indemnified Parties**" has the meaning set forth in Section 12.2(a).

"**Buyer Indemnity Cap**" has the meaning set forth in Section 12.4(b).

"**Capital Projects**" has the meaning set forth in Section 10.6.

"**Certificate of Need**" means a written statement issued by the State Health Agency or other agency having jurisdiction thereof evidencing community need for a new, converted, expanded or otherwise significantly modified health care facility, health service or hospice.

"**Charity Care Policy**" has the meaning set forth in Section 10.4.

"**Closing**" has the meaning set forth in Section 3.1.

"**Closing Cash**" has the meaning set forth in Section 2.5(a).

"**Closing Date**" has the meaning set forth in Section 3.1.

"**Closing Net Working Capital**" has the meaning set forth in Section 2.5(a).

"**CLS**" has the meaning set forth in the Recitals.

"**CLS Consideration**" has the meaning set forth in Section 2.5(b).

"**CLS Interests**" has the meaning set forth in Section 2.5(b).

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Commitments**" has the meaning set forth in Section 7.4.

"**Compliance Program**" has the meaning set forth in Section 4.26.

"**Confidential Information**" has the meaning set forth in Section 13.17.

"**Control**" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of an entity, whether through ownership of voting securities, by contract or otherwise.

"**Cost Reports**" has the meaning set forth in Section 2.2(c).

"**CPSI**" means Computer Programs and Systems, Inc. software, information technology programs, services and systems.

"**Damages**" has the meaning set forth in Section 12.1(a).

"**DEA Power of Attorney**" has the meaning set forth in Section 3.2(m).

"**Direct Claim**" has the meaning set forth in Section 12.4(a).

"**Disputed Items**" has the meaning set forth in Section 2.6(c).

"**Eddyville Lease**" has the meaning set forth in Section 11.6.

"Eddyville Property" means that certain property located at 107 N Third Street, Eddyville, Iowa together with that certain building thereon contain approximately 4,050 square feet.

"**EEOC**" means the Equal Employment Opportunity Commission.

"**Effective Time**" has the meaning set forth in Section 13.25.

"**Employee Lease Agreement**" has the meaning set forth in Section 10.1(c).

"**Environmental Claim**" means any claim, action, cause of action, investigation or notice (in each case in writing or, if not in writing, to the knowledge of the Sellers) by any person alleging potential liability (including potential liability for investigatory costs, cleanup costs, governmental response costs, natural resources damages, property damages, personal injuries, or penalties) arising out of, based on or resulting from: (i) the presence, or release or threat of release into the environment, of any Materials of Environmental Concern at any location, whether or not owned or operated by a Seller Party; or (ii) circumstances forming the basis of any violation or alleged violation of any Environmental Law.

"**Environmental Laws**" means, as they exist on the date hereof and as of the Closing Date, all applicable United States federal, state, local and non-U.S. laws, regulations, codes and ordinances relating to pollution or protection of human health (as relating to the environment or the workplace) and the environment (including ambient air, surface water, ground water, land surface or sub-surface strata), including laws and regulations relating to emissions, discharges, releases or threatened releases of Materials of Environmental Concern, or otherwise relating to the use, treatment, storage, disposal, transport or handling of Materials of Environmental Concern, including, but not limited to Comprehensive Environmental Response, Compensation and Liability Act, 42 U.S.C. Section 9601 *et seq.*, Resource Conservation and Recovery Act, 42 U.S.C. Section 6901 *et seq.*, Toxic Substances Control Act, 15 U.S.C. Section 2601 *et seq.*, Occupational Safety and Health Act, 29 U.S.C. Section 651 *et seq.*, the Clean Air Act, 42 U.S.C.

Section 7401 *et seq.*, the Clean Water Act, 33 U.S.C. Section 1251 *et seq.*, each as may have been amended or supplemented, and any applicable environmental transfer statutes or laws.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, and the rules and regulations promulgated thereunder.

"**ERISA Affiliate**" means the Seller Parties which are treated as a single employer with ORHC for purposes of Section 414 of the IRC, each entity that has adopted or has ever participated in any Benefit Plan, and any predecessor company or trade or business of the Sellers.

"**Escrow Agent**" has the meaning set forth in Section 2.5(a).

"**Escrow Agreement**" has the meaning set forth in Section 2.5(a).

"**Escrow Amount**" has the meaning set forth in Section 2.5(a).

"**Excluded Assets**" has the meaning set forth in Section 2.2.

"**Excluded Contracts**" has the meaning set forth in Section 2.1(k).

"**Excluded Liabilities**" has the meaning set forth in Section 2.4.

"**Executive Order 13224**" means Executive Order 13224 on Terrorism Financing, effective September 24, 2001.

"**Exemption Certificate**" means a written statement from the State Health Agency or other agency having jurisdiction thereof stating that a health care project or expenditure is not subject to the Certificate of Need requirements under applicable state law.

"**Existing Foundation**" has the meaning set forth in Section 2.2(r).

"**Existing Tenant Improvement Obligations**" means tenant improvement expenses (including all hard and soft construction costs, whether payable to the contractor or tenant) and tenant allowances which are the obligation of the landlord under any Tenant Lease.

"**GAAP**" means generally accepted accounting principles.

"**Government Receivables**" has the meaning set forth in Section 2.1(g).

"**Healthcare Providers**" has the meaning set forth in Section 4.9.

"**HHS**" means the Department of Health and Human Services.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, 45 CFR §§ 160-164, and the regulations adopted pursuant thereto, including the Health Information Technology for Economic and Clinical Health Act and the regulations adopted pursuant thereto.

"**Hired Employees**" has the meaning set forth in Section 10.1(a).

"**Hospital**" means the full-service, acute care hospital known as Ottumwa Regional Health Center.

"**Hospital CEO**" has the meaning set forth in Section 10.3(a).

"**HSR Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended.

"**Indemnification Basket**" has the meaning set forth in Section 12.4(a).

"**Indemnified Party**" has the meaning set forth in Section 12.5.

"**Indemnifying Party**" has the meaning set forth in Section 12.5.

"**Infrastructure Projects**" has the meaning set forth in Section 10.6(e).

"**Interim Statements**" has the meaning set forth in Section 6.5.

"**IRC**" means the Internal Revenue Code of 1986, as amended, and the rules and regulations promulgated thereunder.

"**Joint Commission**" has the meaning set forth in Section 4.8.

"**Joint Venture Facilities**" has the meaning set forth in the Recitals.

"**Joint Venture Financial Statements**" has the meaning set forth in Section 4.4.

"**Joint Ventures**" has the meaning set forth in the Recitals.

"**Landlord Estoppel**" has the meaning set forth in Section 6.11.

"**Landlord Estoppel Threshold**" has the meaning set forth in Section 6.11.

"**Leased Real Property**" has the meaning set forth in Section 2.1(b).

"**Legacy Directors**" has the meaning set forth in Section 10.3(a).

"**Legacy Foundation**" has the meaning set forth in Section 11.4.

"**Legal Dispute**" has the meaning set forth in Section 13.14.

"**Material Adverse Effect**" means an event, occurrence, condition, change or circumstance or a series of events, occurrences, conditions, changes or circumstances that, individually or in the aggregate, is or may be materially adverse to the business, financial condition, operations, prospects or results of operations of the Sellers, the Seller Facilities or the Assets, but excluding the effect of: (a) changes in the economy of the United States or any region thereof; and (b) changes generally affecting the industry in which the Sellers operate, including changes in any government or private payor programs generally applicable to operators of hospital and health care facilities in the State of Iowa.

"**Materials of Environmental Concern**" means chemicals, pollutants, contaminants, hazardous materials, hazardous substances and hazardous wastes, medical waste, toxic substances, petroleum and petroleum products and by-products, polychlorinated biphenyls, and any other chemicals, pollutants, substances or wastes, in each case so defined, identified, or regulated under any Environmental Law.

"**MedAssets**" has the meaning set forth in Section 11.7.

"**MedAssets Agreement**" has the meaning set forth in Section 11.7.

"**Medical Waste**" includes, but is not limited to: (a) pathological waste, (b) blood, (c) sharps, (d) wastes from surgery or autopsy, (e) dialysis waste, including contaminated disposable equipment and supplies, (f) cultures and stocks of infectious agents and associated biological agents, (g) contaminated animals, (h) isolation wastes, (i) contaminated equipment, (j) laboratory waste and (k) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings or animals. "Medical Waste" also includes any substance, pollutant, material or contaminant listed or regulated as "Medical Waste," "Infectious Waste," or other similar terms by federal, state, regional, county, municipal or other local laws, regulations and ordinances insofar as they purport to regulate Medical Waste or impose requirements relating to Medical Waste and includes "Regulated Waste" governed by the Occupational Safety and Health Act, 29 U.S.C. Section 651 *et seq.*

"**MOB**" has the meaning set forth in Section 10.6.

"**Name Change Amendment**" has the meaning set forth in Section 11.3.

"**Net Working Capital**" means an amount equal to the value of the Sellers' net patient receivables, other receivables, inventories and supplies, prepaid expenses and other current assets, to the extent that each of these assets is being purchased by Buyer, less the value of the Sellers' accounts payable, construction payable, accrued payroll, accrued vacation, holiday/paid time off and sick time, and other current liabilities consistent with GAAP and the Sellers' historical practices, consistently applied, to the extent that each of these liabilities is a current liability and is an Assumed Liability.

"**Net Working Capital Estimate**" has the meaning set forth in Section 2.6(a).

"**New Treatment Program**" has the meaning set forth in Section 10.16.

"**Note**" has the meaning set forth in Section 3.3(d).

"**NSPS**" means the National Society of Professional Surveyors.

"**Objection**" has the meaning set forth in Section 2.6(c).

"**OFAC**" means the Office of Foreign Asset Control.

"**OIG**" means the Office of Inspector General.

"**ORHC**" has the meaning set forth in the Preamble.

"**ORHC Bonds**" means the Wapello County, Iowa Variable Rate Demand Refunding Revenue Bonds, Series 2006 (Ottumwa Regional Health Center) and the Wapello County, Iowa Variable Rate Demand Revenue Bonds, Series 2004 (Ottumwa Regional Health Center, Incorporated).

"**Owned Intellectual Property**" has the meaning set forth in Section 2.1(m).

"**Owned Real Property**" has the meaning set forth in Section 2.1(a).

"**Party**" has the meaning set forth in the Preamble.

"**Pending Hospital Construction**" has the meaning set forth in Section 6.2(c).

"**Permitted Encumbrances**" has the meaning set forth in Section 4.11.

"**Providing Party**" has the meaning set forth in Section 13.17.

"**Purchase Price**" has the meaning set forth in Section 2.5(a).

"**RAC**" means Recovery Audit Contractors.

"**RE**" has the meaning set forth in the Preamble.

"**Real Property**" has the meaning set forth in Section 2.1(b).

"**Receiving Party**" has the meaning set forth in Section 13.17.

"**Records**" has the meaning set forth in Section 13.5.

"**Required Consents**" has the meaning set forth in Section 6.4.

"**Routine Capital Expenditures**" has the meaning set forth in Section 10.7.

"**RRL**" has the meaning set forth in the Preamble.

"**RRL Bonds**" means the City of Ottumwa, Iowa Revenue Refunding Bonds, Series 1998A and 1998B (Regional Retirement Living, Inc.).

"**RRL Chairman**" has the meaning set forth in Section 10.12(b).

"RRL Deposits" shall have the meaning set forth in Section 2.3(e).

"**RRL Property**" shall mean those certain parcels of land described on Schedule 1.1, and all improvements thereon.

"**Seller Facilities**" has the meaning set forth in the Recitals.

"**Seller Financial Statements**" has the meaning set forth in Section 4.4.

"**Seller Indemnified Parties**" has the meaning set forth in Section 12.1(a).

"**Seller Indemnity Cap**" has the meaning set forth in Section 12.4(a).

"**Seller Leases**" has the meaning set forth in Section 2.1(b).

"**Seller Parties**" has the meaning set forth in the Recitals.

"**Seller Review Period**" has the meaning set forth in Section 13.2.

"**Sellers**" has the meaning set forth in the Preamble.

"**Senior Living Facility**" has the meaning set forth in Section 10.12(a).

"**SIROC**" has the meaning set forth in the Recitals.

"**State Health Agency**" has the meaning set forth in Section 4.6.

"**Studer**" has the meaning set forth in Section 10.10.

"**Substance Abuse Programs**" means the Family Recovery Center and Bridge of Hope programs operated by RE prior to the Closing Date.

"**Successor Foundation**" has the meaning set forth in Section 11.4.

"**Surveys**" has the meaning set forth in Section 7.4.

"**Tax Allocation**" has the meaning set forth in Section 13.2.

"**Tax Return**" means any return, declaration, report, claim for refund, or information return or statement relating to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

"**Taxes**" means any and all federal, state, local, foreign and other net income, tax on unrelated business taxable income, gross income, gross receipts, sales, use, ad valorem, unclaimed property, payments in lieu of taxes, transfer, franchise, profits, license, lease, rent, service, service use, withholding, payroll, employment, excise, severance, privilege, stamp, occupation, premium, property, windfall profits, alternative minimum, estimated, customs, duties or other taxes, fees, assessments, unclaimed property or charges of any kind whatsoever, together with any interest and any penalties, additions to tax or additional amounts with respect thereto.

"**Tenant Estoppel**" has the meaning set forth in Section 6.10.

"**Tenant Estoppel Threshold**" has the meaning set forth in Section 6.10.

"**Tenant Leases**" has the meaning set forth in Section 2.1(j).

"**Title Company**" has the meaning set forth in Section 7.4.

"**Title Objections**" has the meaning set forth in Section 7.4.

"**To the Knowledge of Buyer**" has the meaning set forth in Section 5.10.

"**To the Knowledge of the Sellers**" has the meaning set forth in Section 4.32.

"**USA Patriot Act**" means the United and Strengthening America by Providing Tools Required to Intercept and Obstruct Terrorism Act of 2001, H.R. 3162, Public Law 107-56.

"Vista Woods" means that certain skilled nursing facility operated by Ottumwa Developments, Inc. pursuant to a ground lease with RRL.

"**WARN Act**" means the Worker Adjustment and Retraining Notification Act, and any comparable state law or regulation.

ARTICLE II

PURCHASE OF ASSETS

2.1 Sale of Assets. Subject to the terms and conditions of this Agreement, on the Closing Date, the Sellers shall sell, assign, convey, transfer and deliver to Buyer (or a designated Affiliate of Buyer for the Assets owned by RRL), and Buyer (or a designated Affiliate of Buyer for the Assets owned by RRL) shall purchase, all of Sellers' rights, title and interest in and to the assets that are owned or leased by the Sellers and used in connection with the operation of the Seller Facilities, other than the Excluded Assets (hereinafter defined) (the "**Assets**"), including, without limitation, the following:

(a) all real property owned by any of the Sellers and used in connection with the operation of any of the Seller Facilities (such operations referred to herein as the "**Business**"), as more specifically described in Schedule 2.1(a), together with all buildings, improvements and fixtures located thereupon, all easements, rights of way, and other appurtenances thereto (including appurtenant rights in and to public streets), all architectural plans or design specifications relating to the pending development thereof and all construction in progress (collectively, the "**Owned Real Property**"), such Schedule 2.1(a) to include a description for each such parcel of Owned Real Property consistent with the vesting deed for such Owned Real Property into the applicable Seller;

(b) all real property subject to a leasehold or sub-leasehold estate in favor of any of the Sellers, as tenant, and held or used in or ancillary to the operation of the Business, including the real property described on Schedule 2.1(b)(i) (collectively, the "**Leased Real Property**"; the Owned Real Property and the Leased Real Property being sometimes referred to herein collectively as the "**Real Property**") and all rights and interests in, to and under those lease agreements pursuant to which any of the Sellers, as tenant, is leasing all or some portion of the Leased Real Property, including those lease agreements set forth on Schedule 2.1(b)(ii) (collectively, the "**Seller Leases**");

(c) all tangible personal property, including, without limitation, all major, minor or other equipment, vehicles, furniture, fixtures, machinery, office furnishings and

instruments, the current list of which is set forth on Schedule 2.1(c) hereto, all of such personal property is located at one of the Seller Facilities unless noted on Schedule 2.1(c);

(d) all supplies, drugs, inventory and other disposables and consumables existing on the Closing Date and located at any of the Seller Facilities or owned by any of the Sellers for use in connection with the Business;

(e) all deposits, prepaid expenses, escrows, prepaid Taxes and claims for refunds in connection with the Seller Facilities or the Assets (including, without limitation, rebates from vendors received subsequent to the Closing that exist as of the Closing Date, excluding the settlement amounts described in Section 2.2(c));

(f) all notes receivable, accounts receivable and other rights to receive payment for goods and services (other than the Government Receivables) provided by the Sellers in connection with the Business, billed and unbilled, recorded or unrecorded, including amounts charged off as bad debt and/or submitted to collection agencies or otherwise, pertaining to services rendered through the Closing Date, and all notes receivable from patients and notes receivable from physicians, as more specifically described on Schedule 2.1(f) hereto;

(g) all rights to receive funds swept from the lockbox accounts described in Section 6.14, which are attributable to the accounts receivable arising from the rendering of services to patients at the Seller Facilities, billed and unbilled, recorded or unrecorded, accrued and existing in respect of services rendered through the Closing Date which by law may not be assigned (excluding the settlement amounts described in Section 2.2(c)) (the "**Government Receivables**");

(h) except as set forth in Section 2.2(h), all claims, causes of action and judgments in favor of the Sellers relating to the physical condition or repair of the Assets, all insurance proceeds due to Buyer under Section 13.31, and, to the extent assignable, all warranties (express or implied) and rights and claims assertable by (but not against) the Sellers related to the Assets;

(i) to the extent assignable or transferable, all financial, patient, medical staff, personnel and other records relating to the Business or the Assets, including, without limitation, all accounts receivable records, equipment records, medical and administrative libraries, medical records, patient billing records, documents, construction plans and specifications, catalogs, books, records, files, operating manuals and current personnel records;

(j) all rights and interests in, to and under those lease agreements pursuant to which any of the Sellers, as landlord, has leased to a third party, as tenant, all or some portion of the Owned Real Property or the Leased Real Property, including those lease agreements set forth on Schedule 2.1(j) (collectively, the "**Tenant Leases**");

(k) to the extent assignable and transferable, all rights and interests in, to and under: (i) the contracts, commitments, leases and agreements listed on Schedule 4.18 (including, without limitation, physician employment contracts, physician service contracts, contracts with hospital-based physicians, medical equipment leases and rental arrangements, residency agreements relating to facilities owned and operated by RRL (which rights shall include the right

to receive any amounts payable thereunder that accrues or arises after the Closing Date), transcription service agreements and contracts for management of the acute rehabilitation program), other than those specifically identified thereon as "**Excluded Contracts**"; and (ii) all other contracts commitments, leases and agreements of the Sellers which do not appear on Schedule 4.18, unless such unlisted contracts, commitments, leases and agreements involve a physician or other referral source, are real property leases or require an annual financial commitment in excess of Ten Thousand Dollars ($10,000) (collectively, the "**Assumed Contracts**");

(l) to the extent assignable or transferable, all licenses, Certificates of Need, Exemption Certificates, provider agreements, provider numbers, franchises, accreditations, registrations and other licenses and permits relating to the ownership, development, and operation of the Seller Facilities (including, without limitation, any pending approvals set forth on Schedule 2.1(l));

(m) all rights and interest in the name "Ottumwa Regional Health Center" and all patents, trade names, domain names, copyrights, software, computer programs, trade secrets, trademarks, service marks and other intellectual property rights owned by Sellers and used in the operation of the Business or any of the Assets, all goodwill associated therewith, and all applications and registrations associated therewith (the "**Owned Intellectual Property**");

(n) all goodwill associated with the operation of the Business and the Assets;

(o) to the extent assignable and transferable, all stock, membership interests and other voting and non-voting interests in the Joint Ventures, as more specifically described on Schedule 2.1(o) hereto;

(p) all other assets, other than the Excluded Assets, of every kind, character or description used or held for use primarily in the Business, whether or not reflected on the Financial Statements, wherever located and whether or not similar to the items specifically set forth above, and all other interests owned by the Sellers in connection with the Business or the Assets, to the extent assignable and transferable; and

(q) all property of the foregoing types arising or acquired by the Sellers between the date hereof and the Closing Date.

The Assets and the Excluded Assets together comprise substantially all of the assets and properties currently used in connection with the operation of the Business. All assets and properties currently used in connection with the operation of the Joint Venture Facilities are owned or leased by the Joint Ventures. The Sellers shall transfer good and marketable title to the Assets owned in fee by Sellers and leasehold title in the Assets leased by the Sellers to Buyer (or a designated Affiliate of Buyer for the Assets owned or leased by RRL), free and clear of all claims, assessments, security interests, liens, restrictions and encumbrances, except for: (i) the Assumed Liabilities; (ii) liens and encumbrances related to the Assumed Liabilities; (iii) liens for Taxes not yet due and payable; and (iv) the Permitted Encumbrances.

2.2 Excluded Assets. Those assets of the Sellers described below, together with any assets described on Schedule 2.2 hereto, shall be retained by the Sellers (collectively, the "**Excluded Assets**"), and shall not be conveyed to Buyer:

(a) cash, short-term investments and cash equivalents (including donor restricted funds);

(b) board-designated, restricted and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, working capital trust assets and assets and investments restricted as to use), other donor restricted assets, beneficial interests in charitable trusts and accrued earnings on all of the foregoing;

(c) all amounts payable to any of the Sellers in respect of third party payors pursuant to retrospective settlements (including, without limitation, pursuant to Medicare, Medicaid and CHAMPUS/TRICARE cost reports filed or to be filed by any of the Sellers for periods ending on or prior to the Closing Date ("**Cost Reports**") and all appeals and appeal rights relating to such settlements, including recapture of depreciation and other cost report settlements, for periods ending on or prior to the Closing Date;

(d) all records relating to the Excluded Assets, the Excluded Liabilities, the Bonds and all other records which by law the Sellers are required to maintain in their possession;

(e) the corporate record books, minute books and Tax records of the Sellers;

(f) any reserves or prepaid expenses made in connection with the Excluded Assets and Excluded Liabilities (including, without limitation, prepaid legal expenses or insurance premiums);

(g) all rights to Tax refunds or Tax claims related to the Business or the Assets resulting from the periods ending on or prior to the Closing Date;

(h) except as otherwise provided in Section 13.31, all insurance proceeds (other than payments of patient receivables) arising in connection with the Business or the Assets for periods ending on or prior to the Closing Date and all insurance proceeds relating exclusively to the Excluded Assets and Excluded Liabilities or in relation to work funded by Sellers prior to the Closing Date for which reimbursement has been sought;

(i) the amounts due to any of the Sellers from Affiliates of the Sellers or from the Joint Ventures, as disclosed on Schedule 2.2(i);

(j) all Benefit Plans, agreements related thereto, and assets associated with all Benefit Plans, including but not limited to prepaid pension costs and other assets associated with the Sellers' qualified employee benefits plans;

(k) all rights of the Sellers under this Agreement and the agreements and instruments referred to herein;

(l) all rights and interests of the Sellers in, to and under the contracts, commitments, leases, escrow agreements and agreements to which any of the Sellers are parties, other than the Assumed Contracts, the Tenant Leases and the Seller Leases;

(m) the interest rate swap agreements disclosed on Schedule 2.2(m) and all collateral related thereto;

(n) all funds held under or with respect to any indenture or escrow agreement in connection with the Bonds or bonds refunded with the Bonds;

(o) all claims, causes of action and judgments in favor of the Sellers associated with or arising out of any of the Excluded Assets and/or the Excluded Liabilities;

(p) all self-insured retention trusts and any other similar trust funds related to professional and general liability claims and causes of action;

(q) all consignment inventory as set forth on Schedule 2.2(q);

(r) all non-real estate assets held by Ottumwa Regional Health Foundation, Incorporated, an Iowa non-profit, non-stock corporation (the "**Existing Foundation**");

(s) all rights and interest of the Sellers in the joint ventures set forth on Schedule 2.2(s); and

(t) funds payable to Sellers in relation to interest rate swap agreements.

2.3 Assumed Liabilities. In connection with the conveyance of the Assets to Buyer, Buyer agrees to assume, as of the Effective Time, the payment and performance of the following liabilities of the Sellers (the "**Assumed Liabilities**"):

(a) all obligations accruing, arising or to be performed on or after the Effective Time with respect to the Assumed Contracts, the Tenant Leases and the Seller Leases;

(b) the accounts payable, construction payable, accrued payroll and other current liabilities consistent with historical practices of the Sellers, but only to the extent such liabilities are current liabilities that are included in Net Working Capital;

(c) to the extent included in Net Working Capital, obligations and liabilities as of the Closing Date in respect of accrued vacation, sick time and paid time off benefits of the employees at the Facilities who commence employment with Buyer as of the Effective Time, and related Taxes not yet due and payable;

(d) the Assumed Sick Leave of employees at the Facilities who commence employment with Buyer at the Effective Time, but only to the extent disclosed on Schedule 2.3(d);

(e) to the extent such amount is listed on Schedule 2.3(e) (such amounts being the "**RRL Deposits**"), and provided such amount is delivered by RRL to Buyer (or a designated

Affiliate of Buyer) at Closing, an amount equal to the refundable resident entrance fees and deposits relating to RRL; and

(f) liabilities for the abatement of any asbestos and asbestos-containing materials located on or at the Hospital.

2.4 Excluded Liabilities. Except for the Assumed Liabilities, Buyer shall not assume and under no circumstances shall Buyer be obligated to pay, discharge or assume, and none of the assets of Buyer shall be or become liable for or subject to, any liability, indebtedness, commitment or obligation of any of the Sellers, whether known or unknown, fixed or contingent, recorded or unrecorded, currently existing or hereafter arising or otherwise (collectively, the "**Excluded Liabilities**"), including, without limitation, the following:

(a) any debt, obligation, expense or liability that is not an Assumed Liability, including, without limitation, any termination amounts payable with respect to all interest rate swap agreements;

(b) claims or potential claims for medical malpractice or general liability relating to events asserted to have occurred on or prior to the Closing Date;

(c) those claims and obligations (if any) specified in Schedule 2.4(c) hereto;

(d) any liabilities or obligations associated with or arising out of any of the Excluded Assets;

(e) liabilities and obligations in respect of periods ending on or prior to the Closing Date arising under the terms of the Medicare, Medicaid, CHAMPUS/TRICARE, Blue Cross or other third party payor programs, including, without limitation, in respect of any Cost Report or audit under Medicare's RAC Program;

(f) except as set forth in Section 13.16 of this Agreement, federal, state or local Tax liabilities or obligations in respect of periods ending on or prior to the Closing Date, including, without limitation, any income tax, franchise tax, real or personal property tax, tax recapture, sales and/or use tax, payroll tax, employment tax, unclaimed property obligation and any state and local recording fees and taxes, excluding any Taxes payable with respect to any employee benefits constituting Assumed Liabilities under Section 2.3(c) hereof;

(g) liability for any and all claims by or on behalf of current or former employees arising out of or related to acts, omissions, events or occurrences on or prior to the Closing Date, including, without limitation, liability for any pension, profit sharing, deferred compensation, or health and welfare benefit plans, liability for any EEOC claim, ADA claim, Family and Medical Leave Act claim, wage and hour claim, unemployment compensation claim, or workers' compensation claim, and any liabilities or obligations under COBRA, the Public Health Service Act or similar state laws for qualifying events occurring on or prior to the Closing Date (provided, however, that this clause (g) shall not apply to those benefits constituting Assumed Liabilities and identified in Section 2.3 hereof);

(h) any obligation or liability accruing, arising out of or relating to any federal, state or local investigations of, or claims or actions against, any of the Sellers with respect to acts or omissions on or prior to the Closing Date;

(i) any civil or criminal obligation or liability accruing, arising out of, or relating to any acts or omissions of any of the Sellers or their respective directors, officers, employees, medical staff, agents, vendors or representatives claimed to violate any constitutional provision, statute, ordinance or other law, rule, regulation, interpretation or order of any governmental entity;

(j) liabilities or obligations arising out of any breach by any of the Sellers at any time of any contract or commitment, including, without limitation, any Assumed Contract, Tenant Lease or Seller Lease;

(k) any obligation or liability asserted under the federal Hill-Burton program or other restricted grant and loan programs with respect to the ownership or operation of the Business or the Assets;

(l) any obligations or liabilities with respect to any Benefit Plans, including but not limited to the Ottumwa Regional Health Center Retirement Income Plan; any post-retiree medical benefits or other benefits described in Section 4.13(f); any other obligations or liabilities of the Sellers or any ERISA Affiliate arising under or in connection with ERISA or the IRC; and any incurred but not paid (regardless of whether reported) medical and dental claims made pursuant to any Benefit Plan;

(m) all deferred compensation liabilities;

(n) the loss or impairment of RRL's fee simple interest in the Vista Woods real property as a result of the foreclosure by Ottumwa Development Inc.'s senior lender of its lien on such real property;

(o) any account payable of a Seller or any Joint Venture to any other Seller, Joint Venture or Affiliate thereof;

(p) liabilities or obligations whenever arising relating to any lease, capitalized lease, contract, commitment or agreement of any of the Sellers or relating to the Business that are not Tenant Leases, Seller Leases or Assumed Contracts, including but not limited to contracts or agreements between or among the Sellers or between any Seller and any Joint Venture;

(q) any Environmental Claim or other obligation or liability arising under any Environmental Law related to acts or omissions of the Seller Parties which occurred on or prior to the Closing Date, except for obligations and liabilities arising under or related to: (i) the physical condition of the Alta Vista Site; (ii) compliance with laws, including the Environmental Laws, or the presence of Materials of Concern, at, in or upon the Alta Vista Site; or (iii) the presence of asbestos or asbestos-containing materials on or at the Hospital;

(r) any liability relating to deposits of RRL residents not listed on Schedule 2.3(e), or for amounts in excess of the amounts listed on Schedule 2.3(e);

(s) all liabilities and obligations related to Sellers' operation or closure of the Substance Abuse Programs including but not limited to: regulatory claims; patient claims; contractual obligations of the Substance Abuse Programs; any severance payments; or employee claims; and

(t) liabilities of the Sellers in relation to interest rate swap agreements.

2.5 Consideration.

(a) Subject to the terms and conditions hereof and in reliance upon the representations and warranties of the Sellers set forth herein, as consideration for the conveyance and transfer of the Assets, Buyer shall: (i) pay to the Sellers Eighty-six Million Dollars ($86,000,000) (the "**Closing Cash**"), plus, if applicable, the CLS Consideration (as defined in Section 2.5(b)), which aggregate amount shall be increased or decreased by the difference, whether positive or negative, between the Net Working Capital as of the Closing Date (the "**Closing Net Working Capital**") and the Net Working Capital as of March 31, 2009 (the "**Baseline Net Working Capital**"), which amount was Three Million Seven Hundred Sixty-three Thousand Five Hundred Thirty-nine Dollars ($3,763,539), as determined pursuant to Section 2.6 (as so adjusted, the "**Purchase Price**"); and (ii) assume as of the Effective Time the Assumed Liabilities. At the Closing, Buyer shall deposit Three Million Dollars ($3,000,000) of the Purchase Price (the "**Escrow Amount**") with the escrow agent (the "**Escrow Agent**") identified in that certain Escrow Agreement substantially in the form of Exhibit B hereto (the "**Escrow Agreement**"), which amount shall be held and disbursed by the Escrow Agent in accordance with the terms of the Escrow Agreement.

(b) In the event ORHC purchases all of the interests in CLS held by the University of Iowa Community Medical Services (the "**CLS Interests**") prior to the Closing, the Purchase Price shall be increased by the cash portion of the price paid or to be paid by ORHC for the CLS Interests, which shall not exceed Seven Hundred Fifty Thousand Dollars ($750,000) (the "**CLS Consideration**").

2.6 Determination of Purchase Price; Net Working Capital Adjustment.

(a) For purposes of determining the amount of cash or otherwise immediately available funds to be delivered by Buyer at the Closing in accordance with Section 2.5, not later than two (2) business days prior to the Closing Date, the Sellers shall deliver to Buyer their good faith estimate of the amount of the Closing Net Working Capital, together with supporting documentation of reasonable specificity (such estimate being the "**Net Working Capital Estimate**"). At the Closing, Buyer shall pay to the Sellers by wire transfer of immediately available funds to an account or accounts of the Sellers' designation either: (i) Eighty-six Million Dollars ($86,000,000), plus, if applicable, the CLS Consideration, plus the amount that the Net Working Capital Estimate exceeds the Baseline Net Working Capital minus the Escrow Amount minus the RRL Deposits; or (ii) Eighty-six Million Dollars ($86,000,000), plus, if applicable, the CLS Consideration, minus the amount that the Baseline Net Working Capital exceeds the Net Working Capital Estimate minus the Escrow Amount minus the RRL Deposits.

(b) Within one hundred and fifty (150) days after the Closing Date, Buyer shall prepare, or cause to be prepared, and deliver to the Sellers a statement (the "**Actual Closing Net Working Capital Statement**") setting forth an itemized calculation of the Closing Net Working Capital, together with supporting documentation of reasonable specificity for such calculations.

(c) The Sellers and their accountants shall have forty-five (45) days to review the Actual Closing Net Working Capital Statement after their receipt thereof, and Buyer shall provide Sellers reasonable access to the work papers of Buyer and its accountants used in preparing the Actual Closing Net Working Capital Statement. If the Sellers dispute the accuracy of the Actual Closing Net Working Capital Statement, the Sellers shall inform Buyer in writing (an "**Objection**") setting forth a specific description of the basis of the Objection, which Objection must be delivered to Buyer on or before the last day of such forty-five (45)-day period. Buyer and the Sellers shall then have thirty (30) additional days to attempt in good faith to reach an agreement with respect to any disputed matters in respect of the Closing Net Working Capital. In reviewing any Objection, Buyer and its accountants shall have reasonable access to the work papers of the Sellers and their accountants. If Buyer and the Sellers are unable to resolve all of their disagreements with respect to the determination of the foregoing items within said thirty (30)-day period, they shall submit the remaining items subject to dispute (the "**Disputed Items**") to an independent, regional accounting firm as Buyer and the Sellers shall mutually agree upon (the "**Audit Firm**"); provided, however, that if Sellers and Buyer cannot agree upon an audit firm, then they each shall select an independent, regional accounting firm, and the two (2) accounting firms so selected shall agree upon a third independent accounting firm of national standing, which shall act as the Audit Firm for purposes of this Section 2.6. The Audit Firm shall determine in accordance with this Agreement, and only with respect to the Disputed Items, whether and to what extent, if any, the Actual Closing Net Working Capital Statement requires adjustment. The Parties shall direct the Audit Firm to use all reasonable efforts to render its determination within thirty (30) days after such submission. The Audit Firm's determination of the Closing Net Working Capital shall be conclusive and binding upon the Parties. The fees and disbursements of the Audit Firm in rendering its determination shall be paid fifty percent (50%) by the Sellers and fifty percent (50%) by Buyer. Buyer and the Sellers shall make readily available to the Audit Firm all relevant books and records and any work papers (including those of the Parties' respective accountants) relating to the Actual Closing Net Working Capital Statement and all other items reasonably requested by the Audit Firm. The Closing Net Working Capital shall be deemed to be: (i) the amount of Net Working Capital as stated in the Actual Closing Net Working Capital Statement if no Objection is delivered by the Sellers during the thirty (30)-day period specified above; or (ii) if an Objection is so delivered by the Sellers, the amount of the Closing Net Working Capital as determined by either: (A) the agreement of the Parties; or (B) the Audit Firm.

(d) If the Closing Net Working Capital is less than the Net Working Capital Estimate, then within thirty (30) days after the final determination of the Closing Net Working Capital, the amount of the difference between the Net Working Capital Estimate and the Closing Net Working Capital shall be paid by the Sellers to Buyer via wire transfer of immediately available funds as an adjustment to the Purchase Price. If the Net Working Capital Estimate is less than the Closing Net Working Capital, then within thirty (30) days after the final determination of the Closing Net Working Capital, the amount of the difference between the

Closing Net Working Capital and the Net Working Capital Estimate shall be paid by Buyer to the Sellers via wire transfer of immediately available funds as an adjustment to the Purchase Price.

2.7 Prorations and Utilities. To the extent not otherwise prorated pursuant to this Agreement, Buyer and the Sellers shall prorate as of the Closing Date charges against the Real Property, power and utility charges and all other income and expenses that are normally prorated upon the sale of a going concern (to the extent Sellers' pre-Closing operations were not exempt from such charges). As to charges against the Real Property, all prorations shall be based upon the most recent tax bill received by the Seller. As to power and utility charges, such amounts shall be prorated as of the Closing Date among the parties on the basis of an estimate of the amounts in accordance with GAAP and mutually agreed upon by Buyer and the Sellers.

2.8 Bonds. The Sellers shall take all steps necessary to maintain and ensure the tax exempt status of all of the Bonds prior to the Closing Date. The Sellers shall provide Buyer with reasonably satisfactory evidence of the confirmation of the bond payoff amount no later than two (2) days prior to Closing Date. The Sellers hereby agree to provide for the redemption of the ORHC Bonds on the Closing Date and the defeasance of the RRL Bonds on the Closing Date by directing Buyer to pay the Bond Trustee a portion of the Purchase Price equal to the bond payoff amount for the Bonds. The Sellers shall promptly provide Buyer with copies of all pay-off letters, redemption notices, escrow agreements or similar documents executed by any Seller, the issuer of any Bond or any Bond Trustee prior to or following the Closing with respect to the redemption and/or defeasance of the Bonds.

ARTICLE III

CLOSING

3.1 Closing. Subject to the satisfaction or waiver by the appropriate Party of all of the conditions specified in Articles VIII and IX hereof, the consummation of the transactions contemplated by and described in this Agreement (the "**Closing**") shall take place at the offices of Waller Lansden Dortch & Davis, LLP, 511 Union Street, Suite 2700, Nashville, Tennessee 37219 on the date hereof (the date of consummation is referred to herein as the "**Closing Date**").

3.2 Actions of the Sellers at the Closing. At the Closing and unless otherwise waived in writing by Buyer, the Sellers shall deliver to Buyer the following:

(a) one or more special warranty deeds in recordable form executed by a duly authorized officer of the appropriate Seller(s), conveying to Buyer good and marketable fee title to the Owned Real Property, subject only to the Permitted Encumbrances and any Assumed Liabilities affecting such parcels (provided, however, the Sellers acknowledge and agree that Buyer may designate an Affiliate to take title to the RRL Property and, in such event, at the Closing, RRL shall convey the RRL Property to such Affiliate of Buyer);

(b) one or more General Assignments, Conveyances and Bills of Sale in the form attached as Exhibit C (the "**Bills of Sale**"), fully executed by a duly authorized officer of the appropriate Seller(s), conveying to Buyer (or a designated Affiliate of Buyer for the Assets

owned by RRL) good and marketable title to the Assets, free and clear of all claims, assessments, liens, security interests, restrictions and encumbrances other than the Permitted Encumbrances, liens for Taxes not yet due and payable and the Assumed Liabilities;

(c) one or more Assignment and Assumption Agreements in the form attached as Exhibit D (the "**Assignment and Assumption Agreements**"), fully executed by a duly authorized officer of the appropriate Seller(s), conveying to Buyer (or a designated Affiliate of Buyer for the liabilities of RRL) all of Sellers' right, title and interest in, to and under the Assumed Contracts, the Tenant Leases and Seller Leases, to the extent assignable;

(d) a copy of resolutions duly adopted by the Board of Directors of each of the Sellers authorizing and approving such Seller's performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and of full force as of the Closing Date by an appropriate officer of such Seller;

(e) a certificate of the President, a Vice President or other appropriate officer of each Seller, certifying the fulfillment of the conditions set forth in Section 8.1;

(f) a certificate of incumbency for the respective officers of each Seller executing this Agreement or the agreements herein contemplated or making certifications for the Closing, dated as of the Closing Date;

(g) pay-off letters or other documentation provided by the Sellers' lenders in relation to the indebtedness described on Exhibit E, committing to release any liens such lenders may have on the Assets or the Real Property when the indebtedness is paid in full by or on behalf of the Sellers on the Closing Date;

(h) the Non-Competition Agreement substantially in the form attached hereto as Exhibit F, executed by a duly authorized officer of each Seller;

(i) the Transition Services Agreement, executed by a duly authorized officer of ORHC;

(j) the Escrow Agreement, executed by a duly authorized officer of each Seller;

(k) such documents as may be reasonably requested by the Title Company to evidence the commitment of lenders to release the Assets from any and all mortgages and security interests created at any time on or prior to the Closing Date, except the Permitted Encumbrances and the Assumed Liabilities, or to insure Buyer's fee ownership interest in the Owned Real Property and Buyer's leasehold interest in the Leased Real Property;

(l) copies of certificates of insurance evidencing the insurance described in Section 6.7;

(m) a DEA limited power of attorney fully executed by a duly authorized officer of Seller (the "**DEA Power of Attorney**"), substantially in the form attached hereto as Exhibit G;

(n) a certificate of non-foreign status, dated as of the Closing Date, executed by a duly authorized officer of each Seller, in form and substance required under the Treasury Regulations pursuant to Section 1445 of the IRC;

(o) the Employee Lease Agreement, executed by a duly authorized officer of ORHC;

(p) one or more special warranty deeds evidencing the transfer to ORHC of all Real Property owned by the Existing Foundation effective on or before the Closing Date;

(q) an affidavit executed by each Seller certifying that it is not a "blocked person" under Executive Order 13224, which form shall be acceptable to Buyer;

(r) such other instruments and documents as Buyer reasonably deems necessary to effectuate the transactions contemplated hereby.

3.3 Actions of Buyer at the Closing. At the Closing and unless otherwise waived in writing by the Sellers, Buyer shall deliver to the Sellers the following:

(a) the amount of the Purchase Price determined pursuant to the methodology set forth in Section 2.6(a), which shall be transferred to the Sellers by wire transfer of immediately available funds to an account or accounts of Sellers' designation;

(b) the Bills of Sale, fully executed by a duly authorized officer of Buyer;

(c) the Assignment and Assumption Agreements, fully executed by a duly authorized officer of Buyer, pursuant to which Buyer shall assume the future performance of the Assumed Contracts, the Tenant Leases and the Seller Leases as contemplated herein;

(d) a promissory note in the original principal amount of Thirty-Five Million Dollars ($35,000,000) payable by Buyer to ORHC substantially in the form attached hereto as Exhibit H (the "**Note**"), executed by a duly authorized officer of Buyer;

(e) the Transition Services Agreement, executed by a duly authorized officer of Buyer;

(f) the Escrow Agreement, executed by a duly authorized officer of Buyer;

(g) a copy of resolutions duly adopted by the Board of Directors of Buyer, authorizing and approving Buyer's performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and in full force as of the Closing Date by an appropriate officer of Buyer;

(h) a certificate of the President, a Vice President or other appropriate officer of Buyer, certifying the fulfillment of the conditions set forth in Section 9.1;

(i) a certificate of incumbency for the officers of Buyer executing this Agreement or the agreements herein contemplated or making certifications for the Closing, dated as of the Closing Date;

(j) a certificate of existence and good standing of Buyer from the Secretary of State of the State of Delaware, dated the most recent practical date prior to the Closing Date;

(k) the Employee Lease Agreement, executed by a duly authorized officer of Buyer;

(l) the DEA Power of Attorney, executed by a duly authorized officer of Buyer; and

(m) such other instruments and documents as the Sellers reasonably deem necessary to effectuate the transactions contemplated hereby.

ARTICLE IV

REPRESENTATIONS AND WARRANTIES OF THE SELLERS

The Sellers, jointly and severally, represent and warrant to Buyer the following:

4.1 Existence and Capacity.

(a) ORHC is an Iowa not-for-profit corporation that is duly organized, validly existing and in good standing under the laws of the State of Iowa.

(b) RRL is an Iowa not-for-profit corporation that is duly organized, validly existing and in good standing under the laws of the State of Iowa, whose sole corporate member is ORHC. RE is an Iowa corporation that is duly organized, validly existing and in good standing under the laws of the State of Iowa, whose sole shareholder is ORHC. Other than ORHC's interests in RRL and RE, no other party owns, directly or indirectly, beneficially or equitably, any capital stock or other equity interest in such entities, nor does any party own or hold any right of first refusal, purchase option or other rights with respect thereto.

(c) Schedule 4.1(c) sets forth the beneficial owners, type of entity and state of organization of each Joint Venture. Each Joint Venture is validly existing and in good standing under the laws of the State of Iowa. Except as set forth on Schedule 4.1(c), to the Sellers' knowledge, no other party owns or holds any right of first refusal, purchase option or other rights with respect to the Joint Ventures.

(d) Except as set forth above or described on Schedule 4.1(d), none of the Sellers owns, directly or indirectly, beneficially or equitably, any capital stock or other equity interest in any corporation, partnership, limited partnership, limited liability company or other entity or association, nor does any Seller own or hold any right of first refusal, purchase option or other rights with respect thereto.

(e) Exhibit A-1 sets forth each of the Seller Facilities owned, leased or operated by the Sellers. Except as set forth on Exhibit A-1, none of the Sellers owns, leases or operates any healthcare facility. Exhibit A-2 sets forth each of the Joint Venture Facilities owned, leased or operated by the Joint Ventures. Except as set forth on Exhibit A-2, none of the Joint Ventures owns, leases or operates any healthcare facility.

(f) Each of the Sellers has the requisite power and authority to enter into this Agreement, to perform its obligations hereunder and to conduct its business as now being conducted.

4.2 Powers; Consents; Absence of Conflicts With Other Agreements, Etc. The execution, delivery, and performance of this Agreement by the Sellers and all other agreements referenced herein, or ancillary hereto, to which any of the Sellers is a party, and the consummation of the transactions contemplated herein by the Sellers:

(a) are within each Seller's organizational powers, are not in contravention of law or of the terms of such Seller's organizational documents and have been duly authorized by all appropriate action;

(b) except as set forth on Schedule 4.2(b), do not require any approval or consent of, or filing with, any governmental agency or authority bearing on the validity of this Agreement which is required by law or the regulations of any such agency or authority;

(c) except as set forth on Schedule 4.2(c), will not conflict with, require consent under or result in any breach or contravention of, or the creation of any lien, charge, or encumbrance under, any indenture, agreement, lease, instrument or understanding to which any Seller is a party or by which it is bound or any of its assets is subject;

(d) will not violate any statute, law, ordinance, rule or regulation of any governmental authority to which any Seller or the Assets may be subject; and

(e) will not violate any judgment, decree, order, writ or injunction of any court or governmental authority to which any Seller or the Assets may be subject.

4.3 Binding Agreement. This Agreement and all agreements to which any of the Sellers will become a party pursuant hereto are and will constitute the valid, legal and binding obligations of such Seller, and are and will be enforceable against such Seller in accordance with the respective terms hereof or thereof.

4.4 Financial Statements. Each of the Sellers has made available to Buyer copies of the following financial statements of or pertaining to the Business and the Assets (the "**Seller Financial Statements**"), which Seller Financial Statements are maintained on an accrual basis, and copies of which are attached hereto as Schedule 4.4(a):

(a) unaudited Balance Sheet dated as of February 28, 2010 (the "**Balance Sheet Date**");

(b) unaudited Income Statement for the eleven (11) month period ended on February 28, 2010; and

(c) audited Balance Sheets, Income Statements, and Statements of Cash Flows for the fiscal year ended March 31, 2008 and for the fiscal year ended March 31, 2009.

Such Seller Financial Statements are true, complete and accurate in all material respects, and conform to GAAP consistently applied, except: (i) for year-end audit adjustments; (ii) for a lack of footnotes; and (iii) as set forth in Schedule 4.4(a). Except as set forth in the footnotes to the audited Seller Financial Statements, the audited Seller Financial Statements have been prepared in accordance with GAAP, applied on a consistent basis throughout the periods indicated. Such Balance Sheets present fairly the financial condition of the Business as of the dates indicated thereon, and such Income Statements present fairly the results of operations of the Business for the periods indicated thereon.

The Sellers have made available to Buyer copies of the financial statements of or pertaining to each of the Joint Ventures and their operations (the "**Joint Venture Financial Statements**"), which Joint Venture Financial Statements are maintained on an accrual basis, and copies of which are attached hereto as Schedule 4.4(d):

(d) unaudited Balance Sheet for the two (2) month period ended February 28, 2010;

(e) unaudited Income Statement for the two (2) month period ended on February 28, 2010; and

(f) audited Balance Sheets, Income Statements, and Statements of Cash Flows for the fiscal year ended December 31, 2008 and for the fiscal year ended December 31, 2009 for CLS and unaudited Balance Sheets, Income Statements, and Statements of Cash Flows for the fiscal year ended December 31, 2008 and for the fiscal year ended December 31, 2009 for SIROC.

Such Joint Venture Financial Statements are true, complete and accurate in all material respects and conform to GAAP consistently applied, except: (i) for year-end audit adjustments for CLS; (ii) for a lack of footnotes; and (iii) as set forth on Schedule 4.4(d). Except as set forth in the footnotes to the audited Joint Venture Financial Statements for CLS, such audited Joint Venture Financial Statements have been prepared in accordance with GAAP, applied on a consistent basis throughout the periods indicated. Such Balance Sheets present fairly the financial condition of the Joint Venture's facilities as of the dates indicated thereon, and such Income Statements present fairly the results of operations of such facilities for the periods indicated thereon.

4.5 Certain Post-Balance Sheet Results. Except as set forth on Schedule 4.5, since the Balance Sheet Date, there has not been any:

(a) material damage, destruction or loss (whether or not covered by insurance) affecting the Business, the Assets or the Joint Venture Facilities;

(b) threatened employee strike, work stoppage or labor dispute pertaining to the Seller Facilities or the Joint Venture Facilities;

(c) sale, assignment, transfer or disposition of any item of property, plant or equipment included in the Assets having a value in excess of Ten Thousand Dollars ($10,000), except in the ordinary course of business with comparable replacement thereof;

(d) increase in the compensation payable by any of the Sellers or the Joint Ventures to any of such entity's employees or independent contractors, other than in the ordinary course of business, or any increase in, or establishment or amendment of, any bonus, insurance, pension, profit-sharing or other employee benefit plan, remuneration or arrangements made to, for or with such employees, other than as required by applicable law;

(e) changes in the composition of the medical staff of the Hospital, other than normal turnover occurring in the ordinary course of business;

(f) changes in the rates charged by the Seller Facilities or the Joint Venture Facilities for their services, other than those made in the ordinary course of business;

(g) adjustments or write-offs in accounts receivable or reductions in reserves for accounts receivable outside the ordinary course of business of the Seller Facilities or the Joint Venture Facilities; or

(h) change in accounting policies or procedures of the Sellers or the Joint Ventures.

4.6 Licenses. The Hospital is duly licensed as a general acute care hospital pursuant to the applicable laws of the State of Iowa. The pharmacies, laboratories and all other ancillary departments located at the Hospital or operated for the benefit of the Hospital that are required to be specially licensed are duly licensed by the Iowa Department of Inspections and Appeals, the Iowa Department of Public Health or other appropriate licensing agency (the "**State Health Agency**"). Each of the other Seller Facilities and the Joint Venture Facilities (to the extent required) has all licenses, registrations, permits and approvals that are needed or required by law to operate the businesses related to or affecting the Seller Facilities, the Joint Venture Facilities, the Assets, or any ancillary services that are part of the Business or the Joint Venture Facilities. Schedule 4.6 sets forth an accurate list of all such licenses, registrations, permits and approvals for the Seller Facilities and the Joint Venture Facilities, identifying specifically each Seller Party and Seller Facility or Joint Venture Facility related thereto, all of which: (i) if held by a Seller or the Sellers, are now, and as of the Closing Date shall be, in good standing and, to the knowledge of Sellers, are not subject to meritorious challenge; and (ii) if held by the Joint Ventures, are now, and as of the Closing Date shall be, in good standing and, to the knowledge of the Sellers, not subject to meritorious challenge.

4.7 Certificates of Need. Except as set forth on Schedule 4.7 hereto, no application for any Certificate of Need, Exemption Certificate or declaratory ruling has been made by any of the Sellers or the Joint Ventures with the State Health Agency or other agency having jurisdiction thereof that is currently pending or open before such agency, and no such application (an "**Application**") filed by any of the Sellers or the Joint Ventures within the past three (3)

years has been ultimately denied by any commission, board or agency or withdrawn by any Seller Party. No Seller or Joint Venture has, except for the Application related to the cardiac catheterization laboratory, prepared, filed, supported or presented opposition to any Application filed by another hospital or health agency within the past three (3) years. Except as set forth on Schedule 4.7 hereto, no Seller or Joint Venture has any Application pending nor any approved Application which relates to a project not yet completed, except for the Application related to the cardiac catheterization laboratory. Each Seller and Joint Venture has properly filed all required Applications with respect to any and all improvements, projects, changes in services, zoning requirements, construction and equipment purchases, and other changes for which approval is required under any applicable federal or state law, rule or regulation, and all such Applications are complete and correct in all material respects.

4.8 Medicare Participation/Accreditation. Each of the Seller Facilities and the Joint Venture Facilities is qualified for participation in the Medicare, Medicaid and CHAMPUS/TRICARE programs to the extent such qualification is appropriate and desired; have current and valid provider contracts with such programs; are in material compliance with the conditions of participation and, where applicable, conditions of coverage for such programs; and have received all approvals or qualifications necessary for reimbursement. The Seller Facilities and the Joint Venture Facilities listed on Schedule 4.8 are accredited by The Joint Commission (the "**Joint Commission**"). Except as set forth on Schedule 4.8 or otherwise disclosed to Buyer in a writing referencing this Section 4.8 on the date hereof, all billing practices of each of the Sellers and the Joint Ventures with respect to all third party payors, including the Medicare, Medicaid and CHAMPUS/TRICARE programs and private insurance companies, are in compliance with all applicable laws, regulations and written policies of such third party payors and the Medicare, Medicaid and CHAMPUS/TRICARE programs. Except as set forth on Schedule 4.8 or otherwise disclosed to Buyer in a writing referencing this Section 4.8 on the date hereof, none of: (i) the Sellers or the Seller Facilities; or (ii) the Joint Ventures or the Joint Venture Facilities has billed or received any payment or reimbursement in excess of amounts allowed by law. None of the Seller Facilities or the Joint Venture Facilities has been excluded from participation in the Medicare, Medicaid or CHAMPUS/TRICARE programs, nor to the knowledge of Sellers is any such exclusion threatened. Each provider agreement to which a Seller or a Joint Venture is a party is in full force and effect, and no events or facts exist that would cause any such provider agreement not to remain in force or effect after the Closing. None of the officers, directors, employees, physicians or independent contractors of any of the Sellers or the Joint Ventures has been excluded from participating in any federal health care program during the past five (5) years, nor is any exclusion pending or, to the knowledge of Sellers, threatened. Except as set forth on Schedule 4.8, none of the Sellers or the Joint Ventures is aware of or has received any notice from any of the Medicare, Medicaid or CHAMPUS/TRICARE programs, or any other third party payor program, of any pending or threatened investigations or surveys.

4.9 Regulatory Compliance. Except as set forth on Schedule 4.9 or otherwise disclosed to Buyer in a writing referencing this Section 4.9 on the date hereof, all of the Sellers' and the Joint Ventures' contracts with physicians or other healthcare providers or entities in which physicians or other healthcare providers are equity owners (collectively, "**Healthcare Providers**") involving services, supplies, payments or any other type of remuneration, whether such services or supplies are provided by a Healthcare Provider to a Seller or a Joint Venture or

provided by a Seller or a Joint Venture to a Healthcare Provider, and all of the Sellers' and the Joint Ventures' leases of personal or real property with Healthcare Providers, whether such personal or real property is leased by a Healthcare Provider to a Seller or a Joint Venture, or leased by a Seller or a Joint Venture to a Healthcare Provider, are in writing, are signed, set forth the services to be provided, and provide for a fair market value compensation in exchange for such services, space or goods. Except as set forth on Schedule 4.9 or otherwise disclosed to Buyer in a writing referencing this Section 4.9 on the date hereof, each of the Seller Facilities, the Business, the Assets, the Joint Ventures and the Joint Venture Facilities has been and presently is in material compliance with all applicable statutes, rules, regulations, ordinances and requirements of all federal, state and local commissions, boards, bureaus, and agencies having jurisdiction over the Seller Facilities, the Joint Venture Facilities, and the Assets, including but not limited to the false claims, false representations, anti-kickback and all other provisions of the Medicare/Medicaid fraud and abuse laws (42 U.S.C. Section 1320a-7 *et seq.*) and the physician self-referral provisions of the Stark Law (42 U.S.C. Section 1395nn). Each of the Sellers and the Joint Ventures and has timely filed all material reports, data, and other information required by law to be filed with such commissions, boards, bureaus, and agencies regarding the Business, the Assets and the Joint Venture Facilities. None of: (i) the Sellers, the Seller Facilities or any of their respective officers, directors, or managing employees; or (ii) the Joint Ventures, the Joint Venture Facilities or any of their respective officers, directors, or managing employees has engaged in any activities that are prohibited under 42 U.S.C. Section 1320a-7 *et seq.*, or the regulations promulgated thereunder, or under any other federal or state statutes or regulations (including laws pertaining to "patient dumping"), or which are prohibited by applicable rules of professional conduct, including but not limited to the following:

(a) knowingly and willfully making or causing to be made a false statement or representation of a material fact in any application for any benefit or payment;

(b) knowingly and willfully making or causing to be made a false statement or representation of a material fact for use in determining rights to any benefit or payment;

(c) presenting or causing to be presented a claim for reimbursement for services under Medicare, Medicaid or other state or federal healthcare program that is for an item or service that is known, or should be known, to be: (i) not provided as claimed; or (ii) false or fraudulent;

(d) failing to disclose knowledge by a claimant of the occurrence of any event affecting the initial or continued right to any benefit or payment on its own behalf or on behalf of another, with intent to fraudulently secure such benefit or payment;

(e) knowingly and willfully offering, paying, soliciting or receiving any remuneration (including any kickback, bribe or rebate, but excluding any legally permissible copayment or other payment), directly or indirectly, overtly or covertly, in cash or in kind: (i) in return for referring an individual to a person for the furnishing, or arranging for the furnishing, of any item or service for which payment may be made in whole or in part by Medicare, Medicaid, or a state healthcare program; or (ii) in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any good, facility, service or item for which payment may be made in whole or in part by Medicare, Medicaid or a state healthcare program;

(f) knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit necessary services to individuals who are under the direct care of the physician and who are entitled to benefits under Medicare, Medicaid or a state healthcare program, in a manner that would violate applicable law;

(g) knowingly or willfully making or causing to be made or inducing or seeking to induce the making of any false statement or representation (or omitting to state a material fact) required to be stated therein (or necessary to make the statement contained therein not misleading) of a material fact with respect to: (i) the conditions or operations of a Seller Facility or Joint Venture Facility in order that such Seller Facility or Joint Venture Facility may qualify for Medicare, Medicaid, or a state healthcare program certification; or (ii) information required to be provided under Section 1124A of the Social Security Act (42 U.S.C. Section 1320a-3a); or

(h) knowingly and willfully: (i) charging for any Medicaid service money or other consideration at a rate in excess of the rates established by the state; or (ii) charging, soliciting, accepting or receiving, in addition to amounts paid by Medicaid, any gift money, donation or other consideration (other than a charitable, religious, or other philanthropic contribution from an organization or from a person unrelated to the patient) (A) as a precondition of admitting the patient; or (B) as a requirement for the patient's continued stay in a Seller Facility in a manner that violates applicable law.

Each of the Sellers, the Seller Facilities and the Joint Ventures is in material compliance with the administrative simplification provisions required under HIPAA.

4.10 Equipment. Set forth on Schedule 4.10 is a depreciation schedule that lists all Assets having a positive book value as of the Balance Sheet Date. Subject to Section 4.12(b), and except for the items set forth on Exhibit O-1, Exhibit O-2 and Exhibit O-3, all of the Assets consisting of equipment, whether reflected in the Seller Financial Statements or otherwise, are in good operating condition and repair, reasonable wear and tear excepted and except for items that have been written down in the Seller Financial Statements to a realizable market value. Except as disclosed on Schedule 4.10, the only transactions related thereto since the Balance Sheet Date have been additions thereto and dispositions thereof in the ordinary course of business.

4.11 Real Property. The Sellers own good, clear, insurable and marketable fee title to the Owned Real Property, together with all appurtenances and rights thereto, and good, clear insured leasehold title to the Leased Real Property, which ownership interests, as of the Closing Date, will be free and clear of any and all mortgages, deeds of trust, security interests, mechanics or other liens or encumbrances, subject only to those more particularly described on Schedule 4.11 (the "**Permitted Encumbrances**"). Except as set forth on Schedule 4.11 or otherwise disclosed to Buyer in a writing referencing this Section 4.11 on the date hereof, all improvements, including all utilities which are a part of the Real Property, have been substantially completed and installed in accordance with any required permits issued by the governmental entities having jurisdiction thereover to the extent required by law and to the extent applicable and transferable to Buyer. All licenses, permits, Certificates of Need (if applicable), permanent certificates of occupancy, authorizations and approvals required by all governmental entities having jurisdiction thereover, and the requisite certificates of the local

board of fire underwriters (or other body exercising similar functions), have been issued for the Real Property, and, as of the Closing, all of the same will be in full force and effect. Subject to Section 4.12(b), to the knowledge of Sellers, the improvements which are a part of the Owned Real Property, as designed and constructed, comply with all statutes, restrictions, regulations and ordinances applicable thereto, including but not limited to the ADA and Section 504 of the Rehabilitation Act of 1973. Subject to Section 4.12(b), the existing water, sewer, gas and electricity lines, storm sewer and other utility systems on the Real Property are, to the knowledge of Sellers, adequate to serve the utility needs of the Real Property as of the Closing Date, and all approvals, licenses and permits required for said utilities have been obtained and are, and will be as of the Closing, in full force and effect. All of said utilities are installed and operating, and all installation and connection charges have been paid in full. Subject to Section 4.12(b), the location, construction, occupancy, operation and use of the Real Property (including the improvements which are a part of the Real Property) do not violate any applicable law, statute, ordinance, rule, regulation, order or determination of any governmental authority or any board of fire underwriters (or other body exercising similar functions), judicial precedent or any restrictive covenant or deed restriction (recorded or otherwise) affecting the Real Property or the location, construction, occupancy, operation or use thereof, including, without limitation, all applicable laws. The Real Property comprises all of the real property currently used in connection with the Business or the Assets being acquired by Buyer. Subject to Section 4.12(b), with respect to the Real Property and any real property owned or leased by the Joint Ventures:

(a) except as described on Schedule 4.11(a), no Seller or Joint Venture has received during the past two (2) years notice of a violation of any applicable ordinance or other law, order, regulation, or requirement or notice of condemnation, lien, assessment, or the like relating to any part of such properties or the operation thereof, and has no knowledge of any such violation, proceeding, lien or assessment;

(b) except as described on Schedule 4.11(b), such properties and their operation are in compliance with all applicable zoning ordinances, and the consummation of the transactions contemplated herein will not result in a violation of any applicable zoning ordinance or the termination of any applicable zoning variance now existing;

(c) except for the Permitted Encumbrances, such properties are subject to no easements, restrictions, encumbrances, or such other limitations on title so as to make any such property unusable for its current use or the title uninsurable or unmarketable or which restrict or impair its use, marketability or insurability;

(d) except as described on Schedule 4.11(d), there is no pending or, to the knowledge of the Sellers, threatened litigation, administrative action or complaint (whether from a state, federal or local government or from any other person, group or entity) relating to the Real Property, including compliance of any of such properties with the Rehabilitation Act of 1973, Title III of the ADA or any comparable state statute related to accessibility;

(e) with respect to the Owned Real Property, the Leased Real Property and the Joint Venture Facilities, there are no tenants or other persons or entities occupying any space in such properties other than pursuant to the Tenant Leases described in Schedule 2.1(j) or as set forth on Schedule 4.11(e);

(f) attached as Schedule 4.11(f) is a "rent roll" for all Tenant Leases that sets forth: (i) the premises covered; (ii) the date of the Tenant Lease and all amendments and modifications thereto; (iii) the name of the tenant, licensee or occupant; (iv) the term; (v) the rents and other charges payable thereunder; (vi) any charges in arrears or prepaid thereunder, if any; (vii) any security deposit held by the landlord; and (viii) options to renew held by tenant;

(g) except as described on Schedule 4.11(g), no Seller or Joint Venture has received any written notice, and has no knowledge, of any existing, proposed or contemplated plans to modify or realign any street or highway or any existing, proposed or contemplated eminent domain proceeding that would result in the taking of all or any part of such properties or that would adversely affect the current use of any part thereof;

(h) except as described on Schedule 4.11(h), the existing improvements located upon such properties do not, with respect to the Seller Facilities and the Joint Venture Facilities, encroach upon adjacent premises or upon existing utility company easements;

(i) except as described on Schedule 4.11(i), to the knowledge of the Sellers, no party owns or holds any right of first refusal to purchase or lease or an option to purchase or lease all or any portion of the Real Property or property owned or leased by a Joint Venture;

(j) except as set forth in Schedule 4.11(j), there will be no incomplete construction projects affecting the Real Property as of the Closing Date. Schedule 4.18 includes all design service contracts, engineering services contracts, construction contracts and construction management contracts relating to those construction projects that will be incomplete as of the Closing Date;

(k) all Existing Tenant Improvement Obligations will have been fully performed and funded by each of the Sellers on or before the Closing Date;

(l) no Seller is a person or entity with whom U.S. persons are restricted from doing business with under regulations of the OFAC of the Department of Treasury (including those named on the OFAC's Specially Designated and Blocked Persons list) or under any statute, executive order (including Executive Order 13224), or the USA Patriot Act, or any other governmental action;

(m) no subdivision shall be required for the lawful conveyance of the Owned Real Property to Buyer; and

(n) no brokerage or leasing commissions or other compensation will be due or payable as of Closing to any person, firm, corporation or other entity with respect to, or on account of, any Tenant Lease, any Seller Lease or any extensions or renewals thereof.

4.12 Title to and Condition of the Assets.

(a) As of the Closing Date, the Sellers shall own and hold good and valid title to all of the Assets, subject only to the Permitted Encumbrances and Assumed Liabilities. Except as otherwise set forth on Schedule 4.12(a) and as set forth in Section 4.12(b), in respect of their physical condition and defects, the Real Property and all machinery and equipment used

in the operation of the Business are in good operating condition and repair, reasonable wear and tear excepted, and suitable for the purpose for which they are intended. Except as set forth on Schedule 4.12(a) and as set forth in Section 4.12(b), there are no material defects, structural or other, in any of the Assets, including, without limitation, the Real Property and the implements, machinery and equipment used in the Business.

(b) Notwithstanding anything herein to the contrary, Sellers make no representation, warranty or covenant as to: (i) the physical condition of the Alta Vista Site; (ii) compliance with laws, including the Environmental Laws, or the presence of Materials of Concern, at, in or upon the Alta Vista Site; or (iii) the presence of asbestos or asbestos-containing materials and compliance with applicable laws related thereto in, on or at the Real Property, the Seller Facilities, the Joint Venture Facilities or other improvements located on the Real Property.

4.13 Employee Benefit Plans.

(a) Schedule 4.13(a) includes a true, complete and correct list of all "employee benefit plans," as defined in Section 3(3) of ERISA, all specified fringe benefit plans as defined in Section 6039D of the IRC, and all other pension, profit-sharing, stock bonus, stock option, deferred compensation, or other retirement plans, including any IRC Section 403(b) or Section 457 plans; welfare benefit plans, including group health and group insurance plans; cafeteria, flexible benefit or tuition assistance plans; executive compensation, bonus, or incentive plans; severance plans; salary continuation plans, programs, or arrangements; vacation, holiday, sick-leave, paid-time-off, or other employee compensation, bonus, or incentive plans, procedures, programs, payroll practices, policies, agreements, commitments, contracts, or understandings; or any annuity contracts, custodial agreements, trusts or other agreements related to any of the foregoing (collectively, the "**Benefit Plans**"), whether qualified or nonqualified, funded or unfunded: (i) that are currently, or have been within the past six (6) years, sponsored, maintained or contributed to by any of the Sellers or any ERISA Affiliate; (ii) with respect to which any of the Sellers or any ERISA Affiliate has any liability or obligation to any current or former officer, employee or service provider, or the dependents of any thereof; or (iii) which could result in the imposition of liability or any obligation of any kind or nature, whether accrued, absolute, contingent, direct, indirect, perfected or inchoate or otherwise, and whether or not now due or to become due to any of the Sellers or any ERISA Affiliate. None of the Sellers or any ERISA Affiliate has ever been required to pay premiums to the Pension Benefit Guaranty Corporation.

(b) Sellers have made available to Buyer accurate and complete copies of the Benefit Plans; insurance contracts or any other funding instruments; governmental rulings; determination, advisory, notification, or opinion letters; actuarial reports for each of the past three (3) years; contracts with third party administrators and other independent contractors; summary plan descriptions, modifications, memoranda and employee handbooks. All returns, reports, disclosure statements, and premium payments have been or will be timely filed, delivered, or paid as required by applicable law.

(c) None of the Sellers or any ERISA Affiliate has ever participated in or sponsored, contributed to, or had an obligation to contribute to a plan subject to Section 412 of

the IRC, Section 302 of ERISA and/or Title IV of ERISA, multiemployer plan, multiple employer plan, or single employer plan to which at least two or more of the contributing sponsors are not part of the same controlled group; participated in any benefit plan that is a multiple employer welfare arrangement; had asserted against it any claim for any excise tax, interest, or penalty; or committed a breach of any responsibilities or obligations imposed upon fiduciaries by law. There have been no prohibited transactions with respect to any Benefit Plan.

(d) Each Benefit Plan that is a pension or other retirement plan (other than those nonqualified deferred compensation plans and plans established under Sections 403(b) or 457 of the IRC that are disclosed on Schedule 4.13(a)) and each related trust agreement, annuity contract, or other funding instrument is qualified and tax-exempt under the provisions of Sections 401(a) and 501(a) of the IRC, respectively; each Benefit Plan that is a plan established under Section 403(b) of the IRC and each related trust agreement, annuity contract, custodial account or other funding instrument is in compliance with the requirements of Section 403(b) of the IRC; each Benefit Plan that is a plan established under Section 457 of the IRC and each related trust agreement, annuity contract or other funding instrument is in compliance with the requirements of Section 457 of the IRC; each Benefit Plan that is a nonqualified deferred compensation plan and each related trust agreement, insurance contract, or other funding instrument is in compliance with the requirements of Section 409A of the IRC; no Benefit Plan has any unfunded accrued liability; no Benefit Plan has experienced any reportable events; no Benefit Plan presently has any accumulated funding deficiencies or liquidity shortfalls; no Benefit Plan has any liabilities required by law to be disclosed that have not been disclosed; no Benefit Plan has been partially or fully terminated; and no governmental entity has instituted or threatened a proceeding to terminate any Benefit Plan or to appoint a new trustee for such Benefit Plan. Except as set forth on Schedule 4.13(d), all Benefit Plans are operated and administered in accordance with their terms and all applicable laws, including ERISA and the IRC. Each of the Sellers and each of the ERISA Affiliates have paid in full all amounts that are required under the terms of each Benefit Plan to have been paid.

(e) No Benefit Plan is currently or has been within the last six (6) years under audit, inquiry, or investigation by any governmental entity, and there are no Benefit Plan matters pending before any governmental agency. Other than routine claims for benefits, there are no actions, mediations, audits, arbitrations, suits, claims, or investigations pending or threatened against or with respect to any of the Benefit Plans or their assets, and there are no pending or, to the Sellers' knowledge, threatened claims by or on behalf of the Benefit Plans or by any employee of the Sellers alleging a breach of fiduciary duties or violations of law nor, to the Sellers' knowledge, is there any basis for such claims.

(f) Except as set forth on Schedule 4.13(f), each of the Sellers and each of the ERISA Affiliates is in material compliance with the continuation coverage provisions of COBRA, the Public Health Service Act and similar state laws, as applicable, with respect to all current and former employees and their beneficiaries. Except as set forth on Schedule 4.13(f), no Benefit Plans provide for, and no written or oral agreements have been entered into promising or guaranteeing the continuation of, medical, dental, vision, life or disability insurance coverage for any current or former employees of any of the Sellers or any ERISA Affiliate, their spouses, or their dependents or beneficiaries for any period of time beyond termination of employment (except to the extent of coverage required under COBRA or the Public Health Service Act).

Schedule 4.13(f) lists all individuals who are currently receiving or are eligible to elect continuation coverage under the Benefit Plans.

(g) Except as set forth on Schedule 4.13(g), the consummation of the transactions contemplated by this Agreement will not accelerate the time of vesting, or payment, or increase the amount, of compensation payable to any current or former employee. No Benefit Plan or other contract or arrangement provides for payments that would be triggered by the consummation of the transactions contemplated by this Agreement that would subject any person to excise tax under Section 4999 of the IRC.

4.14 Litigation or Proceedings. Except as set forth on Schedule 4.14, there are no claims, actions, suits, proceedings, investigations, judgments, decrees, orders, writs or injunctions pending or, to the knowledge of the Sellers, threatened against or related to any of the Sellers, the Business, the Assets, any of the Joint Ventures or any of the Joint Venture Facilities, at law or in equity, or before or by any governmental entity. None of the Sellers or the Joint Ventures is in default under any judgment, decree, order, writ or injunction of any court or governmental entity.

4.15 Hill-Burton and Other Liens. None of the Sellers or the Joint Ventures has received any loans, grants or loan guarantees pursuant to the Hill-Burton Act program, the Health Professions Educational Assistance Act, the Nurse Training Act, the National Health Planning and Resources Development Act or the Community Mental Health Centers Act, as amended, or similar laws or acts relating to healthcare facilities that remain unpaid or which impose restrictions on the operation of the Facilities or the Assets.

4.16 Taxes.

(a) Each of ORHC and RRL: (i) is an organization described in Section 501(c)(3) of the IRC and is exempt from taxation to the extent described in Section 501(a) of the IRC; (ii) is not a private foundation within the meaning of Section 509(a) of the IRC; and (iii) has received a determination letter from the Internal Revenue Service to such effect, which determination letter has not been revoked or otherwise modified. Each of ORHC and RRL is in material compliance with all applicable federal and state laws, regulations, rulings and orders pertaining to the operation of an organization described in Section 501(c)(3) of the IRC, including, without limitation, requirements as to private benefit, inurement, self-dealing, conflicts of interest and other applicable requirements. Neither ORHC nor RRL has entered into any transaction which has constituted or may constitute an "excess benefit transaction" within the meaning of Section 4958 of the IRC and the Treasury Regulations thereunder. Except as provided on Schedule 4.16(a), the Leased Real Property, the Owned Real Property, the Seller Facilities and the Assets are, and shall be through the Closing Date, exempt from all real and personal property taxes and there are no municipal assessments, for betterments or otherwise, on, related to or, to the knowledge of the Sellers, under consideration for, either the Leased Real Property or Owned Real Property.

(b) Each of the Sellers and the Joint Ventures has filed all Tax Returns required to be filed by it (all of which are true and correct in all material respects). All Taxes due and owing (whether or not shown on any Tax Return) by each of the Sellers and the Joint

Ventures have been paid. There are no liens for Taxes on any of the Assets, the Seller Facilities or the Joint Venture Facilities and, to the knowledge of the Sellers, no basis exists for the imposition of any such liens. None of the Sellers or the Joint Ventures has waived any statute of limitations in respect of Taxes or agreed to any extension of time with respect to a Tax assessment or deficiency. Except as set forth on Schedule 4.16(b)(i), none of the Sellers or the Joint Ventures is currently the beneficiary of any extension of time within which to file any Tax Return. Each of the Sellers and the Joint Ventures has withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, or other third party, and all Internal Revenue Service Forms W-2 and 1099 required with respect thereto have been properly completed and timely filed. There is no dispute or claim concerning any Tax liability of any of the Sellers or the Joint Ventures either: (i) claimed or raised by any governmental authority; or (ii) as to which the Sellers have knowledge. Except as provided on Schedule 4.16(b)(ii), none of the Assets constitutes an ownership interest in a joint venture, partnership or other arrangement or contract that could be treated as a partnership for federal income tax purposes. Each of the Joint Ventures has not elected, and will not elect prior to the Closing, to be treated as an association taxable as a corporation.

4.17 Employee Relations.

(a) Except as set forth on Schedule 4.17(a), all individuals who provide services at any of the Seller Facilities are employees of the Sellers. There has not been within the last three (3) years, and there is not presently pending or, to the knowledge of the Sellers, threatened, any strike, slowdown, picketing, work stoppage, or employee grievance process, or any proceeding against or affecting any of the Sellers or the Joint Ventures relating to an alleged violation of any legal requirements pertaining to labor relations, including any charge, complaint or unfair labor practices claim filed by an employee, union, or other person with the National Labor Relations Board or any governmental entity, organizational activity, or other labor dispute against or affecting any of the Sellers, the Joint Ventures or their operations or assets. With respect to the employees of the Seller Facilities, no collective bargaining agreement exists or is currently being negotiated by any of the Sellers; no application for certification of a collective bargaining agent is pending; no demand has been made for recognition by a labor organization; and, to the knowledge of the Sellers, no union representation question exists, no union organizing activities are taking place, and none of the employees of the Sellers are represented by any labor union or organization.

(b) Each of the Sellers has materially complied with all legal requirements relating to employment; employment practices; terms and conditions of employment; equal employment opportunity; nondiscrimination; immigration; wages; hours; benefits; payment of employment, social security, and similar taxes; occupational safety and health; and plant closing. Except as set forth on Schedule 4.17(b), there are no pending or, to the knowledge of the Sellers, threatened claims for failure to comply with any of the foregoing legal requirements.

(c) The Sellers have made available to Buyer the personnel records for all employees of the Sellers potentially affected by the transactions contemplated by this Agreement, including records reflecting salary or wages, and sick (or extended illness), paid-time-off, and vacation leave that is accrued or credited but unused or unpaid. Schedule 4.18 lists

each employment, consulting, independent contractor, bonus or severance agreement to which any of the Sellers is a party. Each of the Benefit Plans, Sellers and all ERISA Affiliates has properly classified individuals providing services to any of the Seller Parties as independent contractors or employees, as the case may be. Schedule 4.17(c) sets forth the employees who had an "employment loss," as such term is defined in the WARN Act or any similar state or local legal requirements, within the ninety (90) days preceding the Closing Date; in relation to the foregoing, the Sellers have not violated the WARN Act or any similar state or local legal requirements.

4.18 Agreements and Commitments. Schedule 4.18 sets forth an accurate list of all commitments, contracts, leases, and agreements, written or oral, relating to the Business or the Assets to which any Seller is a party or by which any of the Sellers or the Assets or any portion thereof is bound, including: (a) physician agreements; (b) agreements with health maintenance organizations, preferred provider organizations or other alternative delivery systems; (c) joint venture or partnership agreements; (d) employment contracts or any other contracts, agreements, or commitments to or with individual employees or agents; (e) contracts or commitments affecting ownership of, title to, use of or any interest in the Real Property, including any Tenant Leases; (f) equipment leases; (g) equipment maintenance agreements; (h) agreements with municipalities or quasi-governmental agencies or entities; (i) collective bargaining agreements or other contracts or commitments to or with any labor unions, labor organizations or other employee representatives or groups of employees; (j) loan agreements, bonds, mortgages, liens or other security agreements; (k) patent licensing agreements or any other agreements, licenses or commitments with respect to patents, patent applications, trademarks, trade names, service marks, technical assistance, copyrights, or other intellectual property affecting the Facilities or the Assets; (l) agreements, licenses or commitments relating to data processing programs, software, or source codes utilized in connection with the Business or the Assets; (m) all agreements with residents of the facilities operated by RRL; or (n) any other contracts or commitments not identified in (a)-(m) above, whether in the ordinary course of business or not, which involve future payments, performance of services or delivery of goods or materials, to or by any of the Sellers in an amount exceeding Ten Thousand Dollars ($10,000) on an annual basis.

4.19 The Assumed Contracts, Tenant Leases and Seller Leases. Schedule 2.1(j) sets forth an accurate list of the Tenant Leases. Schedule 2.1(b)(ii) sets forth an accurate list of the Seller Leases. The Sellers have made available to Buyer accurate copies of the Assumed Contracts, the Tenant Leases and the Seller Leases. Schedule 2.3(e) sets forth a complete and accurate list of each RRL resident and their deposit pursuant to the residency agreement between RRL and such residents. The Sellers represent and warrant with respect to the Assumed Contracts, the Tenant Leases and the Seller Leases that:

(a) the Assumed Contracts, the Tenant Leases and the Seller Leases constitute valid and legally binding obligations of one or more of the Sellers and are enforceable against such Sellers in accordance with their respective terms, and, to the knowledge of the Sellers, the Assumed Contracts, the Tenant Leases and the Seller Leases constitute valid and legally binding obligations of the other party or parties to the Assumed Contracts, the Tenant Leases and the Seller Leases and are enforceable against such parties in accordance with their terms;

(b) each Assumed Contract, Tenant Lease or Seller Lease constitutes the entire agreement by and between the respective parties thereto, with respect to the subject matter thereof;

(c) all obligations required to be performed by one or more of the Sellers under the terms of the Assumed Contracts, the Tenant Leases and the Seller Leases have been performed in all material respects, and no Seller has received notice that any act or omission by any such Seller has occurred or failed to occur which, with the giving of notice, the lapse of time or both, would constitute a default under any such Assumed Contract, Tenant Lease or Seller Lease, and each of such Assumed Contracts, Tenant Leases and Seller Leases is now and at the Closing Date will be in full force and effect without default on the part of any of the Sellers;

(d) except as expressly set forth on Schedule 4.18, none of the Assumed Contracts, the Tenant Leases or the Seller Leases requires consent to its assignment to and assumption by Buyer, and the Sellers will use commercially reasonable efforts to obtain any required consents prior to the Closing Date; and

(e) except as expressly set forth on Schedule 4.18, the assignment of the Assumed Contracts, the Tenant Leases and the Seller Leases to and the assumption of such Assumed Contracts, Tenant Leases and Seller Leases by Buyer will not result in any penalty or premium, or variation of the rights, remedies, benefits or obligations of any party thereunder.

4.20 Supplies. Except as set forth in Section 4.12(b), all the inventory and supplies constituting any part of the Assets are of a quality and quantity usable in the ordinary course of business of the Business, consistent with Sellers' historic practices.

4.21 Insurance. Schedule 4.21 sets forth an accurate schedule disclosing the insurance policies covering the Business and the Assets, which Schedule reflects the policies' numbers, identity of insurers, amounts, and coverage. All of such insurance policies are in full force and effect with no premium arrearage. Each of the Sellers has given in a timely manner to its respective insurers all notices required to be given under such insurance policies with respect to all of the claims and actions covered by insurance, and no insurer has denied coverage of any such claims or actions. Except as set forth on Schedule 4.21, none of the Sellers have: (a) received any written notice or other communication from any such insurance company canceling or materially amending any of such insurance policies and, to the knowledge of the Sellers, no such cancellation or amendment is threatened; or (b) failed to give any required notice or to present any claim which is still outstanding under any of such policies with respect to the Business or any of the Assets.

4.22 Third Party Payor Cost Reports. The Hospital has duly filed all required Cost Reports for all fiscal years through and including the fiscal year ended March 31, 2009. All of such Cost Reports accurately reflect the information required to be included thereon and such Cost Reports do not claim, and none of the Seller Facilities or the Sellers has received, reimbursement in any amount in excess of the amounts provided by law or any applicable agreement. Schedule 4.22 indicates which of such Cost Reports have not been audited and finally settled and a brief description of any and all notices of program reimbursement, proposed or pending audit adjustments, disallowances, appeals of disallowances and any and all other

unresolved claims or known disputes in respect of such cost reports. The Hospital has established adequate reserves to cover any potential reimbursement obligations that the Hospital may have in respect of any such Cost Reports, and such reserves are accurately set forth in the Financial Statements.

4.23 Medical Staff Matters. The Sellers have made available to Buyer true, correct and complete copies of the Hospital's bylaws and rules and regulations of the Hospital's medical staff, as well as a list of all current members of the Hospital's medical staff. Except as set forth on Schedule 4.23 or otherwise disclosed to Buyer in a writing referencing this Section 4.23 on the date hereof, there are no adverse actions with respect to any medical staff member of the Seller Facilities or the Joint Venture Facilities, or any applicant thereto, for which a medical staff member or applicant has requested a judicial review hearing that has not been scheduled or has been scheduled but has not been completed, and there are no pending or, to the knowledge of the Sellers, threatened disputes with applicants, staff members or health professional affiliates, and all appeal periods in respect of any adverse actions against any medical staff member or applicant have expired. Schedule 4.23 sets forth a brief description of all adverse actions taken against medical staff members or applicants during the past three (3) years that, to Sellers' knowledge, could result in claims or actions against any of the Sellers and which are not disclosed in the minutes of the meetings of the Medical Executive Committee of the medical staff of the Seller Facilities, which minutes have been made available to Buyer.

4.24 Accounts Receivable. All accounts receivable constituting a part of the Assets represent and constitute bona fide claims owing to the Sellers for services actually performed or for goods or supplies actually provided in the amounts indicated in the Net Working Capital with no known set-offs, deductions, compromises, or reductions (other than reasonable allowances for bad debts and contractual allowances in an amount consistent with historical policies and procedures of the Sellers and which are taken into consideration in the preparation of the Financial Statements). The Sellers have made available to Buyer a complete and accurate aging report of all such accounts receivable, a copy of its policy regarding write-offs of receivables and a schedule of all accounts receivable, whether recorded or unrecorded, which have been assigned to collection agencies or are otherwise held or assigned for collection.

4.25 Experimental Procedures. During the past five (5) years, neither the Seller Facilities nor the Joint Venture Facilities have performed or permitted the performance of any experimental or research procedure or study involving patients not authorized and conducted in accordance with the procedures of the Seller Facilities or the Joint Venture Facilities, as applicable.

4.26 Compliance Program. The Sellers have made available to Buyer a copy of the Seller Facilities' current compliance program materials and, if applicable, the compliance materials of the Joint Venture Facilities, including, without limitation, all program descriptions, compliance officer and committee descriptions, ethics and risk area policy materials, training and education materials, auditing and monitoring protocols, reporting mechanisms, and disciplinary policies. Except as set forth on Schedule 4.26, within the past three (3) years none of the Sellers or the Joint Ventures: (a) has been or is a party to an outstanding Corporate Integrity Agreement with the OIG of HHS; (b) has had or has reporting obligations pursuant to any settlement agreement entered into with any governmental entity; (c) to the knowledge of the Sellers, has

been or is the subject of any government payor program investigation conducted by any federal or state enforcement agency; or (d) has been or is a defendant in any *qui tam*/False Claims Act litigation and, to the knowledge of the Sellers, no such litigation has been or is threatened. For purposes of this Agreement, the term "**compliance program**" refers to provider programs of the type described in the compliance guidance published by the OIG of HHS.

4.27 Environmental Matters. Except as provided under Section 4.12(b), or as set forth on Schedule 4.27:

(a) The operations and properties of each of the Sellers and the Joint Ventures are and at all times have been in compliance with the Environmental Laws, which compliance includes but is not limited to the possession by the appropriate Seller or Joint Venture of all permits and governmental authorizations required under applicable Environmental Laws, and compliance with the terms and conditions thereof.

(b) None of the Sellers or the Joint Ventures has treated, stored, managed, disposed of, transported, handled, released or used any Material of Environmental Concern, except in the ordinary course of its business and in compliance with all Environmental Laws.

(c) There are no Environmental Claims pending or, to the knowledge of the Sellers, threatened against any of the Sellers or the Joint Ventures, and, to the knowledge of the Sellers, no circumstances exist that could reasonably be expected to lead to the assertion of an Environmental Claim against any Seller Party.

(d) There are no off-site locations (other than locations operated or managed by waste management providers with whom the Sellers or Joint Ventures contract) where any of the Sellers or the Joint Ventures has stored, disposed or arranged for the disposal of Materials of Environmental Concern, and none of the Sellers or the Joint Ventures has been notified in writing that such entity is a potentially responsible party at any such location under any Environmental Laws.

(e) None of the Sellers or the Joint Ventures has assumed or undertaken or otherwise become subject to any liability or corrective, investigatory or remedial obligation of any other person relating to any Environmental Law.

(f) (i) There are no underground storage tanks located on property owned, leased or operated by any of the Sellers or the Joint Ventures; and (ii) there are no polychlorinated biphenyls or polychlorinated biphenyls-containing items contained in or forming part of any building, building component, structure or office space owned, leased or operated by any of the Sellers or the Joint Ventures.

(g) No property used in the Sellers' or the Joint Ventures' operations is subject to an encumbrance imposed by or arising under any Environmental Law, and there is no proceeding pending or, to the knowledge of the Sellers, threatened for the imposition of such encumbrance, nor, to the knowledge of the Sellers, is there any basis for any such encumbrance or proceeding.

(h) The operations of each of the Sellers and the Joint Ventures are in compliance with laws concerning Medical Waste.

4.28 Intellectual Property Rights.

(a) Schedule 4.28(a) contains a true, complete and correct list of all intellectual property that is owned by the Sellers. Except as set forth in Schedule 4.28(a), all Owned Intellectual Property is owned by the Sellers free and clear of all liens, claims and encumbrances. At the Closing, the Sellers will transfer to Buyer good and valid title to the Owned Intellectual Property, free and clear of all liens, claims and encumbrances other than the Permitted Encumbrances. Except as described in Schedule 4.28(a), no Seller has granted any license to any person or entity relating to any of the Owned Intellectual Property.

(b) Schedule 4.28(b) contains a true, complete and correct list of all intellectual property (other than software available on reasonable terms in consumer retail stores) that is used by the Sellers and constitutes all intellectual property (other than the Owned Intellectual Property) used in connection with the operation of the Business.

(c) No Seller has received notice of any unresolved claim asserting a conflict with the rights of another person or entity in connection with the use by it of any of the intellectual property listed in Schedule 4.28(a) or 4.28(b).

(d) Except as set forth on Schedule 4.28(d), all patents, registered copyrights and registered trademarks that are a portion of the intellectual property of the Sellers and the Joint Ventures and applications with respect thereto: (i) have been duly maintained including without limitation the proper, sufficient and timely submission of all necessary filings and fees; (ii) have not lapsed, expired or been abandoned; and (iii) are not the subject of any opposition, interference, cancellation, or other proceeding before any governmental registration or other authority in any jurisdiction.

(e) None of the Sellers or the Joint Ventures has received any notice that infringement exists by it on the intellectual property rights of any other person or entity that results in any way from the Business, the Assets or the Joint Venture Facilities.

4.29 Absence of Undisclosed Liabilities. Except: (i) as and to the extent reflected or specifically reserved against (which reserves are believed adequate in amount) in the Seller Financial Statements or the Joint Venture Financial Statements; (ii) liabilities incurred in the ordinary course of business since the Balance Sheet Date; and (iii) as set forth on Schedule 4.29, neither the Sellers nor the Joint Ventures has, and is not subject to, any liability or obligation of any nature, whether accrued, absolute, contingent or otherwise, asserted or unasserted, known or unknown.

4.30 Disclosure. No representation or warranty by any of the Sellers contained in this Agreement, and no statement contained in any Schedule (including any supplement or amendment thereto) and the documents to be delivered at the Closing by or on behalf of any of the Sellers to Buyer or any of its representatives in connection with the transactions contemplated hereby, contains or will contain any untrue statement of material fact or omits or will omit to state a material fact necessary in order to make the statements and information

contained therein untrue. The Sellers have made available to Buyer true, correct and complete copies of all documents described on any Schedule hereto.

4.31 Brokers. Except as set forth on Schedule 4.31, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transactions contemplated by this Agreement based upon arrangements made by or on behalf of the Sellers.

4.32 The Sellers' Knowledge. When used herein, the phrases "**to the knowledge of the Sellers**," "**known**" and similar references to the knowledge of the Sellers shall mean and refer to all matters with respect to which: (a) any Seller has received a written notice; or (b) the actual knowledge of the representatives of the Sellers identified on Schedule 4.32, after inquiry of the individuals identified on Schedule 4.32.

ARTICLE V

REPRESENTATIONS AND WARRANTIES OF BUYER AND RCHP

Buyer and RCHP represent and warrant to the Sellers the following:

5.1 Existence and Capacity. Buyer is a Delaware corporation that is duly organized, validly existing and in good standing under the laws of the State of Delaware. Buyer has the requisite power and authority to enter into this Agreement, to perform its obligations hereunder and to conduct its business as now being conducted. RCHP is a Delaware corporation that is duly organized, validly existing and in good standing under the laws of the State of Delaware. RCHP has the requisite authority to enter into this Agreement, to perform its obligations hereunder, and to conduct its business as now conducted. Buyer is a wholly-owned subsidiary of RCHP.

5.2 Powers; Consents; Absence of Conflicts With Other Agreements, Etc. The execution, delivery, and performance of this Agreement by Buyer and RCHP and all other agreements referenced herein, or ancillary hereto, to which Buyer or RCHP is a party and the consummation of the transactions contemplated herein by Buyer or RCHP:

(a) are within its powers, are not in contravention of law or of the terms of its organizational documents and have been duly authorized by all appropriate action;

(b) except as set forth on Schedule 5.2(b), do not require any approval or consent of, or filing with, any governmental agency or authority bearing on the validity of this Agreement which is required by law or the regulations of any such agency or authority;

(c) will neither conflict with, nor result in any breach or contravention of, or the creation of any lien, charge or encumbrance under, any indenture, agreement, lease, instrument or understanding to which it is a party or by which it is bound;

(d) will not violate any statute, law, rule or regulation of any governmental authority to which it may be subject; and

(e) will not violate any judgment, decree, writ, or injunction of any court or governmental authority to which it may be subject.

5.3 Binding Agreement. This Agreement and all agreements to which Buyer or RCHP will become a party pursuant hereto are and will constitute the valid, legal and binding obligations of Buyer or RCHP, respectively, and are and will be enforceable against Buyer or RCHP, respectively, in accordance with the respective terms hereof and thereof.

5.4 Availability of Funds. Buyer has the ability to obtain funds in cash in amounts equal to the Purchase Price, and will at the Closing have immediately available funds in cash that are sufficient to pay the Purchase Price.

5.5 Legal Proceedings. There are no claims, actions, suits, proceedings, investigations, judgments, decrees, orders, writs or injunctions pending or, to the knowledge of Buyer or RCHP, threatened against or related to the Buyer or RCHP, respectively, at law or in equity, or before or by any governmental entity. Buyer is not in default under any judgment, decree, order, writ or injunction of any court or governmental entity.

5.6 Operations. As of the date hereof, Buyer was recently formed, has no operations, does not own any healthcare facilities and has not generated any revenue.

5.7 Disclosure. No representation or warranty by Buyer or RCHP contained in this Agreement, and no statement contained in any Schedule (including any supplement or amendment thereto) and none of the documents to be delivered at the Closing by or on behalf of Buyer or RCHP to any of the Sellers or any of their representatives in connection with the transactions contemplated hereby contain or will contain any untrue statement of material fact or omit to state a material fact necessary in order to make the statements and information contained therein untrue.

5.8 Brokers. Except as set forth on Schedule 5.8, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transactions contemplated by this Agreement based upon arrangements made by or on behalf of the Buyer or RCHP.

5.9 Liabilities.

(a) Buyer has only incurred routine operational liabilities for a recently formed entity and has no indebtedness or pending litigation, or contingent liabilities other than those related to this Agreement.

(b) RCHP has only incurred routine operational liabilities for recently a formed entity, and has no indebtedness or pending litigation, or contingent liabilities other than those set forth in this Agreement and in relation to its execution of a non-binding letter of intent to acquire two (2) hospitals in Alabama.

5.10 Buyer's Knowledge. When used herein, the phrases "**to the knowledge of Buyer**," "**known**" and similar references to the knowledge of Buyer shall mean and refer to all

matters with respect to which: (a) Buyer has received a written notice; or (b) the actual knowledge, after reasonable inquiry, of the representatives of Buyer set forth on Schedule 5.10.

ARTICLE VI

COVENANTS OF THE SELLERS PRIOR TO THE CLOSING

Between the date of this Agreement and the Closing Date:

6.1 Information. Each of the Sellers shall afford to the officers and authorized representatives and agents (which shall include accountants, attorneys, bankers, and other consultants) of Buyer reasonable access to, and the right to inspect the plants, properties, books, and records of, the Facilities and Assets at such times and in such manner as Buyer may from time to time reasonably request of the Sellers. In addition, each of the Sellers shall furnish Buyer with such additional financial and operating data and other information in respect of the Business and the Assets as Buyer may from time to time reasonably request without regard to where such information may be located. Buyer's right of access and inspection shall be exercised in such a manner as not to interfere unreasonably with the operations of the Facilities, and shall at all times be coordinated in advance through ORHC's Chief Financial Officer. Upon reasonable notice, each of the Sellers shall also make their officers and employees available to Buyer at reasonable times and places, as mutually agreed by the Sellers and Buyer, and provided that such requests are coordinated in advance through ORHC's Chief Financial Officer.

6.2 Operations. Each of the Sellers will:

(a) carry on the Business in substantially the same manner as presently conducted and not make any material change in personnel, operations, finance, charity care policies, accounting policies, or real or personal property affecting the Business or the Assets;

(b) maintain the Seller Facilities and the Assets and all parts thereof in their current operating condition, ordinary wear and tear excepted;

(c) perform, when required, all of its obligations under agreements relating to or affecting the Business or the Assets, including, without limitation, those incurred or entered into in connection with the current expansions and renovations relating to the Hospital (collectively, the "**Pending Hospital Construction**");

(d) keep in full force and effect present insurance policies or other comparable insurance pertaining to the Business or the Assets; and

(e) use its reasonable best efforts to maintain and preserve its business organizations intact, retain its present employees and maintain its relationships with physicians, suppliers, customers, and others having business relations with any of the Sellers.

6.3 Negative Covenants. None of the Sellers will, without the prior written consent of Buyer:

(a) amend, renew or terminate any of the Assumed Contracts, the Tenant Leases or the Seller Leases valued in excess of Twenty-five Thousand Dollars ($25,000) or enter into any new Tenant Leases or Seller Leases valued in excess of Twenty-five Thousand Dollars ($25,000);

(b) enter into any contract or commitment obligating any Seller or Seller Facility to purchase any supplies, assets or services in excess of Twenty Five Thousand Dollars ($25,000) or enter into any contract or arrangement with a referral source;

(c) increase compensation payable or to become payable or make or increase any bonus payment to or otherwise enter into one or more bonus agreements with any employee of any of the Sellers, except in the ordinary course of business in accordance with existing personnel policies and consistent with prior practice;

(d) institute, amend or increase the benefits, rights or obligations under any Benefit Plan, policy or arrangement other than as required by applicable law;

(e) create, assume or permit to exist any new debt, lease, mortgage, pledge or other lien or encumbrance upon any of the Assets, whether now owned or hereafter acquired;

(f) acquire (whether by purchase or lease) or sell, assign, lease or otherwise transfer or dispose of any personal property, plant, equipment or Real Property, except for: (i) the transfer of real property from the Existing Foundation to ORHC; and (ii) dispositions or retirement of equipment in the normal course of business with comparable replacement thereof;

(g) enter into a collective bargaining agreement;

(h) enter into negotiations with or recognize voluntarily a bargaining representative;

(i) take any action outside the ordinary course of business (apart from those actions contemplated by this Agreement), including but not limited to the disposition of any Assets;

(j) reduce inventory or supplies of the Seller Facilities, except in the ordinary course of business and consistent with prior practice; and

(k) materially modify the nature or the scope of the Pending Hospital Construction, where such material modification results in the submission of a change order or new agreement valued, in the aggregate, in excess of Twenty Five Thousand Dollars ($25,000).

6.4 Governmental Approvals; Third Party Consents. Each of the Sellers shall: (a) use commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow it to perform its obligations under this Agreement; and (b) assist and cooperate with Buyer and its representatives and counsel in obtaining all governmental consents, approvals and licenses that Buyer deems necessary or appropriate and in the preparation of any document or other material which may be required by any governmental agency as a predicate to or as a result of the transactions contemplated herein. Each of the

Sellers will use commercially reasonable efforts to obtain all consents of all third parties necessary or desirable for the purpose of: (y) consummating the transactions contemplated hereby; or (z) enabling Buyer to operate the Business and the Assets in the ordinary course after the Closing. Without limiting the generality of the foregoing, the Sellers shall obtain the consents to the assignment of the Assumed Contracts, the Tenant Leases and the Seller Leases designated as "**Required Consents**" on Schedule 4.18.

6.5 Additional Financial Information. Within two (2) business days after they are sent to the Board of Directors (but in any event no later than twenty (20) days following the end of each calendar month prior to the Closing Date), the Seller Parties shall deliver to Buyer true and complete copies of the unaudited balance sheets and the related unaudited statements of income (collectively, the "**Interim Statements**") of, or relating to, the Facilities for each month then-ended, together with a year to date compilation and the notes, if any, related thereto, which presentation shall be true, correct and complete in all material respects, shall have been prepared from and in accordance with the books and records of the Seller Parties and shall fairly present the financial position and results of operations of the Facilities as of the date and for the period indicated, all in accordance with GAAP consistently applied, except that such Interim Statements need not include required footnote disclosures.

6.6 No-Shop Clause. Each of the Sellers agrees that it shall not, and shall direct and cause its officers, directors, employees, agents and representatives (including any investment banker, broker, attorney or accountant retained by it) not to directly or indirectly: (a) offer for sale or lease all or any portion of the Assets or any ownership interest in any entity owning any of the Assets; (b) solicit offers to purchase all or any portion of the Assets or any ownership interest in any entity owning any of the Assets; (c) initiate, encourage or provide any documents or information to any third party in connection with, or discuss or negotiate with any person regarding any inquires, proposals or offers relating to, any disposition of all or any portion of the Assets or a merger or consolidation of any entity owning any of the Assets; or (d) enter into any agreement or discussions with any party (other than Buyer) with respect to the sale, assignment or other disposition of all or any portion of the Assets or any ownership interest in any entity owning any of the Assets or with respect to a merger or consolidation of any entity owning any of the Assets. Each Seller will promptly communicate to Buyer the substance of any inquiry or proposal concerning any such transaction, and will notify the third party of the existence of this covenant. Without limiting the foregoing, it is understood that any violation of the restrictions set forth in this Section 6.6 shall be deemed a material breach of this Agreement by the Sellers. Notwithstanding the foregoing, this Section 6.6 shall not apply to ORHC's acquisition of the CLS Interests or any attempt by ORHC prior to the Closing Date to acquire AMM Partnership's membership interests in SIROC.

6.7 Tail Insurance. For each general or professional liability policy that is written on a claims-made basis, the Sellers, at their sole cost and expense, shall obtain "tail" insurance to insure against professional and general liabilities of the Sellers, the Seller Facilities and/or the Assets relating to all periods ending on or prior to the Closing Date. Such tail insurance shall have coverage levels equal to the current general and professional liability policies insuring the Sellers, the Business and the Assets.

6.8 Capital Expenditures. The Sellers shall consult with Buyer with respect to the acquisition of a lithotripter and the development of a cardiac catheterization laboratory, and any capital expenditure that: (a) is not included in the Sellers' FY 2010 budget that has been previously provided to Buyer; or (b) is outside the ordinary course of business consistent with historical practices.

6.9 HSR Filing. Without limiting the generality or effect of Section 6.4, the Sellers shall, if and to the extent required by law, file promptly all reports or other documents required or requested by the Federal Trade Commission or the United States Department of Justice under the HSR Act and all regulations promulgated thereunder, concerning the transactions contemplated hereby, and comply promptly with any requests by the Federal Trade Commission or the United States Department of Justice for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably practicable after the execution and delivery of this Agreement. The Sellers shall furnish to Buyer such information as the other Party needs to perform its obligations under Section 7.2.

6.10 Tenant Estoppels. The Sellers shall deliver to Buyer at least five (5) business days prior to the Closing Date, to the extent reasonably obtainable, in a form substantially similar to that attached hereto as Exhibit I (the "**Tenant Estoppel**") or in such other form as may be prescribed in any relevant Tenant Lease, estoppel certificates for all Tenant Leases for tenant spaces containing more than 2,500 square feet of usable space, including the ground lease to Ottumwa Developments, Inc. (the "**Tenant Estoppel Threshold**"), pursuant to which each such tenant shall certify as of a date within fifteen (15) days of the Closing Date all of the matters set forth on the Tenant Estoppel or on the form prescribed in the relevant Tenant Lease, as the case may be. If the Tenant Estoppel Threshold is not timely met, despite the Sellers' efforts to obtain the same, then Buyer shall have the right to waive the requirement of satisfaction of this condition precedent and proceed with the Closing.

6.11 Landlord Estoppels. The Sellers shall deliver to Buyer at least five (5) business days prior to the Closing Date, to the extent reasonably obtainable, in a form substantially similar that to attached hereto as Exhibit J (the "**Landlord Estoppel**") or in such other form as may be prescribed in any relevant Seller Lease, landlord estoppel certificates for all Seller Leases for tenant spaces containing more than 3,000 usable space (the "**Landlord Estoppel Threshold**") pursuant to which each such landlord shall certify as of a date within fifteen (15) days of the Closing Date all of the matters set forth on the Landlord Estoppel. If the Landlord Estoppel Threshold is not timely met, despite the Sellers' efforts to obtain the same, then Buyer shall have the right to waive the requirement of satisfaction of this condition precedent and proceed with the Closing..

6.12 Reserved.

6.13 Title Insurance and Survey. The Sellers shall satisfy or give Buyer notice of their intent not to satisfy the conditions set forth in Section 7.4 relating to the Title Objections.

6.14 Lockbox Accounts. As of the Closing Date, the Sellers shall transfer to, and otherwise vest in, Buyer the exclusive right to receive the funds swept from the Sellers' lockbox

accounts or other depository accounts (excluding those funds that are Excluded Assets hereunder) for the purpose of receiving funds in an amount equal to the Government Receivables, and shall instruct the bank which maintains such lockbox accounts or other depository accounts to transfer automatically each business day all available funds held in the such lockbox accounts or other depository accounts to an account designated by Buyer. If the Sellers come into possession or control of any payments with respect to any Government Receivables, they shall deposit such payments into the lockbox accounts or other depository accounts. The Parties acknowledge and agree that, following the Closing, Buyer or its designees shall have sole dominion and control over the lockbox accounts or other depository accounts, including, without limitation, the exclusive right to revoke any instructions given to the bank that maintains the lockbox accounts or other depository accounts and the exclusive right to cancel or change the automatic transfer instructions related to the lockbox accounts or other depository accounts.

6.15 Discharge of Indebtedness. At or before the Closing, the Sellers shall discharge or defease all of their indebtedness, their capital lease obligations, their unfunded pension liabilities and any other indebtedness secured by any of the Assets or to which any of the Assets may be subject, including intercompany obligations. The Sellers hereby agree to provide for the redemption or defeasance of all of the Bonds at the Closing by directing Buyer to pay the Bond Trustee a portion of the Purchase Price equal to the bond payoff amount. The Sellers shall promptly provide Buyer with copies of all redemption notices, escrow agreement or similar documents executed by the Sellers prior to or following the Closing with respect to the redemption and/or defeasance of the Bonds.

6.16 Insurance Rating. Each of the Sellers shall cooperate with Buyer's efforts to succeed to its Workmen's Compensation and Unemployment Insurance ratings, property, automobile or any other insurance policies, deposits and other interests with respect to the operation of the Business and other ratings for insurance or other purposes established by such Seller. Buyer shall not be obligated to succeed to any such rating, insurance policy, deposit or other interest, except as it may elect to do so.

6.17 Reasonable Efforts to Close. Each Seller shall use reasonable commercial efforts to proceed toward the Closing and to cause Buyer's conditions to the Closing to be met as soon as practicable and consistent with the other terms contained herein. Each Seller shall notify Buyer as soon as practicable of any event or matter that comes to such Seller's attention that may reasonably be expected to prevent the conditions of such Seller's obligations being met.

6.18 Notice; Efforts to Remedy. Each Seller shall promptly give notice to Buyer upon becoming aware of the impending occurrence of any event that would cause or constitute a breach of any of the representations, warranties or covenants contained or referred to in this Agreement or cause, or be likely to cause, a Material Adverse Effect and shall use its commercially reasonable efforts to prevent or promptly remedy the same.

ARTICLE VII

COVENANTS OF BUYER PRIOR TO THE CLOSING

7.1 Governmental Approvals; Third Party Consents. Between the date of this Agreement and the Closing Date, Buyer shall: (a) use commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow Buyer to perform its obligations under this Agreement; (b) assist and cooperate with the Sellers and their representatives and counsel in obtaining all governmental consents, approvals and licenses that the Sellers deem necessary or appropriate and in the preparation of any document or other material that may be required by any governmental agency as a predicate to or as a result of the transactions contemplated herein; and (c) obtain the Commitments and the Surveys described in Section 7.4. Buyer will use commercially reasonable efforts to obtain all consents of all third parties necessary or desirable for the purpose of: (i) consummating the transactions contemplated hereby; or (ii) enabling Buyer to operate the Seller Facilities and the Assets in the ordinary course after the Closing.

7.2 HSR Filing. Without limiting the generality or effect of Section 7.1, Buyer shall, if and to the extent required by law, file promptly all reports or other documents required or requested by the Federal Trade Commission or the United States Department of Justice under the HSR Act and all regulations promulgated thereunder, concerning the transactions contemplated hereby, and comply promptly with any requests by the Federal Trade Commission or the United States Department of Justice for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably practicable after the execution and delivery of this Agreement. Buyer shall furnish to the Sellers such information as the other Party needs to perform its obligations under Section 6.9.

7.3 Promissory Note. At the Closing, Buyer shall evidence its ability to fund the Capital Projects, the physician recruiting obligations set forth in Section 10.8(a) and the information technology commitment set forth in Section 10.14 by delivering to the Sellers the Note, which shall be secured by a first mortgage lien on the Real Property, a pledge of the equity interests of Buyer and a first priority security interest in all other assets of Buyer (including, but not limited to, all accounts receivable, general intangibles, inventory and equipment of Buyer).

7.4 Title Insurance and Survey. Not later than twenty (20) days after the date of this Agreement, Buyer shall receive commitments (the "**Commitments**") from Chicago Title Insurance Company (the "**Title Company**") to issue as of the Closing Date an ALTA owner's policy of title insurance (Form 2006), with extended coverage and zoning endorsements and such other endorsements as Buyer shall reasonably require, for the Owned Real Property and for the Leased Real Property (which policies with respect to the Leased Real Property shall be leasehold title policies), together with improvements, buildings and fixtures thereon, in amounts equal to the reasonable value assigned to such Real Property by Buyer and in the customary form prescribed for use in the State of Iowa. Buyer shall order the Commitments through Fidelity National Title Group's National Commercial Services office located at 7130 Glen Forest Drive, Suite 403, Richmond, Virginia 23226, Attention: Melodie Rochelle, National Title Officer, and such National Commercial Services office shall be responsible for all underwriting decisions with respect to the policy or policies issued pursuant to the Commitments. The Commitments

shall provide for the issuance of such policy (or policies) to Buyer as of the Closing and shall insure fee simple title to the Owned Real Property and leasehold title to the Leased Real Property subject only to the Permitted Encumbrances and Assumed Liabilities. Not later than ten (10) days after the date of this Agreement, the Sellers shall cause to be prepared an as-built survey of the land and improvements comprising the Real Property (collectively, the "**Surveys**") by a registered Iowa surveyor in accordance with the "Minimum Standard Detail Requirements for ALTA/ACSM Land Title Surveys" jointly established and adopted by ALTA and NSPS in 2005, and shall include Items 1, 2, 3, 4, 6, 7, 8, 9, 10, 11 and 13 of Table A thereof. The Surveys will be certified to Buyer, the Sellers, and the Title Company and shall include a surveyor's certification acceptable to Buyer and the Title Company. The legal description of the Real Property created by the surveyor shall be used to convey title to Buyer per the special warranty deed or deeds described in Section 3.2(a). Notwithstanding anything to the contrary herein, a Survey shall not be required for any Leased Real Property in which any of the Sellers does not own a leasehold interest in the land relating to such Leased Real Property. On or before the date that is the later of: (a) twenty (20) days after the date of this Agreement; and (b) five (5) days after Buyer's receipt of the last of the Surveys for the Real Property, Buyer shall deliver to the Sellers written notice of any title defects, liens, encumbrances or any other title and survey matters that are not acceptable to Buyer (the "**Title Objections**"). Not less than five (5) days after receiving Buyer's notice, the Sellers shall notify Buyer in writing of any such Title Objections which the Sellers are unable or unwilling to cause to be removed or which cannot be insured against prior to or at the Closing; provided, however, the Sellers must cause to be released (or indemnified over or bonded around) any financing liens or mechanics and materialmen's liens caused by the Sellers or any of their Affiliates. Sellers shall have fifteen (15) days to cure any such Title Objections. In the event the Sellers provide notice to Buyer that they will not or cannot remove, discharge, cure or cause to be insured over by the Title Company (other than financing liens or mechanics and materialmen's liens) any Title Objection, Buyer shall have the right to: (x) terminate this Agreement by giving the Sellers written notice of such termination within five (5) days after receipt of the Sellers' notice of unwillingness or inability to cure such Title Objections; or (y) consummate the transactions contemplated herein with respect to all Assets without waiving any rights to indemnification with respect to such Title Objections. The Sellers agree to deliver any information as may be reasonably requested by the Title Company under the requirements section of the Commitment or otherwise in connection with the issuance of Buyer's title insurance policy. The Sellers also agree to provide an affidavit of title and/or such other information as the Title Company may reasonably request in order for the Title Company to insure over the "gap" (i.e., the period of time between the effective date of the Title Company's last checkdown of title to such Real Property and the Closing Date) and to cause the Title Company to delete all standard exceptions (including any exception for mechanics liens related to the Real Property) from the final title insurance policy. If, after the condition of title to the Real Property has been approved by Buyer as provided by this Section 7.4, the Real Property becomes encumbered or subject to any matter other than those shown on the original Commitments, and if Buyer objects to such new encumbrance or matter, then the Sellers may, but shall not be obligated to, cure any such objections of Buyer, at Sellers' expense, within thirty (30) days after receiving notice of such objections. If any objection described in this paragraph is not satisfied by the Sellers, Buyer shall have the same rights as described in clauses (x) and (y) in this Section. The costs of such title policy or policies (including the endorsements to such policy or policies, but after taking into account all credits available, including any reissue credits)

and the costs of such surveys shall be shared equally by Buyer and the Sellers in accordance with the provisions of Section 13.16 herein. Buyer covenants and agrees that it shall be responsible for repairing any damage caused by the Phase I or other environmental surveys conducted prior to the Closing Date.

7.5 Reasonable Efforts to Close. Buyer shall use its reasonable commercial efforts to proceed toward the Closing and to cause each Seller's conditions to the Closing to be met as soon as practicable and consistent with the other terms contained herein. Buyer shall notify the Sellers as soon as practicable of any event or matter that comes to Buyer's attention that may reasonably be expected to prevent the conditions of Buyer's obligations being met.

7.6 Notice; Efforts to Remedy. Buyer shall promptly give notice to each Seller upon becoming aware of the impending occurrence of any event which would cause or constitute a breach of any of the representations, warranties or covenants contained or referred to in this Agreement or cause, or be likely to cause, a Material Adverse Effect and shall use its commercially reasonable efforts to prevent or promptly remedy the same.

ARTICLE VIII

CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

Notwithstanding anything herein to the contrary, the obligations of Buyer to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by Buyer at the Closing:

8.1 Representations/Warranties. The representations and warranties of each of the Sellers contained in this Agreement that are qualified as to materiality shall be true and correct in all respects, and those not so qualified shall be true and correct in all material respects, when made and as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date. Each and all of the terms, covenants, and conditions of this Agreement to be complied with or performed by the Sellers on or before the Closing Date pursuant to the terms hereof shall have been duly complied with, performed and satisfied in all material respects.

8.2 Pre-Closing Confirmations. Buyer shall have obtained documentation or other evidence satisfactory to Buyer in its reasonable discretion that Buyer has:

(a) received approval from all governmental agencies whose approval is required to complete the transactions herein contemplated, including a "no action" statement from the Attorney General of the State of Iowa acceptable to the Parties;

(b) received confirmation from all applicable licensure agencies that upon the Closing all licenses required by law to operate each of the Seller Facilities and the Assets as currently operated will be transferred to, or issued or reissued in the name of, Buyer; and

(c) obtained reasonable assurances that Medicare and Medicaid certification of the Seller Facilities for their operation by Buyer will be effective as of the Closing Date and

that Buyer may participate in and receive reimbursement from such programs effective as of the Closing Date.

8.3 Actions/Proceedings. No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened that may reasonably be expected to prohibit the sale of the Assets or seeks damages in a material amount by reason of the consummation of the transactions herein contemplated.

8.4 Adverse Change. Since the date hereof, there shall not have occurred any event, change or occurrence that has or could reasonably be expected to have a Material Adverse Effect, and none of the Sellers shall have suffered any material adverse change: (a) in the business, operations, financial condition or prospects of the Business or the Seller Facilities; or (b) the Assets. In addition, each of the Sellers shall have conducted the Business and the Seller Facilities only in the ordinary course of business since the date hereof.

8.5 Insolvency. None of the Sellers shall: (a) be in receivership or dissolution; (b) have made any assignment for the benefit of creditors; (c) have admitted in writing their inability to pay its debts as they mature; (d) have been adjudicated bankrupt; or (e) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against any of the Sellers.

8.6 Vesting/Recordation. The Sellers shall have furnished to Buyer, in form and substance satisfactory to Buyer, assignments or other instruments of transfer and consents and waivers by others necessary or appropriate to transfer to and effectively vest in Buyer all right, title, and interest in, to and under the Assets, in proper statutory form for recording if such recording is necessary or appropriate.

8.7 Closing Deliveries. The Sellers shall have made the deliveries required to be made by it under Section 3.2 hereof.

8.8 Opinions of the Sellers' Counsel.

(a) Buyer shall have received an opinion or opinions from Harrison, Moreland & Webber, P.C., counsel to the Sellers, dated as of the Closing Date and addressed to Buyer, in substantially the form attached as Exhibit K hereto.

(b) Buyer shall have received the written opinion of Katten Muchin Rosenman LLP, bond counsel to Seller, in substantially the form attached as Exhibit L hereto, opining that, among other things, the Bonds have been defeased or repaid, as appropriate.

8.9 Consents. All required consents, authorizations, approvals and waivers described in Section 6.4 shall have been obtained.

8.10 Schedules. Buyer shall have been furnished with the Schedules to this Agreement and Buyer shall not have expressed any objection to the Sellers in writing with respect thereto.

8.11 Title Insurance and Survey. Buyer shall have received the Commitments from the Title Company and the Surveys in conformity with Section 7.4.

8.12 HSR Act. The required waiting period under the HSR Act applicable to the transaction contemplated hereby shall have expired or been earlier terminated.

8.13 No Investigation. No material regulatory investigation or proceeding involving the Internal Revenue Service, the Centers for Medicare & Medicaid Services, the United States Department of Justice or any other federal or state agency involving or related to any Seller, the Business or the Assets shall have commenced or been threatened, other than: (a) those approval processes initiated in relation to the transactions contemplated by this Agreement; (b) the OIG self-audit referenced in that certain January 6, 2010 letter from the OIG (provided that Sellers shall not have received a subpoena or notice of further investigation by the OIG beyond the scope of such letter); (c) pending investigations disclosed to Buyer by Sellers in the Schedules to this Agreement or a writing referencing this Agreement; or, (d) inquiries made in the ordinary course of business (including, but not limited to, RAC and MIC audits).

8.14 Releases. Buyer shall have received pay-off letters or other satisfactory evidence that all indebtedness of each of the Sellers that is not an Assumed Liability or related to an Assumed Contract shall have been released or defeased as of, or simultaneous with, the Closing. All liens and encumbrances currently encumbering the Assets (to the extent such liens and encumbrances are not Permitted Encumbrances) shall have been duly released by the secured parties and other lien holders, and UCC-3 releases or termination statements and other lien discharging documents shall have been properly recorded or the recording thereof shall have been duly arranged pursuant to the relevant secured party's written authorization.

8.15 Tenant Estoppels. Buyer shall have received the Tenant Estoppels or other satisfactory evidence as set forth in Section 6.10.

8.16 Landlord Estoppels. Buyer shall have received the Landlord Estoppels or other satisfactory evidence as set forth in Section 6.11.

8.17 Vista Woods. Buyer shall have received either (i) evidence of release of the lien on Sellers' fee interest in the Vista Woods real property which lien secures an indebtedness of Ottumwa Developments, Inc., or (ii) a written agreement from the lender that is the holder of such indebtedness of Ottumwa Developments, Inc. whereby such lender agrees to give Buyer or Buyer's Affiliate written notice of any default under such loan and give Buyer or Buyer's Affiliate the right to cure any such default before taking legal action to foreclose the lien.

8.18 Alta Vista Site. All programs located on the Alta Vista Site shall have ceased their operations, and any Tenant Leases for space at the Alta Vista Site shall have been terminated, the tenants thereunder shall have vacated the previously leased premises and the Alta Vista Site will be unoccupied.

8.19 Name Change. Buyer shall have received evidence of the filing of the Name Change Amendment with the Secretary of State of Iowa.

8.20 Substance Abuse Programs. Sellers shall file with the State Health Agency a "Deletion of Health Service" form and discontinue operation of the Substance Abuse Programs, effective no later than the Closing Date.

8.21 Encroachment Easement. Buyer shall have received evidence that Sellers and Ottumwa Medical Clinic, Inc. have executed an encroachment easement agreement in form and substance acceptable to Buyer and the Title Company which easement agreement shall memorialize the existence of certain encroaching improvements and provide that the owner of such improvements shall not be required to remove such encroaching improvements.

ARTICLE IX

CONDITIONS PRECEDENT TO OBLIGATIONS OF THE SELLERS

Notwithstanding anything herein to the contrary, the obligations of the Sellers to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by the Sellers at the Closing:

9.1 Representations/Warranties. The representations and warranties of Buyer contained in this Agreement that are qualified as to materiality shall be true and correct in all respects, and those not so qualified shall be true and correct in all material respects, when made and as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date. Each and all of the terms, covenants, and conditions of this Agreement to be complied with or performed by Buyer on or before the Closing Date pursuant to the terms hereof shall have been duly complied with and performed in all material respects.

9.2 Governmental Approvals. All material consents, authorizations, orders and approvals of (or filings or registrations with) any government entity or other party required in connection with the execution, delivery and performance of this Agreement shall have been obtained, except for any documents required to be filed, or consents, authorizations, orders or approvals required to be issued, after the Closing Date. Buyer shall also have obtained documentation or other evidence satisfactory to the Sellers in their reasonable discretion that Buyer has:

(a) received approval from all governmental agencies whose approval is required to complete the transactions herein contemplated, including a consent or "no action" statement from the Attorney General of the State of Iowa acceptable to the Parties;

(b) received confirmation from all applicable licensure agencies that upon the Closing all licenses required by law to operate each of the Seller Facilities and the Assets as currently operated will be transferred to, or issued or reissued in the name of, Buyer; and

(c) obtained reasonable assurances that Medicare and Medicaid certification of the Seller Facilities for their operation by Buyer will be effective as of the Closing Date and that Buyer may participate in and receive reimbursement from such programs effective as of the Closing Date.

9.3 Actions/Proceedings. No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened that may reasonably be expected to prohibit the sale of the Assets or seeks damages in a material amount by reason of the consummation of the Transaction.

9.4 Insolvency. Buyer shall not: (a) be in receivership or dissolution; (b) have made any assignment for the benefit of creditors; (c) have admitted in writing its inability to pay its debts as they mature; (d) have been adjudicated bankrupt; or (e) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against Buyer.

9.5 Closing Deliveries. Buyer shall have made the deliveries required to be made by it under Section 3.3 hereof.

9.6 Opinion of Buyer's Counsel. The Sellers shall have received from Waller Lansden Dortch & Davis, LLP, counsel to Buyer, an opinion dated as of the Closing Date and addressed to the Sellers, substantially in the form attached hereto as Exhibit M.

9.7 HSR Act. The required waiting period under the HSR Act applicable to the transaction contemplated hereby shall have expired or been earlier terminated.

9.8 No Investigation. No material regulatory investigation or proceeding involving the Internal Revenue Service, the Centers for Medicare & Medicaid Services, the United States Department of Justice or any other federal or state agency involving or related to Buyer shall have commenced or been threatened, other than (a) those approval processes initiated in relation to the transactions contemplated by this Agreement; or (b) inquiries made in the ordinary course of business.

ARTICLE X

PARTICULAR COVENANTS OF BUYER

10.1 Employee Matters.

(a) As of the Closing Date, Buyer shall offer employment to: (i) all active employees as determined by Sellers' standards, reasonably applied, commencing as of the Effective Time; and (ii) employees on leave or who are on-call or "PRN" employees, as determined by Sellers' standards, reasonably applied, commencing as of the date such employees are eligible to return to work, consistent with applicable law (collectively, the employees described in (i) and (ii) are referred to herein as the "**Hired Employees**"). Buyer's offer of employment to the Hired Employees shall be contingent upon satisfactory completion of Buyer background checks, drug screenings, immigration status verification and verification that such employees are not excluded from participation in federal healthcare payor programs (all conducted at Buyer's sole cost and expense). The Hired Employees shall be offered positions and wage levels equivalent to those being provided by the Sellers immediately prior to the Closing Date. If a Hired Employee is terminated without cause by Buyer and is re-hired, Buyer shall recognize such employee's original hire date for purposes of seniority, consistent with the

Sellers' pre-Closing procedures and applicable law. Nothing herein shall be deemed to affect the status of the Hired Employees as employees "at will," limit in any way normal management prerogatives of Buyer with respect to employees or to create or grant to any such employees third party beneficiary rights or claims of any kind or nature. Within the ninety (90) days following the Closing Date, Buyer shall not take any action that would result in WARN Act liability with respect to the Hired Employees. In respect of the Hired Employees, Buyer shall provide such employees with employee benefits that are substantially similar to those offered by the Sellers immediately prior to the Closing Date with the understanding that Buyer cannot, by law, offer its employees a 403(b) plan and intends to offer a 401(k) plan. Buyer shall recognize the existing seniority and service credit with the Sellers of all Hired Employees under all applicable Buyer benefit plans. Buyer shall waive any limitations regarding preexisting conditions and eligibility waiting periods under any health benefit plan maintained for the benefit of Hired Employees. Buyer's benefit plans shall not impose materially greater or additional eligibility restrictions or financial burdens on the Hired Employees than the plans offered by Sellers. Buyer shall make arrangements with an investment manager and plan administrator of its choosing to provide for the administration and investment of Sellers' 403(b) Plan. Buyer shall be responsible for administering the 403(b) Plan, including the costs of administration, and shall make arrangements for payroll deductions of loan payments from employees who are obligated to repay participant loans under the 403(b) Plan. Buyer shall honor the flexible spending account elections of Hired Employees in effect with their employer immediately prior to the Effective Time and Buyer shall accept the balances of any flexible spending accounts of Hired Employees, which such balances may be used for claims incurred at and after the Effective Time. For the plan year ending December 31, 2010, Buyer shall provide a matching contribution under its qualified defined contribution plan that is calculated as three and one-half percent (3.5%) of compensation for the Hired Employees who satisfy the conditions for receiving the matching contribution under terms that are no less favorable to the Hired Employees than under Sellers' 401(a) Plan.

(b) Buyer shall credit all Hired Employees for their accrued but unused paid time off (other than assumed sick leave) hours and shall credit each Hired Employee with the unused assumed sick leave hours each such Hired Employee accrued while employed by the Sellers (the "**Assumed Sick Leave**"), but only to the extent disclosed on Schedule 2.3(d).

(c) After the Closing Date, Buyer shall lease to ORHC up to three (3) full-time employees as agreed upon by ORHC and Buyer for a period of twenty four (24) months (or such longer period as agreed to by ORHC and Buyer) to assist ORHC in its post-Closing operations. At Closing, Buyer and ORHC shall enter into an employee lease agreement in substantially the form attached hereto as Exhibit N (the "**Employee Lease Agreement**") to evidence this arrangement.

10.2 Cost Reports. Buyer shall forward to the Sellers any and all correspondence relating to the Cost Reports within ten (10) business days after receipt by Buyer. Buyer shall remit any receipts of funds relating to the Cost Reports promptly after receipt by Buyer and shall forward to the Sellers any demand for payments within ten (10) business days after receipt by Buyer.

10.3 Governance.

(a) During the period that Buyer owns and operates the Hospital, Buyer agrees to maintain a board of directors for the Hospital ("**Board of Directors**") consisting solely of local business and community leaders, physicians and the Chief Executive Officer of the Hospital (the "**Hospital CEO**"). Buyer agrees that any member of the Board of Directors on the Closing Date (the "**Legacy Directors**") shall, at their option, continue to serve on the Board of Directors following the Closing Date for at least three (3) full years (or longer, as provided herein). Beginning on the third (3rd) anniversary of the Closing Date (and each year thereafter), Buyer may rotate off of the Board of Directors no more than one-third (1/3) of the total Legacy Directors then serving on the Board of Directors. The Board of Directors shall meet on a regular basis and have the following responsibilities: developing a strategic plan with Buyer within nine (9) months of the Closing Date; defining the strategic vision of the Hospital; participating in the development and review of operating and capital budgets and facility planning; providing feedback regarding the Hospital's provision of services; approving the hiring and participating in periodic evaluations of the Hospital CEO; granting medical staff privileges and, when necessary, taking disciplinary action consistent with the Bylaws of the Hospital (with the advice of counsel); supporting physician recruitment efforts; fostering community relationships and identifying service and education opportunities; participating in the Hospital's quality assurance initiatives; and serving as the governing body of the Hospital as such term is commonly understood under the accreditation policies of the Joint Commission.

(b) Buyer shall assume as Assumed Contracts the employment contracts with each of Sellers' Hospital CEO, Chief Financial Officer and Chief Nursing Officer as of the Effective Time; provided that Sellers' Hospital CEO, Chief Financial Officer and Chief Nursing Officer may negotiate with Buyer new terms to their respective agreements, with any such negotiated changes to take effect after the Closing Date. Contracts between Buyer and each of the Hospital CEO, Chief Financial Officer and Chief Nursing Officer shall be at compensation levels no less than that paid immediately prior to the Closing Date.

(c) After Closing, the Chief Financial Officer and Chief Nursing Officer shall report directly to the Hospital CEO.

(d) After Closing, Buyer shall have the final approval of the operating and capital budgets for the Seller Facilities. In addition, Buyer shall have the right to terminate the Hospital CEO, but agrees to consult the Board of Directors prior to any such termination.

(e) After Closing, the Hospital CEO shall make a report to the Board of Directors, and shall also make reports to the community on an annual basis.

(f) The Board of Directors shall provide oversight of Buyer's establishment of the New Program (as defined in Section 10.16(f)).

10.4 Charity Care Policies. Buyer agrees to adopt at the Closing (and does hereby adopt by operation of this Agreement without the necessity of further action) and continue to abide by the charity care policy of the Hospital in place on the date hereof for use at the Hospital

(the "**Charity Care Policy**"). Buyer agrees not to amend the Charity Care Policy unless required to do so by any applicable law or after review and approval by the Board of Directors.

10.5 Continuation of Services. Following the Closing, Buyer will continue to operate the Hospital as a full service, general acute care hospital and will continue to provide all services provided by ORHC as of the Closing Date, in each case subject to the availability of qualified physicians. No service may be discontinued without the prior approval of the Board of Directors.

10.6 Capital Projects. Subject to the receipt of any required regulatory approvals, following the Closing and subject to Buyer's right of offset set forth in Section 10.7 below, Buyer shall undertake the following capital projects: (a) as soon after the Closing as is practicable, commence the design and construction of a permanent building to house a catheterization lab in accordance with the specifications described on Exhibit O-1, purchase equipment therefor and recruit a cardiologist (subject to Buyer's receipt of any required Certificate of Need approval, which Buyer shall use reasonable commercial efforts to obtain expeditiously); (b) immediately after the Closing, commence the process to build a new medical office building with a minimum of Fifteen Thousand (15,000) square feet ("**MOB**") in accordance with the specifications described on Exhibit O-1; (c) complete a remodeling of Hospital's nursing unit and intensive care unit in accordance with the specifications described on Exhibit O-1 within one (1) year following the Closing Date; (d) complete a remodeling of Hospital's emergency department in accordance with the specifications described on Exhibit O-1 within two (2) years following the Closing Date; and (e) commit to investment in the following projects: (i) $750,000 for purchase of the CLS Interests, (ii) $1,246,000 for the purchase of a PET scan (subject to Buyer's receipt of Certificate of Need approval, which Buyer shall use reasonable commercial efforts to expeditiously obtain), or, if Buyer is unable to obtain a required Certificate of Need approval for a PET scan, a CT scan, (iii) $2,000,000 for expansion of services and ownership in the cancer center, and (iv) $305,000 for the purchase of a lithotripter; and (f) complete the additional infrastructure projects described on Exhibit O-2 (the "**Infrastructure Projects**") within five (5) years following the Closing Date (collectively, (a) – (e) comprise the "**Capital Projects**"). Notwithstanding the foregoing, following the Closing Date, should any of the mechanical or electrical systems, equipment or elements identified on Exhibit O-3 be broken or in disrepair such that safe, reasonable operations of the Hospital are affected, Buyer agrees that it shall also fund such projects (in addition to, and not in lieu of, the Capital Projects described in this Section 10.6 and the routine capital expenditures described in Section 10.7), provided further, all such expenditures shall be credited against the Note (to the extent it remains outstanding). In addition, Buyer agrees to: (i) build, subject to any required Certificate of Need approval, a second catheterization lab equal to the quality and size of the first catheterization lab if patient volume and usage of the first lab makes it necessary to provide a larger service capability; and (ii) expand the MOB to up to Thirty Five Thousand (35,000) square feet if there is sufficient demand for such an expansion.

10.7 General Capital Expenditures. In addition to the capital expenditures set forth in Section 10.6, during the first five (5) years following the Closing Date, Buyer shall make annual routine capital expenditures in connection with the operation of the Hospital equal to at least two and one-half percent (2.5%) of the Hospital's net patient revenue. Beginning in the sixth year after the Closing, during such time as Buyer owns and operates the Hospital, Buyer

shall make annual routine capital expenditures equal to at least five percent (5%) of the Hospital's net patient revenue. As used herein, "**routine capital expenditures**" shall include expenditures for unforeseen maintenance, new equipment, equipment replacement, facility renovations and other capital improvements. The Board of Directors shall be responsible for overseeing the development of annual operating and capital budgets. Buyer's liability for the costs of remediation of asbestos and asbestos-containing materials on or at the Real Property (other than the Alta Vista Site) shall be offset, at Buyer's option, against either (i) the routine capital expenditure commitment set forth in this Section 10.7, or (ii) the funds allocated to complete the Infrastructure Projects set forth in Section 10.6.

10.8 Physician Recruitment and Development.

(a) Buyer will commit to a physician recruitment plan based upon community need and input from the Hospital's medical staff and the Board of Directors. During the first five (5) years following the Closing Date, Buyer shall expend Seven Million Five Hundred Thousand Dollars ($7,500,000) in its efforts to recruit at least twenty five (25) physicians to the Hospital. Buyer's initial focus after the Closing shall be the recruitment of three (3) to five (5) family practice physicians. As part of its physician recruitment efforts, Buyer agrees to cooperate with the medical staff of the Hospital, the Board of Directors and Hospital administration to honor the Hospital's commitments with River Hills Community Health Center. Buyer also agrees to recruit an orthopedic surgeon, a general surgeon and pediatricians, and agrees to consider the recruitment of a psychiatrist.

(b) Buyer, with input from the Hospital medical staff and the Board of Directors, commits to further physician development at the Hospital (e.g., development of physician practice infrastructure for independent physicians and the development of a physician employment model).

10.9 Residency and Hospitalist Programs. During the period that Buyer owns and operates the Hospital, Buyer agrees, (a) subject to applicable law and approval of the medical staff and the Board of Directors, to work with Iowa training programs to establish a resident rotation program at the Hospital; and (b) to: either (i) develop, within a reasonable time after the Closing Date, a program for hospitalists to cover, at a minimum, weekday nights (7 pm-7 am); or (ii) subject to consultation of the Medical Staff and approval of the Board of Directors, develop an alternative program to enhance call coverage.

10.10 Quality of Care. Buyer shall continue to support and engage in quality assurance and improvement initiatives designed to improve continuously the quality of care provided to patients of the Hospital, including the key elements, principles, techniques and practices of the Studer program. Buyer will assume as an Assumed Contract ORHC's current contract with Studer Group, LLC ("**Studer**"), with such changes as Studer and Buyer agree at the time of assignment or thereafter, which revised contract shall not be terminated by Buyer without consulting the Board of Directors. At least annually, Buyer shall distribute and collect patient satisfaction surveys and strive to achieve patient satisfaction scores above national averages for similarly-situated hospitals.

10.11 Commitment to Auxiliary and Gift Shop. Buyer shall continue to support the activities conducted by the Hospital's auxiliary and gift shop, and provide, on a rent-free basis, sufficient space for the auxiliary and gift shop to continue operations in the same manner as prior to the Closing Date.

10.12 Regional Retirement Living.

(a) Buyer shall cause the Affiliate designated to purchase the Assets of RRL to continue the operations of the continuing care retirement facility conveyed to Buyer's Affiliate by RRL (referred to in this Section 10.12 as the "**Senior Living Facility**") until such time as Buyer can research, interview and, with the participation of the members of the RRL board of directors, identify a purchaser for the Senior Living Facility's assets. For so long as Buyer's Affiliate continues the operation of the Senior Living Facility: (a) Buyer shall cause its Affiliate to make commercially reasonable efforts to maintain quality and resident satisfaction for the facility consistent with historical levels; and (b) the president of the facility shall report directly to the Hospital CEO.

(b) Notwithstanding anything to the contrary in Section 10.12(a): (i) the Chairman of the RRL board of directors (the "**RRL Chairman**") (acting on behalf of himself, other members of the RRL board of directors and/or other interested parties) shall have the right, within ninety (90) following the Closing Date, to submit to Buyer or Buyer's Affiliate a written offer to acquire substantially all of the assets, stock, membership or other equity interests held by Buyer's Affiliate in relation to the Senior Living Facility; and (ii) if, within ninety (90) days of the Closing Date, Buyer's Affiliate otherwise desires to sell substantially all of its assets, stock, membership or other equity interests, Buyer shall notify the RRL Chairman in writing of such fact and provide the RRL Chairman (acting on behalf of himself, other members of the RRL board of directors and/or other interested parties) the opportunity to submit to Buyer a written offer to acquire substantially all of the assets, stock, membership or other equity interests held by Buyer's Affiliate in relation to the Senior Living Facility. Any written offer provided by the RRL Chairman under subsections (i) or (ii) above shall include the financing proposal related thereto. Notwithstanding the foregoing, neither Buyer nor Buyer's Affiliate shall have the obligation to accept such offer, or having received it, to refrain from soliciting or accepting other offers related to the assets, stock, membership or other equity interests held by Buyer's Affiliate.

10.13 Reserved.

10.14 Information Systems and Electronic Medical Records.

(a) Within six (6) months of Closing, Buyer agrees to engage a consultant experienced with CPSI to provide additional training and support for the Hired Employees and medical staff on the existing information technology system and to prepare a report to be delivered to the Buyer and the Board of Directors setting forth recommendations to improve, enhance or replace such system. Buyer, in consultation with the Board of Directors, shall take such commercially reasonable steps as are appropriate to implement such recommendations, including the expenditure of between One Million Three Hundred Thousand Dollars ($1,300,000) and Two Million Three Hundred Thousand Dollars ($2,300,000), with a target implementation date within twelve (12) months after the Closing. Buyer shall consult with the

Board of Directors and medical staff of the Hospital regarding implementation of an "e-ICU" as part of the information technology system.

(b) Buyer agrees to commit an additional One Million Dollars ($1,000,000) to upgrade and supplement the information technology system for the Seller Facilities for add-ons related to electronic medical records. Buyer anticipates that implementation planning for these products will commence within six (6) months following the Closing Date and will be completed no later than thirty six (36) months following the Closing Date. The One Million Dollars ($1,000,000) funding of these upgrades and supplements shall be funded by Buyer and not as a routine capital expense of the Hospital.

10.15 Name of Seller Facilities. For so long as Buyer owns and operates the Hospital, Buyer shall not: (a) change the name of the Hospital or other Seller Facilities; (b) change the naming rights granted to certain Seller Facilities on or prior to the Closing Date; or (c) remove or change the donor recognitions located within the Hospital as of the Closing Date.

10.16 Additional Considerations. Buyer agrees to do the following:

(a) use reasonable commercial efforts to expand services and ownership in the cancer center;

(b) support the continuation of a Level II nursery at the Hospital;

(c) grow the orthopedic services offered at the Hospital;

(d) provide at least one (1) offsite continuing education activity per year for members of the Board of Directors;

(e) implement corporate services allocating overhead charges, only to the extent that these allocated costs will not affect the Hospital's: (i) budget; (ii) capital expenditures; (iii) funding of Buyer's obligations to Sellers under this Agreement or the Note; or (iv) incentive/bonus calculations; and

(f) subject to applicable laws, establish and implement, as soon as practical (but in no event more than ninety (90) days following the Closing Date), an outpatient substance abuse treatment program in Ottumwa, Iowa, affiliated with the Hospital and branded as part of the Hospital (the "**New Treatment Program**"). To the extent permitted by law and the capacity of the New Treatment Program, former patients of the Substance Abuse Programs shall be granted priority access for admission to the New Treatment Program.

10.17 Reserved.

10.18 Post-Closing Assistance. In addition to the Employee Lease Agreement:

(a) Buyer and the Sellers shall enter into a Transition Services Agreement with ORHC or its designee in substantially the form attached hereto as Exhibit P, pursuant to which former employees and resources shall be made available to ORHC for up to twenty four (24) months after Closing (or such longer period as agreed to by ORHC and Buyer) to assist with

transition services, e.g., gather documents and information to assist ORHC with the preparation of the Cost Reports, to assist with gathering documents and information in connection with audits, compliance with governmental requirements and regulations, and the prosecution or defense of claims, to provide information technology and operational support.

(b) For a period of up to twenty four (24) months (or such longer period as agreed to by ORHC and Buyer) following the Closing Date, Buyer shall provide ORHC with exclusive use and quiet enjoyment of the current office location of the Existing Foundation at a mutually agreeable fair market value lease rate. The lease shall provide that ORHC shall have to relocate to another location upon sixty (60) days prior written notice if Buyer wishes to place a physician that has been recruited to work at the Hospital in such space.

10.19 Reporting. For five (5) years after the Closing Date, within sixty days (60) of the end of each calendar year, Buyer shall provide ORHC or its designee with a written report that specifies in reasonable detail Buyer's compliance with its obligations and responsibilities set forth in this Agreement and shall make the Hospital CEO available to discuss the content of such reports as reasonably requested by ORHC.

10.20 Deadlines for Completion. The final scope of the Capital Projects and other commitments set forth in this Article X must be approved by the Board of Directors, and any deadlines for the completion of the projects may be changed by mutual agreement of Buyer, the Board of Directors and ORHC.

ARTICLE XI

PARTICULAR COVENANTS OF SELLERS

11.1 Employee Matters.

(a) As of the Closing Date, the Sellers shall terminate all of their employees. Within the period of ninety (90) days before the Closing Date, the Sellers shall not take any action that would result in WARN Act liability.

(b) The Sellers hereby covenant and agree to amend, terminate or take any other appropriate action with respect to the Benefit Plans and to take all steps necessary to accomplish such actions prior to the Closing Date.

(c) Within thirty (30) days following the Closing Date, the Sellers shall: (i) make or cause to be made all contributions due for all periods prior to the Closing Date, including a prorated contribution for the 2010 plan year, on behalf of all employees who are participants in the 403(b) Plan and the 401(a) Plan; and (ii) fully vest all accounts of employees who are participants in the 403(b) Plan and 401(a) Plan. With respect to the foregoing and for all other purposes, the Sellers shall amend the 403(b) Plan, the 401(a) Plan and the 457(b) Plan and take any other necessary action to comply fully with the requirements under ERISA and the IRC related to Section 403(b) plans, qualified plans, 457(b) Plans and other applicable laws at all times. As soon as administratively feasible following the Closing Date, the Sellers shall take any necessary actions to (i) provide for the continued sponsorship of the 403(b) Plan subject to the Buyer taking the actions required under Section 10.1(a), and (ii) to effectuate a trust-to-trust

transfer of the accounts of Hired Employees in the 401(a) Plan to a qualified retirement plan of the Buyer that is eligible to receive such transfer. Sellers shall, further, take appropriate action to transfer the assets of the 403(b) Plan to the investment manager designated by the Buyer. Sellers' obligations to sponsor the 403(b) Plan shall continue for a period of five (5) years after the Closing Date.

(d) Notwithstanding anything herein to the contrary, the Sellers acknowledge and agree that Buyer does not assume or agree to discharge any liability of the Sellers for any benefits under COBRA, the Public Health Service Act or otherwise for individuals incurring a qualifying event prior to the Closing, and any such liabilities shall remain solely the responsibility of the Sellers.

11.2 Cost Reports. ORHC, at its expense, shall prepare and file within ninety (90) days of the Closing all terminating and other cost reports required or permitted by law to be filed under Medicare, Medicaid and other third party payor programs or with the State Health Agency for periods ending on or prior to the Closing Date, or as a result of the consummation of the transactions described herein. ORHC shall retain all rights and obligations under the Cost Reports including without limitation any amounts receivable or payable or recaptured, in respect of such Cost Reports or reserves relating to such Cost Reports. Such rights shall include the right to appeal any Medicare or Medicaid determinations relating to the Cost Reports. ORHC shall retain the originals of the Cost Reports, correspondence, work papers and other documents relating to the Cost Reports. ORHC agrees to furnish copies of the Cost Reports, correspondence, work papers and other documents as Buyer may reasonably request.

11.3 Name Change. The Sellers acknowledge and agree that Buyer will acquire as part of the Assets the exclusive right to use the name "Ottumwa Regional Health Center", and any variation thereof and the goodwill associated therewith, and that none of the Sellers will use such name or any derivative thereof subsequent to the Closing. ORHC further covenants and agrees to file on the Closing Date an amendment to its Articles of Incorporation changing its name to "Ottumwa Regional Legacy Foundation, Inc." (the "**Name Change Amendment**"). Notwithstanding the foregoing, Sellers and Buyer agree that Ottumwa Regional Health Foundation, Incorporated, an Iowa non-profit, non-stock corporation recognized as exempt under Section 501(c)(3) of the IRC, shall continue use of its corporate name without limitation.

11.4 Foundation. ORHC anticipates that it will hold proceeds from the transaction contemplated by this Agreement (and thereby act as the "**Legacy Foundation**"). The Legacy Foundation may, in the future, elect to transfer certain of its assets, including all or a portion of the Purchase Price, to another charitable foundation or similar tax exempt organization ("**Successor Foundation**"). In the event that the Legacy Foundation transfers all of its assets, including the Purchase Price, to a Successor Foundation while it is obligated to Buyer under the terms of this Agreement, then the Successor Foundation shall execute and deliver a signature page or addendum to this Agreement in form reasonably satisfactory to Buyer whereby the Successor Foundation agrees to assume the Legacy Foundation's obligations hereunder. In addition, the Existing Foundation shall agree to be bound by the provisions of the Non-Competition Agreement and execute and deliver a signature page thereto. In the event a Successor Foundation becomes a party to this Agreement, then the Successor Foundation shall be entitled to enforce the covenants of Buyer contained in this Agreement.

11.5 Corporate Existence/Net Worth. The Legacy Foundation and/or a Successor Foundation shall either maintain its corporate existence or shall provide Buyer with evidence of the assumption of the Legacy Foundation's and/or a Successor Foundation's obligation hereunder by an entity acceptable to Buyer, in its sole discretion for so long as ORHC has obligations and commitments hereunder. Until the third anniversary of the Closing Date, the Legacy Foundation and/or a Successor Foundation or any such entity that assumes the obligations of such foundations hereunder shall maintain an aggregate net worth of not less than Thirty Million and No/100 Dollars ($30,000,000). Subject to compliance with this Section 11.5, ORHC or the Legacy Foundation shall be permitted to dissolve and wind up the operations of Sellers' Affiliates after the Closing Date.

11.6 Eddyville Property. As of the date of this Agreement, Sellers own a leasehold interest in the Eddyville Property and have exercised Sellers' purchase option under its lease with the City of Eddyville for such property (the "**Eddyville Lease**"). If at the time of the Closing, the City of Eddyville has not conveyed the fee simple interest in the Eddyville Property to Sellers, the Eddyville Property shall be deemed a Leased Property at Closing and Sellers shall (a) assign its interest in the Eddyville Lease to Buyer at Closing, (b) pay to the City of Eddyville the full purchase price for the Eddyville Property at Closing, and (c) not later than 30 days after the date of the Closing, either convey the fee interest in the Eddyville Property to Buyer by special warranty deed (reasonably acceptable to Buyer) or cause the City of Eddyville to convey the fee interest in the Eddyville Property to Buyer by a similar special warranty deed. If at the time of the Closing, Sellers own a fee simple interest in the Eddyville Property, the Eddyville Property shall be deemed an Owned Property and Sellers shall convey the fee interest in the Eddyville Property to Buyer by special warranty deed in accordance with Section 3.2(a) hereof. Sellers obligations under this paragraph shall survive the Closing.

11.7 MedAssets Agreement. Buyer has executed an agreement (the "**MedAssets Agreement**") with MedAssets, Inc. (or a subsidiary or Affiliate thereof) ("**MedAssets**"), pursuant to which MedAssets will audit the Hospital's chargemaster and perform related services. The Sellers shall reimburse Buyer for one-half of the fees payable under the MedAssets Agreement.

11.8 Physicians Tail Insurance. Sellers shall bear the costs of the premium for "tail" coverage for professional liability insurance for Gerald M. Paluska, M.D., attributable to acts and omissions prior to Closing.

ARTICLE XII

INDEMNIFICATION

12.1 Indemnification by Buyer. Subject to the limitations set forth in Section 12.4 hereof, Buyer shall indemnify and hold harmless the Sellers, and their respective officers, directors, employees and Affiliates (collectively, the "**Seller Indemnified Parties**"), from and against any and all losses, liabilities, damages, claims, costs (including, without limitation, court costs and costs of appeal) and expenses (including, without limitation, reasonable attorneys' fees and fees of expert consultants and witnesses) (collectively, "**Damages**") that any Seller Indemnified Party incurs as a result of, or with respect to: (a) any misrepresentation or breach of warranty by Buyer under this Agreement or the other agreements and documents executed and

delivered by Buyer pursuant to this Agreement; (b) any breach by Buyer of any covenant or agreement of Buyer under this Agreement or the other agreements contemplated hereby; (c) any of the Assumed Liabilities; or (d) any claim made by a third party with respect to the operation of Buyer or the Seller Facilities on or after the Effective Time.

12.2 Indemnification by the Sellers. Subject to the limitations set forth in Section 12.4 hereof, each of the Sellers, jointly and severally, shall indemnify and hold harmless Buyer, and its officers, directors, employees, stockholders, members and Affiliates (collectively, the "**Buyer Indemnified Parties**"), from and against any and all Damages that any such Buyer Indemnified Party incurs as a result of, or with respect to: (a) any misrepresentation or breach of warranty by any of the Sellers under this Agreement or the other agreements and documents executed and delivered by any or all of the Sellers pursuant to this Agreement; (b) any breach by any of the Sellers of any covenant or agreement of any of the Sellers under this Agreement or the other agreements contemplated hereby; (c) any of the Excluded Liabilities; (d) any claim made by a third party with respect to the Sellers or the operation of the Seller Facilities prior to the Effective Time; (e) any matter related to the January 6, 2010 letter from the OIG; or (f) the operation or closure of the Substance Abuse Programs.

12.3 Survival. Except as otherwise expressly provided in this Agreement, all covenants, representations and warranties contained in this Agreement or in any document delivered at the Closing pursuant hereto shall: (a) be deemed to be material and to have been relied upon by the Parties, notwithstanding any investigation heretofore or hereafter made by any of them or on behalf of any of them; (b) not be deemed merged into any instruments or agreements delivered at the Closing or thereafter; and (c) the representations and warranties shall survive the Closing and shall be fully effective and enforceable for a period of three (3) years following the Closing Date, except for the representations and warranties set forth in Section 4.6 (Licenses), 4.8 (Medicare Participation/Accreditation), 4.9 (Regulatory Compliance), 4.12(a) (Title to and Condition of the Assets), 4.16 (Taxes), and 4.27 (Environmental Matters) which shall survive until the expiration of the applicable statute of limitations taking into account all valid extensions. The covenants set forth in Section 10.15, 11.4 and 11.5 shall survive the Closing and shall be fully enforceable for so long as Buyer owns the Seller Facilities. For the avoidance of doubt, this Section 12.3 shall not affect any rights to bring claims after three (3) years based on: (x) any covenant or agreement of the Parties that contemplates performance after the Closing, including but not limited to those set forth in Articles X, XI and XIII; (y) the obligations of Buyer under Section 12.1(b), 12.1(c) or 12.1(d); or (z) the obligations of the Sellers under Section 12.2(b), 12.2(c), 12.2(d), 12.2(e) or 12.2(f). Notwithstanding anything to the contrary contained in this Section 12.3, the covenants set forth in Section 6.6 shall not survive the termination of this Agreement.

12.4 Limitations.

(a) The Sellers shall be liable under Section 12.2(a) and for any Direct Claims under Section 12.2(c) only when total indemnification claims made under Section 12.2(a) or Section 12.2(c) exceed Six Hundred Thousand Dollars ($600,000) (the "**Indemnification Basket**"), after which the Sellers shall be liable for all Damages in excess of such threshold. The Sellers' total liability for indemnified losses under Section 12.2(a) shall not exceed (in the aggregate) seventy-five percent (75%) of the Closing Cash (the "**Seller Indemnity Cap**").

Notwithstanding the foregoing, any Damages incurred by a Buyer Indemnified Party as a result of a breach or inaccuracy of any representation or warranty made by any of the Sellers in Section 4.8 (Medicare Participation/Accreditation), 4.9 (Regulatory Compliance), 4.12(a) (Title to and Condition of the Assets), 4.16 (Taxes) and 4.27 (Environmental Matters) shall not count towards, nor be subject to, the Indemnification Basket or the Seller Indemnity Cap. For purposes of this Article XII, a "**Direct Claim**" is any claim under Section 12.2(c) except claims by an Indemnified Party (as such term is defined in Section 12.5) seeking to recover out-of-pocket losses arising or incurred by such Indemnified Party in relation to third party claims and actions.

(b) Buyer shall be liable under Section 12.1(a) only when total indemnification claims made under Section 12.1(a) exceed the Indemnification Basket, after which Buyer shall be liable for all Damages in excess of such threshold. Buyer's total liability for indemnified losses under Section 12.1(a) shall not exceed (in the aggregate) seventy-five percent (75%) of the Closing Cash (the "**Buyer Indemnity Cap**").

12.5 Notice and Control of Litigation. If any claim or liability is asserted in writing by a third party against a Party entitled to indemnification under this Article XII (the "**Indemnified Party**") which would give rise to a claim under this Article XII, the Indemnified Party shall notify the person giving the indemnity (the "**Indemnifying Party**") in writing of the same within ten (10) days of the knowledge of such assertion of a claim or liability. The Indemnifying Party shall have the right to defend a claim and control the defense, settlement and prosecution of any litigation. If the Indemnifying Party, within ten (10) days after notice of such claim, fails to defend such claim, the Indemnified Party shall (upon further notice to the Indemnifying Party) have the right to undertake the defense, compromise or settlement of such claim on behalf of and for the account and at the risk of the Indemnifying Party, subject to the right of the Indemnifying Party to assume the defense of such claim at any time prior to settlement, compromise or final determination thereof. Anything in this Section 12.5 notwithstanding: (a) if there is a reasonable probability that a claim may materially and adversely affect the Indemnified Party other than as a result of money damages or other money payments, the Indemnified Party shall have the right, at its own cost and expense, to defend, compromise and settle such claim; and (b) the Indemnifying Party shall not, without the written consent of the Indemnified Party, settle or compromise any claim or consent to the entry of any judgment that does not include a term thereof the giving by the claimant to the Indemnified Party of an unconditional release from all liability in respect of such claim. All Parties agree to cooperate fully as necessary in the defense of such matters. Should the Indemnified Party fail to notify the Indemnifying Party in the time required above, the indemnity with respect to the subject matter of the required notice shall be limited to the damages that would have resulted had the Indemnified Party notified the Indemnifying Party in the time required above after taking into account such actions as could have been taken by the Indemnifying Party had it received timely notice from the Indemnified Party.

12.6 Notice of Claim. If an Indemnified Party becomes aware of any basis for a claim for indemnification under this Article XII (except as otherwise provided for under Section 12.5), the Indemnified Party shall notify the Indemnifying Party in writing of the same within thirty (30) days after becoming aware of such claim, specifying in detail the circumstances and facts which give rise to a claim under this Article XII. Should the Indemnified Party fail to notify the Indemnifying Party within the time frame required above, the indemnity with respect to the

subject matter of the required notice shall be limited to the damages that would have nonetheless resulted had the Indemnified Party notified the Indemnifying Party in the time required above after taking into account such actions as could have been taken by the Indemnifying Party had it received timely notice from the Indemnified Party.

12.7 Exclusive Remedy. Except: (a) in cases of fraud, intentional misrepresentation or willful misconduct; or (b) as set forth in Section 13.1, Section 13.17 and Section 13.28, the sole and exclusive remedy for any breach or inaccuracy of any representation, warranty or covenant contained herein shall be the remedies provided for in this Article XII.

ARTICLE XIII

MISCELLANEOUS

13.1 Schedules and Other Instruments. Each Schedule and Exhibit to this Agreement shall be considered a part hereof as if set forth herein in full.

13.2 Allocation. The Parties agree that Buyer shall prepare a preliminary allocation (the "**Tax Allocation**") of the Purchase Price (and all other capitalizable costs incurred in connection with the transactions hereunder) among the Assets in accordance with Section 1060 of the IRC and the Treasury Regulations thereunder (and any similar provisions of state, local or foreign law, as appropriate). Buyer shall deliver its preliminary Tax Allocation to the Sellers within thirty (30) days after the Net Working Capital calculation has been agreed upon or otherwise determined pursuant to Section 2.6, and the Sellers shall have thirty (30) days after receiving the preliminary Tax Allocation (the "**Seller Review Period**") to object to the preliminary Tax Allocation. If the Sellers timely raise any such objections, Buyer and the Sellers will attempt to resolve such objections in good faith; provided, however, that if Buyer and the Sellers are unable to resolve such issues within thirty (30) days after the end of the Seller Review Period, then either Buyer and the Sellers may elect, by written notice to the other, to have the objections resolved by the Audit Firm, whose decision shall be binding on the Parties in the absence of manifest error and whose fees and expenses shall be paid fifty percent (50%) by Buyer and fifty percent (50%) by the Sellers. If the Sellers fail to object to the preliminary Tax Allocation within the Seller Review Period, then such preliminary Tax Allocation shall be deemed acceptable to the Sellers and such preliminary Tax Allocation shall be binding upon the Parties. Thereafter, Buyer, the Sellers and their respective Affiliates shall report, act and file all Tax Returns (as defined below) (including, but not limited to, Internal Revenue Service Form 8594) in all respects and for all purposes consistent with such finally determined Tax Allocation. Neither Buyer, the Sellers nor any of their respective Affiliates shall take any position (whether in audits, Tax Returns or otherwise) that is inconsistent with such Tax Allocation, unless required to do so by applicable law.

13.3 Termination Prior to Closing. Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (a) on or prior to the Closing, by mutual consent of the Sellers and Buyer; (b) on or prior to the Closing by Buyer, if satisfaction of any condition to Buyer's obligations under Article VIII of this Agreement has not occurred in the time period related to that particular condition, covenant or agreement (unless the failure results primarily from Buyer breaching any representation, warranty or covenant herein) and such condition shall

not have been waived by Buyer; (c) on or prior to the Closing by the Sellers, if satisfaction of any condition to the Sellers' obligations under Article IX of this Agreement has not occurred in the time period related to that particular condition, covenant or agreement (unless the failure results primarily from the Sellers' breaching any representation, warranty or covenant herein) and such condition shall not have been waived by the Sellers; (d) by Buyer or the Sellers, if the Closing shall not have taken place on or before April 30, 2010, which date may be extended by mutual agreement of Buyer and the Sellers; provided, however, that no termination may be made under this Section 13.3(d) by a Party if the failure to close on or prior to such date shall be caused by the failure of such Party to fully comply with its obligations under this Agreement; (e) by either the Sellers or Buyer, pursuant to Section 13.1 hereof; (f) in the event the Sellers, on one hand, or Buyer, on the other hand, commit a material breach of any of the terms hereof, by the non-breaching Party; or (g) by Buyer, in accordance with the provisions of Section 7.4 or Section 13.31.

13.4 Post-Closing Access to Information. The Sellers and Buyer acknowledge that subsequent to the Closing each Party may need access to information or documents in the control or possession of the other Party for the purposes of concluding the transactions herein contemplated, audits, compliance with governmental requirements and regulations and the prosecution or defense of third party claims. Accordingly, subject to applicable law and attorney-client privilege or other applicable privileges, the Sellers and Buyer agree that for a period of ten (10) years after the Closing Date (and longer where the statute of limitations is greater than ten (10) years) each will make reasonably available to the other's agents, independent auditors, counsel and/or governmental agencies upon written request and at the expense of the requesting Party such documents and information as may be available relating to the Business or the Assets for periods ending on or prior to the Closing Date to the extent necessary to facilitate concluding the transactions herein contemplated, audits, compliance with governmental requirements and regulations and the prosecution or defense of claims.

13.5 Preservation and Access to Records After the Closing. Buyer agrees to maintain all patient, medical and other records of the Seller Facilities delivered to Buyer at the Closing in accordance with applicable law (including, if applicable, Section 1861(v)(i)(I) of the Social Security Act (42 U.S.C. Section 1395(v)(l)(i)), the privacy requirements of the Administrative Simplification subtitle of the HIPAA and applicable state requirements with respect to health information privacy and requirements of relevant insurance carriers, all in a manner consistent with the maintenance of patient records generated at the Seller Facilities after the Closing. For purposes of this Agreement, the term "**records**" includes all documents, electronic data and other compilations of information in any form. Buyer acknowledges that as a result of entering into this Agreement and operating the Seller Facilities it will gain access to patient and other information that is subject to rules and regulations regarding confidentiality, and agrees to abide by any such rules and regulations relating to the confidential information it acquires. Buyer shall retain all patient, medical and other records of the Seller Facilities delivered at Closing for the longer of ten (10) years and the relevant statue of limitations applicable to such records. Upon reasonable notice, during normal business hours, at the sole cost and expense of the Sellers and upon Buyer's receipt of appropriate consents and authorizations, Buyer will afford to the representatives of the Sellers, including their counsel and accountants, full and complete access to, and copies of, the records transferred to Buyer at the Closing (including, without limitation, access to patient records in respect of patients treated by

the Sellers at the Seller Facilities). Upon reasonable notice, during normal business hours and at the sole cost and expense of the Sellers, Buyer shall also make its officers and employees available to the Sellers at reasonable times and places after the Closing. In addition, the Sellers shall be entitled, at the Sellers' sole risk, to remove from the Facilities copies of any such patient records, but only for purposes of pending litigation involving a patient to whom such records refer, as certified in writing prior to removal by counsel retained by the Sellers in connection with such litigation and only upon Buyer's receipt of appropriate consents and authorizations. Any patient record so removed from the Seller Facilities shall be promptly returned to Buyer following its use by the Sellers. Any access to the Seller Facilities, their records or Buyer's personnel granted to the Sellers in this Agreement shall be upon the condition that any such access not unreasonably interfere with the business operations of Buyer.

13.6 CON Disclaimer. This Agreement shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of Iowa's Certificate of Need statute, §§135.61-135.71 Code of Iowa (2009), and is specifically exempt pursuant to §135.63(o) Code of Iowa (2009).

13.7 Cooperation on Tax Matters. Following the Closing, the Parties shall cooperate fully with each other and shall make available to the other, as reasonably requested and at the expense of the requesting Party, and to any taxing authority, all information, records or documents relating to Tax liabilities or potential Tax liabilities of the Seller Parties for all periods ending on or prior to the Closing Date and any information that may be relevant to determining the amount payable under this Agreement, and shall preserve all such information, records and documents at least until the expiration of any applicable statute of limitations or extensions thereof. Upon request of Buyer, the Sellers shall use their reasonable commercial efforts to obtain any certificate or other document from any governmental authority or any other person as may be necessary to mitigate, reduce or eliminate any Taxes that could be imposed (including, but not limited to, with respect to the transactions contemplated hereby).

13.8 Misdirected Payments, Etc. Each of the Sellers and Buyer covenant and agree to remit, with reasonable promptness, to the other Party any payments received, which payments are on or in respect of accounts or notes receivable owned by (or are otherwise payable to) the other Party. In addition, in the event of a determination by any governmental or third party payor that payments to the Sellers or the Seller Facilities resulted in an overpayment or other determination that funds previously paid by any program or plan to the Sellers or the Seller Facilities must be repaid, including, without limitation, pursuant to a RAC audit, the Sellers shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered on or prior to the Closing Date, and Buyer shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered after the Closing Date and not arising out of the actions or policies of the Sellers. In the event that, following the Closing, Buyer suffers any offsets against reimbursement under any third party payor or reimbursement programs due to Buyer, relating to amounts owing under any such programs by the Sellers, the Sellers shall promptly upon demand from Buyer pay to Buyer the amounts so offset.

13.9 Tax Returns. Each of the Sellers and each of the Joint Ventures will timely file all Tax Returns, accurately report all income and loss, and pay all Taxes due for tax years or periods ending on the Closing Date or reporting periods that include periods prior to the Closing Date. Joint Venture pass through income Tax Returns, if any, for periods beginning prior to the Closing Date that do not end on or before the Closing Date will use a closing of the books methodology for determining income and loss attributable to the Sellers and Buyer unless otherwise agreed in writing by Buyer. Each of the Joint Ventures will make a Section 754 election on its tax return for the period ending on the Closing Date. Seller will not cause or permit any of the Joint Ventures to take any action with respect to Taxes outside the ordinary course of business that may have an adverse impact on the Joint Ventures or the Joint Venture Facilities as of or subsequent to the Closing Date. Buyer shall provide or cause to be provided to the Sellers the Joint Venture's Tax Returns that include pre-Closing periods for review and comment at least thirty (30) days prior to filing such returns.

13.10 Additional Assurances. The provisions of this Agreement shall be self-operative and shall not require further agreement by the Parties except as may be herein specifically provided to the contrary; provided, however, at the request of a Party, the other Parties shall execute such additional instruments and take such additional actions as the requesting Party may reasonably deem necessary to effectuate this Agreement. In addition and from time to time after the Closing, the Sellers shall execute and deliver such other instruments of conveyance and transfer, and take such other actions as Buyer reasonably may request, more effectively to convey and transfer full right, title, and interest to, vest in, and place Buyer in legal and actual possession of, any and all of the Assets. The Sellers shall also furnish Buyer with such information and documents in their possession or under their control, or which the Sellers can execute or cause to be executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands relating to or constituting a part of the Seller Facilities or the Assets. Additionally, the Sellers shall cooperate and use their best efforts to have their present directors, officers and employees cooperate with Buyer on and after the Closing in furnishing information, evidence, testimony and other assistance in connection with any action, proceeding, arrangement or dispute of any nature with respect to matters pertaining to all periods ending on or prior to the Closing Date in respect of the items subject to this Agreement.

13.11 Consented Assignment. Anything contained herein to the contrary notwithstanding, this Agreement shall not constitute an agreement to assign any claim, right, contract, license, lease, commitment, sales order or purchase order if an attempted assignment thereof without the consent of the other party thereto would constitute a breach thereof or in any material way affect the rights of the Sellers thereunder, unless such consent is obtained. Each of the Sellers shall use commercially reasonable efforts to obtain any third party consents to the transactions contemplated by this Agreement. If such consent is not obtained, or if an attempted assignment would be ineffective or would materially affect the rights thereunder of the Sellers so that Buyer would not in fact receive all such rights, the Sellers and Buyer shall cooperate in good faith in any reasonable arrangement designed to provide for Buyer the benefits under any such claim, right, contract, license, lease, commitment, sales order or purchase order, including, without limitation, enforcement of any and all rights of the Sellers against the other party or parties thereto arising out of the breach or cancellation by such other party or otherwise.

13.12 Consents, Approvals and Discretion. Except as herein expressly provided to the contrary, whenever this Agreement requires any consent or approval to be given by a Party, or whenever a Party must or may exercise discretion, the Parties agree that such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

13.13 Legal Fees and Costs. In the event there is a dispute between the Parties and a Party elects to incur legal expenses to enforce or interpret any provision of this Agreement by judicial proceedings, the prevailing Party will be entitled to recover such legal expenses, including, without limitation, reasonable attorneys' fees, costs and necessary disbursements at all court levels, in addition to any other relief to which such Party shall be entitled.

13.14 Choice of Law; Venue; Mediation.

(a) The Parties agree that this Agreement shall be governed by and construed in accordance with the laws of the State of Iowa without regard to conflict of laws principles. Each of the Parties hereby irrevocably consents and agrees that any action, suit or proceeding arising in connection with any disagreement, dispute, controversy or claim arising out of or relating solely to this Agreement (a "**Legal Dispute**") shall be brought only to the exclusive jurisdiction of the federal or state courts located in Linn County, Iowa. The Parties agree that, after a Legal Dispute is before a court as specified in this Section 13.14 and during the pendency of such Legal Dispute before such court, all actions, suits or proceedings with respect to such Legal Dispute or any other Legal Dispute, including, without limitation, any counterclaim, cross-claim or interpleader, shall be subject to the exclusive jurisdiction of such court. Each of the Parties hereby waives, and agrees not to assert, as a defense in any Legal Dispute, that it is not subject thereto or that such action, suit or proceeding may not be brought or is not maintainable in such court or that its property is exempt or immune from execution, that the action, suit or proceeding is brought in an inconvenient forum or that the venue of the action, suit or proceeding is improper.

(b) In the event that a Legal Dispute arises between the Parties arising out of or relating to this Agreement, the matter shall be submitted to non-binding mediation prior to commencing litigation, except as provided hereafter. The mediation process shall be initiated by either Party giving written notice to the other party of its desire to mediate. Within thirty (30) days of such written notice, the Parties shall agree on a mediator, or, if the Parties are unable to agree, the mediator shall be selected by the American Health Lawyers Association (the "**AHLA**"), and in that event, the mediation shall be administered by the AHLA under its Rules of Procedure for Arbitration and Mediation. The mediator shall be a practicing attorney who has experience with mediating controversies involving complex commercial transactions or the subject matter of the particular dispute involved. The mediation shall be held at a neutral site mutually agreed upon by the Parties, provided, however, that if the Parties cannot agree on such site within fifteen (15) days after written notice of mediation, then the site shall be the location selected by the mediator.

Each Party shall bear its own costs and expenses and an equal share of the mediator's fees and administrative fees of mediation, if any. If at any time more than five (5) hours into the mediation conference the mediator determines that the controversy cannot be

settled in mediation, the mediator may declare an impasse and the mediation process shall end at that point. The mediation shall be held within thirty (30) days after selection or appointment of the mediator. Following declaration of an impasse by the mediator, either Party shall be free to file a legal proceeding.

Notwithstanding the foregoing, nothing in this subsection shall be construed to require a Party to mediate prior to seeking or receiving equitable or injunctive or other extraordinary relief.

13.15 Benefit/Assignment. Subject to provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective legal representatives, successors and permitted assigns. Neither the Sellers, on one hand, nor Buyer, on the other hand, may assign this Agreement without the prior written consent of the other Party; provided, however, that the Sellers agree and acknowledge that Buyer may designate an Affiliate to purchase the Assets owned by RRL.

13.16 Cost of Transaction. Whether or not the transactions contemplated hereby shall be consummated, the Parties agree as follows: (a) the Sellers shall pay the fees, expenses and disbursements of the Sellers and their agents, representatives, accountants and legal counsel incurred in connection with the subject matter hereof and any amendments hereto; (b) Buyer shall pay the fees, expenses and disbursements of Buyer and its agents, representatives, accountants and legal counsel, lenders and private equity sponsors incurred in connection with the subject matter hereof and any amendments hereto; (c) Buyer shall pay the cost of the HSR Filing; and (d) the Sellers shall pay one-half and Buyer shall pay one-half of all costs of any title search, title commitment, title policy, surveys and endorsements to title policies, as well as all transfer and recording taxes and fees, incurred in connection with the transactions contemplated by this Agreement.

13.17 Confidentiality. It is understood by the Parties that any information provided by another Party (the "**Providing Party**") concerning such Providing Party obtained, directly or indirectly, from the Providing Party in connection with the transactions contemplated by this Agreement ("**Confidential Information**"), and the documents and other written information delivered to a receiving Party (the "**Receiving Party**"), or its stockholders, members, Affiliates, officers, employees or agents (collectively, "**Agents**"), are of a confidential and proprietary nature. To the extent permitted by law, the Receiving Party agrees that it will, and will use its reasonable best efforts to cause the Agents to, maintain the confidentiality of all such Confidential Information, and will only disclose such Confidential Information to Agents as necessary to effect the transactions contemplated hereby. The parties further agree that if the transactions contemplated hereby are not consummated, the Receiving Party and its Agents will promptly return all documents and other written information acquired from the Providing Party or its Affiliates and all copies thereof in their possession to the Providing Party. Each of the Parties hereto recognizes that any breach of this Section 13.17 would result in immediate and irreparable harm to the other Parties to this Agreement and their Affiliates which could not be adequately remedied through the payment of monetary damages, and that therefore either the Sellers or Buyer shall be entitled to an injunction to prohibit any such breach or anticipated breach, without the necessity of posting a bond, cash, or otherwise, in addition to all of its other legal and equitable remedies. Nothing in this Section 13.17, however, shall prohibit the use of

such Confidential Information, documents or information for such governmental filings as in the opinion of the Sellers' counsel or Buyer's counsel are required by law or governmental regulations or are otherwise required to be disclosed pursuant to applicable law. The foregoing restrictions in this Section 13.17 shall not apply to any information that: (a) is on the date hereof or hereafter becomes generally available to the public other than as a result of a disclosure, directly or indirectly, by the Receiving Party or its Agents; (b) was in the possession of the Receiving Party on a non-confidential basis prior to its disclosure; or (c) becomes available to the Receiving Party on a non-confidential basis from a source other than the Providing Party or its representatives, which source was not itself bound by a confidentiality agreement.

13.18 Public Announcements. No Party hereto shall release, publish or otherwise make available to the public in any manner whatsoever any information or announcement regarding the transactions herein contemplated without the prior written consent of the other Parties, except for information and filings reasonably necessary to be directed to governmental agencies to fully and lawfully effect the transactions herein contemplated or as required by law. Notwithstanding the foregoing, the Sellers, in consultation with Buyer, may make periodic announcements to their employees regarding the transactions contemplated by this Agreement. Notwithstanding the foregoing, in the event a Party hereto determines that the terms hereof will be the subject of discovery in any litigation involving such Party, such Party shall promptly notify the other Parties hereto of such determination and if Sellers, on one hand, and Buyer, on the other hand, conclude that such disclosure through discovery is inevitable, then: (a) the Parties shall make a public announcement of the terms hereof prior to such discovery taking place; (b) such public announcement shall be made in a manner and at a time mutually agreed by the Parties; and (c) the Parties shall be represented at, and permitted to participate in, such announcement. In recognition of the status of the Hospital as a not-for-profit, tax-exempt hospital, Buyer acknowledges that ORHC, from time to time, may find it necessary to make public statements or conduct public meetings regarding the transactions herein contemplated. Therefore, Buyer agrees that it will respond promptly to requests from ORHC for Buyer's review of public statements and not to withhold its consent unreasonably. If ORHC determines it is necessary to conduct public meetings regarding the transactions contemplated hereby, ORHC shall provide Buyer with reasonable advance notice of any such meetings, and afford Buyer the opportunity to attend and, if appropriate, participate.

13.19 Waiver of Breach. The waiver by any Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to constitute, a waiver of any subsequent breach of the same or any other provision hereof.

13.20 Notice. Any notice, demand, or communication required, permitted or desired to be given hereunder shall be deemed effectively given when personally delivered, when received by overnight delivery or five (5) days after being deposited in the United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, addressed as follows:

The Sellers:

Ottumwa Regional Health Center, Incorporated
(to be known as the "Ottumwa Regional Legacy Foundation, Inc." effective as of the Effective Time)
935 Pennsylvania Avenue

Ottumwa, Iowa 52501
Attention: Chairman

Regional Retirement Living, Inc.
c/o Ottumwa Regional Legacy Foundation
935 Pennsylvania Avenue
Ottumwa, Iowa 52501
Attention: Chairman

Regional Enterprises, Inc.
c/o Ottumwa Regional Legacy Foundation
935 Pennsylvania Avenue
Ottumwa, Iowa 52501
Attention: Chairman

With simultaneous copies to:

Harrison, Moreland & Webber, P.C.
129 West Fourth Street
Ottumwa, Iowa 52501
[redacted]

McDermott, Will & Emery LLP
227 West Monroe Street, Suite 4700
Chicago, Illinois 60606-5096
[redacted]

Buyer:

RCHP-Ottumwa, Inc.
103 Continental Place, Suite 410
Brentwood, Tennessee 37027
Attention: Chief Executive Officer
[redacted]

With a simultaneous copy to:

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, Tennessee 37219
[redacted]

or to such other address, and to the attention of such other person or officer as any Party may designate, with copies thereof to the respective counsel thereof as notified by such Party.

13.21 Severability. In the event any provision of this Agreement is held to be invalid, illegal or unenforceable for any reason or in any respect, such invalidity, illegality, or unenforceability shall in no event affect, prejudice or disturb the validity of the remainder of this Agreement, which shall be and remain in full force and effect, enforceable in accordance with its terms.

13.22 Gender and Number. Whenever the context of this Agreement requires, the gender of all words herein shall include the masculine, feminine and neuter, and the number of all words herein shall include the singular and plural.

13.23 Divisions and Headings. The divisions of this Agreement into sections and subsections and the use of captions and headings in connection therewith are solely for convenience and shall have no legal effect in construing the provisions of this Agreement.

13.24 Waiver of Jury Trial. EACH PARTY HERETO HEREBY IRREVOCABLY WAIVES ANY AND ALL RIGHTS IT MAY HAVE TO DEMAND THAT ANY ACTION, PROCEEDING OR COUNTERCLAIM ARISING OUT OF OR IN ANY WAY RELATED TO THIS AGREEMENT OR THE RELATIONSHIPS OF THE PARTIES HERETO BE TRIED BY JURY. THIS WAIVER EXTENDS TO ANY AND ALL RIGHTS TO DEMAND A TRIAL BY JURY ARISING FROM ANY SOURCE INCLUDING, BUT NOT LIMITED TO, THE CONSTITUTION OF THE UNITED STATES OR ANY STATE THEREIN, COMMON LAW OR ANY APPLICABLE STATUTE OR REGULATIONS. EACH PARTY HERETO ACKNOWLEDGES THAT IT IS KNOWINGLY AND VOLUNTARILY WAIVING ITS RIGHT TO DEMAND TRIAL BY JURY.

13.25 Accounting Date. The transactions contemplated hereby shall be effective for accounting purposes as of 12:01 a.m. on the day following the Closing Date (the "**Effective Time**"), unless otherwise agreed in writing by the Sellers and Buyer.

13.26 No Inferences. Inasmuch as this Agreement is the result of negotiations between sophisticated parties of equal bargaining power represented by counsel, no inference in favor of, or against, either Party shall be drawn from the fact that any portion of this Agreement has been drafted by or on behalf of such Party.

13.27 No Third Party Beneficiaries. The terms and provisions of this Agreement are intended solely for the benefit of Buyer and the Sellers and their respective successors and permitted assigns, and it is not the intention of the Parties to confer, and this Agreement shall not confer, third party beneficiary rights upon any other person or entity.

13.28 Enforcement of Agreement. The Parties hereto agree that immediate and irreparable harm would occur (which could not be remedied wholly through the payment of monetary damages) in the event that any of the provisions of this Agreement was not performed in accordance with its specific terms or was otherwise breached. It is accordingly agreed that the Parties shall be entitled to an injunction or injunctions (without the need to post bond or other security) to prevent breaches of this Agreement and to enforce specifically the terms and provisions hereof in any court of competent jurisdiction, this being in addition to any other remedy to which they are entitled at law or in equity.

13.29 Entire Agreement/Amendment. This Agreement, together with its Schedules, Exhibits and documents delivered at the Closing, supersedes all previous contracts or understandings, including any offers, letters of intent, proposals or letters of understanding, and constitutes the entire agreement of whatsoever kind or nature existing between or among the Parties with respect to the subject matter hereof. As between or among the Parties, no oral statements or prior written material not specifically incorporated herein shall be of any force and effect. The Parties specifically acknowledge that in entering into and executing this Agreement, the Parties are relying solely upon the representations and agreements contained in this Agreement and its Schedules and Exhibits, and no others. No changes in, or additions to, this Agreement shall be recognized unless and until made in writing and signed by all Parties hereto.

13.30 Counterparts. This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. Facsimile or electronic signatures on this Agreement shall be deemed to be original signatures for all purposes.

13.31 Risk of Loss. The risk of loss in respect to casualty to the Assets shall be borne by the Sellers until the Closing, and by Buyer on and after the Closing. Notwithstanding the foregoing, if any material part of the Hospital is damaged so as to be rendered unusable or destroyed prior to the Closing, Buyer may elect to terminate this Agreement and all obligations of the parties hereunder. In the event the Assets are destroyed or damaged, but such destruction or damage does not entitle Buyer or Buyer does not elect to terminate this Agreement, then Buyer shall be entitled to all insurance proceeds paid prior to the Closing in respect of such damage or destruction prior to the Closing (provided that Buyer shall not be entitled to insurance proceeds received and expended by the Sellers in repair of the Assets prior to the Closing). In the event insurance proceeds are not paid prior to the Closing, Buyer, following the Closing, shall be entitled to receive all proceeds payable in respect of such damage or destruction (provided that Buyer shall not be entitled to insurance proceeds received and expended by the Sellers in repair of the Assets prior to the Closing) and the Sellers shall use their commercially reasonable efforts to obtain all such proceeds that may be payable pursuant to their insurance policies with respect to such matters. This Section 13.31 shall survive the Closing.

13.32 RCHP Guaranty. RCHP hereby unconditionally and absolutely guarantees the prompt performance and observation of Buyer for each and every obligation, covenant and agreement of Buyer arising out of, connected with, or related to this Agreement or any ancillary documents hereto and any extension, renewal and/or modification thereof. RCHP hereby waives any defenses to enforcement of this guaranty that would not be a defense of Buyer under this Agreement. The obligation of RCHP under this Section 13.32 is a continuing guaranty and shall remain in effect, and the obligations of RCHP shall not be affected, modified or impaired upon the happening from time to time of any of the following events, whether or not with notice or consent of RCHP:

(a) The compromise, settlement, release, change, modification, amendment (except to the extent of such compromise, settlement, release, change, modification or amendment) of any or all of the obligations, duties, covenants, or agreements of any party under this Agreement or any ancillary documents hereto; or

(b) The extension of the time for performance of payment of money pursuant to this Agreement, or of the time for performance of any other obligations, covenants or agreements under or arising out of this Agreement or any ancillary documents thereto or the extension or the renewal thereof.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

OTTUMWA REGIONAL HEALTH CENTER, INCORPORATED

By: _____

Name Thomas R. Siemers

Title President and Chief Executive Officer

REGIONAL RETIREMENT LIVING, INC.

By: _____

Name Thomas R. Siemers

Title Authorized Signatory

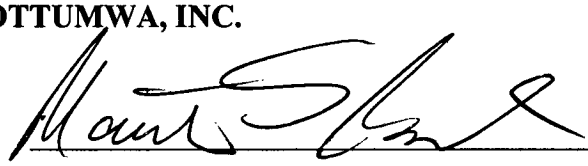
REGIONAL ENTERPRISES, INC.

By: _____

Name Thomas R. Siemers

Title President

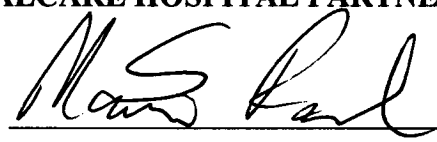
RCHP-OTTUMWA, INC.

By: 

Name Martin S. Rash

Title Chief Executive Officer

REGIONALCARE HOSPITAL PARTNERS, INC.

By: 

Name Martin S. Rash

Title Chief Executive Officer

Schedules

Schedule 1.1	RRL Real Property
Schedule 2.1(a)	Owned Real Property
Schedule 2.1(b)(i)	Leased Real Property
Schedule 2.1(b)(ii)	Seller Leases
Schedule 2.1(c)	Tangible Personal Property
Schedule 2.1(f)	Notes Receivable
Schedule 2.1(j)	Tenant Leases
Schedule 2.1(l)	Pending Approvals
Schedule 2.1(o)	Joint Venture Interests
Schedule 2.2	Excluded Assets
Schedule 2.2(i)	Amounts Due to the Sellers
Schedule 2.2(m)	Interest Rate Swap Agreements
Schedule 2.2(q)	Consignment Inventory
Schedule 2.2(s)	Excluded Joint Venture Interests
Schedule 2.3(d)	Assumed Sick Leave
Schedule 2.3(e)	RRL Resident Entrance Fees
Schedule 2.4(c)	Excluded Liabilities
Schedule 4.1(c)	Joint Ventures
Schedule 4.1(d)	Other Ownership Interests
Schedule 4.2(b)	Government Approvals
Schedule 4.2(c)	Conflicts
Schedule 4.4(a)	Seller Financial Statements
Schedule 4.4(d)	Joint Venture Financial Statements
Schedule 4.5	Post-Balance Sheet Results
Schedule 4.6	Licenses and Permits
Schedule 4.7	CONs
Schedule 4.8	Medicare Participation/Accreditation
Schedule 4.9	Regulatory Compliance
Schedule 4.10	Equipment
Schedule 4.11	Real Property and Permitted Encumbrances
Schedule 4.11(a)	Notice of Violation
Schedule 4.11(b)	Zoning
Schedule 4.11(d)	Real Property Actions
Schedule 4.11(e)	Real Property Occupants
Schedule 4.11(f)	Rent Roll
Schedule 4.11(g)	Notice of Modification
Schedule 4.11(h)	Encroachments
Schedule 4.11(i)	Third Party Rights
Schedule 4.11(j)	Construction Projects
Schedule 4.12	Condition of the Assets
Schedule 4.13(a)	Benefit Plans
Schedule 4.13(d)	Benefit Plan Compliance
Schedule 4.13(f)	COBRA and Continuing Coverage
Schedule 4.13(g)	Benefit Plan Acceleration

Schedule 4.14	Litigation or Proceedings
Schedule 4.16(a)	Tax Status
Schedule 4.16(b)(i)	Extension of Time to File Returns
Schedule 4.16(b)(ii)	Additional Interests
Schedule 4.17(a)	Sellers' Employees
Schedule 4.17(b)	Employment Claims
Schedule 4.17(c)	Employment Loss
Schedule 4.18	Contracts
Schedule 4.21	Insurance
Schedule 4.22	Open Cost Reports
Schedule 4.23	Medical Staff Matters
Schedule 4.26	Compliance Matters
Schedule 4.27	Environmental Matters
Schedule 4.28(a)	Owned Intellectual Property
Schedule 4.28(b)	Other Intellectual Property
Schedule 4.28(d)	Patents, Copyrights and Trademarks
Schedule 4.29	Undisclosed Liabilities
Schedule 4.31	Brokers
Schedule 4.32	Sellers' Knowledge
Schedule 5.2(b)	Buyer Approvals
Schedule 5.8	Buyer's Brokers
Schedule 5.10	Buyer's Knowledge

OTTUMWA REGIONAL HEALTH CENTER

OUR COMMUNITY IMPACT

OttumwaRegionalHealth.com

1001 Pennsylvania Avenue, Ottumwa, Iowa 52501 | **641.684.2300**

Ottumwa Regional Health Center's mission is simple: Making Communities Healthier®. By creating places where people choose to come for healthcare, physicians want to practice and employees want to work, we are providing quality care close to home and investing in our region's overall well-being. Your support allows us to continue to enhance the many ways we serve and care for Ottumwa and the Southeast Iowa region today and for generations to come. Thank you.

— Phil Noel, *CEO*

In 2019, we...

- **...added 52 employed and affiliated providers**
- **...made nearly $2 million in capital improvements**
- **...distributed a payroll of $49,397,723 to more than 660 employees**
- **...donated more than $7.5 million in services to those in need**
- **...paid $5,237,132 in taxes**

Inviting the best possible providers into our community and supporting them is essential to ensuring access to high quality care. This year, we added providers in pediatrics, obstetrics and gynecology, emergency medicine, radiation oncology, heart care and more.

By continually investing in our facilities, we're helping to ensure that we continue to meet our community's healthcare needs. This year, we invested in surgical equipment upgrades, service elevator replacements and more.

We strive to create an environment where talent is recognized, job satisfaction is valued and our employees can effectively use their skills to provide high quality care and service.

Delivering care to all of our neighbors, regardless of their ability to pay, is foundational to our mission and our commitment to our community.

We are proud to be a leader in our region, and our dedication to ensuring fiscal responsibility extends both to our hospital and to our community.

OTTUMWA REGIONAL HEALTH CENTER

SPONSORSHIPS AND DONATIONS

It was our pleasure to be able to support the following activities and organizations during the past year:

- Brain Injury Support Group
- Chamber Rodeo
- Courier Senior Expo
- Family Fest
- Fremont Days
- Holiday Nights & Lights
- Kiwanis Thursday Morning
- Ottumwa Oktoberfest
- Ottumwa Pro Balloon Race
- Ottumwa Symphony Orchestra
- Southeast Iowa Symphony
- Susan G. Komen Race for the Cure
- Tenco Foundation Golf Classic

Employee Jean Day Fundraisers supported:

- Blessings Soup Kitchen
- Ezra Free Clinic
- Jacob's Gift
- Ottumwa Lord's Cupboard Food Pantry

ECONOMIC IMPACT

Charity and other uncompensated care
(includes charity care, uninsured discounts and uncompensated care).....**$7,580,197**

Community benefit programs.....**$154,789**

Professional development $129,871
Physician recruitment $22,368
Community health services $2,550

Taxes paid **$5,237,132**

Property and other taxes $1,547,741
Provider taxes.....$496,467
Payroll taxes.....$2,468,924
Local sales taxes $103,000
State sales taxes $621,000

2019 TOTAL: $12,972,118

2019 Board of Trustees

LIFEPOINT HEALTH®
MAKING COMMUNITIES HEALTHIER

Charity care and other uncompensated care includes charity care, uninsured discounts and uncompensated care. Physician recruitment costs include recruitment costs and support of new physicians' initial practice establishment in the community. Payroll includes consolidated salaries, wages, benefits and contract labor costs. Capital investments include facility expansions/renovations, equipment purchases, technology replacement, information technology additions/updates and routine facility upkeep and maintenance. All references to "LifePoint," "LifePoint Health" or the "Company" used in this release refer to subsidiaries of LifePoint Health, Inc.

Ottumwa Regional Health Center is part of LifePoint Health®, a leading healthcare company dedicated to Making Communities Healthier®. Through its subsidiaries, it provides quality inpatient, outpatient and post-acute services close to home. LifePoint owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in 29 states. It is the sole community healthcare provider in the majority of the non-urban communities it serves. More information about the company can be found at LifePointHealth.net.

OTTUMWA REGIONAL HEALTH CENTER

OUR COMMUNITY IMPACT

OttumwaRegionalHealth.com

1001 Pennsylvania Avenue, Ottumwa, Iowa 52501 | **641.684.2300**

Our mission of Making Communities Healthier® has always been central to the contributions we make to Ottumwa and the Southeast Iowa region. As our area found itself impacted by the COVID-19 pandemic, that mission became even more critical to the well-being of our community. We are proud to be part of a national healthcare network that provided quality care for more than 20,000 COVID-19 patients in 2020 – including those here at home. LifePoint Health's continued support – and yours – allows us to create places where people choose to come for healthcare, physicians want to practice and employees want to work. As we look ahead to a bright future, we look forward to further enhancing how we serve our neighbors today and for generations to come. Thank you.

— Dennis Hunger, *CEO*

In 2020, we...

...added 30 employed, affiliated, telehealth and temporary providers

Inviting the best possible providers into our community and supporting them is essential to ensuring access to high quality care. This year, we added providers in telepsychiatry, teleneurology, teleradiology, emergency care and hospital medicine.

...made more than $5.3 million in capital improvements

By continually investing in our facilities, we're helping to ensure that we continue to meet our community's healthcare needs. This year's investments included a remodel of our McCreery Cancer Center and a new linear accelerator.

...distributed a payroll of $46,061,201 to more than 600 employees

We strive to create an environment where talent is recognized, job satisfaction is valued and our employees can effectively use their skills to provide high quality care and service.

...donated more than $6 million in services to those in need

Delivering care to all of our neighbors, regardless of their ability to pay, is foundational to our mission and our commitment to our community.

...paid $4,929,692 in taxes

We are proud to be a leader in our region, and our dedication to ensuring fiscal responsibility extends both to our hospital and to our community.

ORHC's environmental services staff work hard each day to keep our hospital clean and safe for patients, visitors and staff.

ORHC's ORMICS Crew encouraged community members to stay home in an effort to stop the spread of COVID-19 in 2020.

OTTUMWA REGIONAL HEALTH CENTER

SPONSORSHIPS AND DONATIONS

It was our pleasure to be able to support the following activities and organizations during the past year:

- 25 Men Who Can Cook
- Chamber Rodeo
- Holiday Nights and Lights
- Indian Hills Basketball
- Ottumwa Duck Races
- Ottumwa Lord's Cupboard Food Pantry
- Ottumwa Pro Balloon Races
- Ottumwa Race for the Cure
- Tenco Gold Tournament

Employee Jean Day Fundraisers supported:

- Blessings Soup Kitchen
- Ezra Free Clinic
- Jacob's Gift

ECONOMIC IMPACT

Charity and other uncompensated care (includes charity care, uninsured discounts and uncompensated care)	**$6,145,968**
Community benefit programs	**$160,515**
Professional development	$135,352
Physician recruitment	$25,163
Taxes paid	**$4,929,692**
Property and other taxes	$1,573,112
Provider taxes	$496,467
Payroll taxes	$2,198,452
Local sales taxes	$94,523
State sales taxes	$567,138

2020 TOTAL: $11,236,175

2020 Board of Trustees

LIFEPOINT HEALTH®
MAKING COMMUNITIES HEALTHIER

Charity care and other uncompensated care includes charity care, uninsured discounts and uncompensated care. Physician recruitment costs include recruitment costs and support of new physicians' initial practice establishment in the community. Payroll includes consolidated salaries, wages, benefits and contract labor costs. Capital investments include facility expansions/renovations, equipment purchases, technology replacement, information technology additions/updates and routine facility upkeep and maintenance. All references to "LifePoint," "LifePoint Health" or the "Company" used in this release refer to subsidiaries of LifePoint Health, Inc.

Ottumwa Regional Health Center is part of LifePoint Health®, a leading healthcare company dedicated to Making Communities Healthier®. Through its subsidiaries, it provides quality inpatient, outpatient and post-acute services close to home. LifePoint owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in 29 states. It is the sole community healthcare provider in the majority of the non-urban communities it serves. More information about the company can be found at LifePointHealth.net.

OTTUMWA REGIONAL HEALTH CENTER

OUR COMMUNITY IMPACT

OttumwaRegionalHealth.com

1001 Pennsylvania Avenue, Ottumwa, Iowa 52501 | **641.684.2300**

Our role as a leading provider of healthcare and economic support for our neighbors is driven by our mission of Making Communities Healthier®. We are privileged to call this vital community home and proud to be part of a national diversified healthcare delivery network that allows us to continue to enhance how we care for those we serve.

The support of LifePoint Health and community partners like you help us to advance our mission and create places where people choose to come for healthcare, physicians want to practice and employees want to work. Thank you.

— Dennis Hunger, *CEO*

In 2021, we...

...added 32 employed, affiliated and telemedicine providers

...made more than $5.2 million in capital improvements

...distributed a payroll of $45,414,492 to more than 550 employees

...donated more than $12 million in services to those in need

...paid $4,993,939 in taxes

Inviting the best possible providers into our community and supporting them is essential to ensuring access to high quality care. This year, we added providers in emergency medicine, hospital medicine, cardiology, surgery, telepsychiatry, teleneurology and teleradiology.

By continually investing in our facilities, we're helping to ensure that we continue to meet our community's healthcare needs. This year's investments included OR video towers, a portable digital X-ray machine and equipment for our radiation oncology department.

We strive to create an environment where talent is recognized, job satisfaction is valued and our employees can effectively use their skills to provide high quality care and service.

Delivering care to all of our neighbors, regardless of their ability to pay, is foundational to our mission and our commitment to our community.

We are proud to be a leader in our region, and our dedication to ensuring fiscal responsibility extends both to our hospital and to our community.

ORHC hosted a Breast Cancer Awareness Walk in October.

ORHC leadership served complimentary breakfast to hospital staff.

OTTUMWA REGIONAL HEALTH CENTER

SPONSORSHIPS AND DONATIONS

It was our pleasure to be able to support the following activities and organizations during the past year:

- 25 Men Who Can Cook
- Babe Ruth World Series
- Chamber Rodeo
- Holiday Nights and Lights

Employee Jean Day Fundraisers supported:

- Blessings Soup Kitchen
- Ezra Free Clinic
- Jacob's Gift
- Ottumwa Lord's Cupboard Food Pantry

ECONOMIC IMPACT

Charity and other uncompensated care
(includes charity care, uninsured discounts and uncompensated care) **$12,133,183**

Community benefit programs.....**$117,104**

Professional development $78,017
Physician recruitment $39,087

Taxes paid **$4,993,939**

Property and other taxes $1,525,540
Provider taxes.....$496,467
Payroll taxes.....$2,194,637
Local sales taxes $111,042
State sales taxes $666,253

2021 TOTAL: $17,244,226

2021 Board of Trustees

LIFEPOINT HEALTH®
MAKING COMMUNITIES HEALTHIER

Charity care and other uncompensated care includes charity care, uninsured discounts and uncompensated care. Physician recruitment costs include recruitment costs and support of new physicians' initial practice establishment in the community. Payroll includes consolidated salaries, wages, benefits and contract labor costs. Capital investments include facility expansions/renovations, equipment purchases, technology replacement, information technology additions/updates and routine facility upkeep and maintenance. All references to "LifePoint," "LifePoint Health" or the "Company" used in this release refer to subsidiaries of LifePoint Health, Inc.

Ottumwa Regional Health Center is part of LifePoint Health®, a leading provider of healthcare that serves patients, clinicians, communities and partner organizations across the healthcare continuum. Driven by a mission of Making Communities Healthier, the company has a growing diversified healthcare delivery network comprised of nearly 50,000 dedicated employees, 63 community hospital campuses, 32 rehabilitation and behavioral health hospitals and 170 additional sites of care, including acute rehabilitation units, outpatient centers and post-acute care facilities. More information about LifePoint can be found at LifePointHealth.net.

OTTUMWA REGIONAL HEALTH CENTER

Our Community Impact

OttumwaRegionalHealth.com
1001 Pennsylvania Avenue, Ottumwa, Iowa 52501
641.684.2300

Ottumwa Regional Health Center is committed to providing high-quality care close to home, further enhancing and expanding our services, and making the right investments to promote and protect the health of our region. We take seriously our responsibility to advance our mission of *making communities healthier®* and support our community as a vital economic engine. Our dedicated team is committed to going above and beyond to meet the needs of those we serve – both inside and outside our hospital walls. With support from Lifepoint Health and community partners, like you, we continue to make a positive difference together and create places where people choose to come for healthcare, physicians and providers want to practice and employees want to work. Thank you.

William Kiefer, CEO

2022 Community Benefits

Expanded medical staff to a total of 42 employed and independent providers

Inviting the best possible providers into our community and supporting them is essential to ensuring access to high-quality care. This year, we added providers in urology.

Made nearly $3.6 million in capital improvements

By continually investing in our facilities, we're helping to ensure that we continue to meet our community's healthcare needs. This year's investments included ligature-safe furniture for behavioral health, breaking ground on a new catheterization lab and renovating a building to be used for primary care.

Distributed a payroll of $44,719,951 to approximately 470 employees

We strive to create an environment where talent is recognized, job satisfaction is valued and our employees can effectively use their skills to provide high-quality care and service.

Donated more than $13.6 million in services to those in need

Delivering care to all of our neighbors, regardless of their ability to pay, is foundational to our mission and our commitment to our community.

Paid $5,504,408 in taxes

We are proud to be a leader in our region, and our dedication to ensuring fiscal responsibility extends both to our hospital and to our community.

OTTUMWA REGIONAL HEALTH CENTER

Our 2022 Community Impact

Ottumwa Regional Health Center hosted a robotic surgery open house and ribbon-cutting ceremony.

Ottumwa Regional Health Center team members attended the Women in Leadership Conference.

Economic Impact

Charity and other uncompensated care (includes charity care, uninsured discounts and uncompensated care)	**$13,622,587**
Community benefit programs	**$126,040**
Professional development	*$92,199*
Physician recruitment	*$33,841*
Taxes paid	**$5,504,408**
Property and other taxes	*$2,094,154*
Provider taxes	*$496,467*
Payroll taxes	*$2,380,714*
Sales taxes	*$533,073*

2022 Total
$19,253,035

Sponsorships and Donations

It was our pleasure to be able to support the following activities and organizations during the past year:

- Bridge View Center Family Fest
- Greater Ottumwa Partners in Progress
- Holiday Nights & Lights
- Iowa Heart Foundation
- Ottumwa Has Heart
- Ottumwa Leadership Academy
- Ottumwa Oktoberfest
- SE Iowa Kidney Walk
- SE Iowa Symphony Orchestra

2023 Board of Directors

OFFICERS

Eric Carlson, Chairman
Owner, South Side Drug

William Kiefer, Secretary
CEO, Ottumwa Regional Health Center

MEMBERS

Mahmoud Alameddine, MD
Chief of Staff
Urologist, Ottumwa Health Group

Kurt Anderson, MD
Owner, Ear Nose Throat of SE Iowa

Kim Brown, ARNP
MercyOne Ottumwa

Brian McWilliams
Owner, McCune & Reed Insurance

Thomas Mukkada, MD
Owner/Anesthesiology, Mukkada PLLC

Nate Nicholson, MD
Orthopedic Surgery, Ottumwa Health Group

Matt Thompson
President, Indian Hills Community College

Lifepoint Health
Great care lives here

Charity care and other uncompensated care includes charity care, uninsured discounts and uncompensated care. Physician recruitment costs include recruitment costs and support of new physicians' initial practice establishment in the community. Payroll includes consolidated salaries, wages, benefits and contract labor costs. Capital investments include facility expansions/renovations, equipment purchases, technology replacement, information technology additions/updates and routine facility upkeep and maintenance. All references to "Lifepoint," "Lifepoint Health" or the "Company" used in this release refer to subsidiaries of Lifepoint Health, Inc.

Ottumwa Regional Health Center is part of Lifepoint Health®, a leading healthcare provider that serves patients, clinicians, communities and partner organizations across the healthcare continuum. Driven by a mission of *making communities healthier®*, the company has a growing diversified healthcare delivery network comprised of more than 50,000 dedicated employees, 62 community hospital campuses, more than 50 rehabilitation and behavioral health hospitals and more than 200 additional sites of care, including managed acute rehabilitation units, outpatient centers and post-acute care facilities. For more information about the company, visit www.LifepointHealth.net.

REAL PROPERTY ASSET PURCHASE AGREEMENT

BY AND BETWEEN

LIMA HOLDCO, LLC

("Lima Holdco"),

AND

THE ENTITIES LISTED ON *ANNEX A* ATTACHED HERETO AS "LIMA SUBSIDIARIES"
(Collectively, the "Lima Subsidiaries" and, together with Lima Holdco, the "Lima Parties"),

AND

THE ENTITIES LISTED ON *ANNEX A* ATTACHED HERETO AS "MPT PARTIES",
(Collectively, the "MPT Parties").

Dated as of November 4, 2019

TABLE OF CONTENTS

ANNEXES

EXHIBITS

SCHEDULES

Schedule 4.4	Consents and Approvals
Schedule 4.5(b)	Tenant Leases that Include ROFR Purchase Rights
Schedule 4.5(c)(i)	Tenant Leases
Schedule 4.5(c)(ii)	Collateral Leases
Schedule 4.5(d)(i)	Matters Relating to Assumed Lima Leases, Tenant Leases, and Collateral Leases
Schedule 4.5(d)(ii)	Matters Relating to Tenant Defaults
Schedule 4.5(g)	Construction Projects; Construction Documents; Estimated Development Costs
Schedule 4.5(h)	Noncompliance Matters regarding Real Property
Schedule 4.5(i)	Management Agreements
Schedule 4.5(l)	Notices Regarding Condemnation Proceedings
Schedule 4.6	Environmental Matters
Schedule 4.7	Litigation
Schedule 4.8(a)	Healthcare Licenses
Schedule 4.8(b)	Noncompliance Matters regarding Healthcare Licenses
Schedule 4.9	Noncompliance with Applicable Laws
Schedule 4.11	Taxes
Schedule 4.12(a)	Benefit Plans
Schedule 4.12(b)	Funding of Benefit Plans
Schedule 4.12(c)	Other Noncompliance Matters regarding Benefit Plans
Schedule 4.12(d)	Extraordinary Payment Obligations
Schedule 4.12(e)	Benefit Plan Audits
Schedule 4.13(a)	Collective Bargaining Agreements
Schedule 4.13(b)	Labor Matters
Schedule 4.13(c)	Labor Complaints and Litigation
Schedule 6.5(a)	Requested Tenant Estoppels
Schedule 6.5(b)	Requested Collateral Assignments of Leases
Schedule 6.8	Repayment of Indebtedness and Release of Encumbrances
Schedule 6.11	Construction Project Timelines
Schedule 7.2(e)(ii)	Required Conemaugh Collateral Leases

REAL PROPERTY ASSET PURCHASE AGREEMENT

THIS REAL PROPERTY ASSET PURCHASE AGREEMENT ("**Agreement**") is made and entered into as of the 4th day of November, 2019, by and between Lima HoldCo, LLC, a Delaware limited liability company ("**Lima Holdco**"); the entities listed on ***ANNEX A*** hereto under the heading "Lima Subsidiaries" (individually and collectively as the context may require, the "**Lima Subsidiaries**" and together with Lima Holdco, the "**Lima Parties**"); and the entities listed on ***ANNEX A*** hereto under the heading "MPT Parties" (individually and collectively as the context may require, the "**MPT Parties**"). The Lima Parties and the MPT Parties are herein sometimes referred to individually as a "**Party**" and collectively, as the "**Parties**."

W I T N E S S E T H:

WHEREAS, certain of the Lima Subsidiaries collectively (i) own certain tracts of land located in various states, the common street addresses and/or legal descriptions of which are set forth on ***EXHIBIT A-1*** attached hereto (provided that the legal descriptions for such Owned Property shall be finalized prior to the applicable Closing pursuant to Section 6.13), including all hereditaments, easements, rights of way and other appurtenances related thereto (the "**Owned Land**"), and all Improvements (as hereinafter defined) located thereon (the Owned Land and such Improvements located thereon are sometimes collectively referred to herein as the "**Owned Real Property**" and each, an "**Owned Property**"), and (ii) lease pursuant to the Assumed Lima Leases certain tracts of land located in various states, all being more particularly described on ***EXHIBIT A-2*** attached hereto, including all heredíments, easements, rights of way and other appurtenances related thereto (the "**Leased Land,**" and together with the Owned Land, the "**Land**"), and all Improvements located thereon (the Leased Land and the Improvements located thereon are sometimes referred to herein as the "**Leased Real Property,**" and together with the Owned Real Property, collectively, the "**Real Property**");

WHEREAS, the Lima Subsidiaries set forth on the attached ***EXHIBIT B*** (each, a "**Lessee**" and, collectively, the "**Lessees**") collectively own and operate various acute care hospitals (collectively, the "**Hospitals**") and related medical office buildings and other healthcare and ancillary facilities located on the Real Property (each Hospital, together with the related medical office buildings and other healthcare and ancillary facilities related to such Hospital, collectively, a "**Facility**"), all of which are listed on the attached ***EXHIBIT B***;

WHEREAS, subject to the terms and conditions hereinafter set forth, the applicable Lima Parties desire to sell, transfer, convey and assign to the applicable MPT Parties, and the applicable MPT Parties desire to purchase and acquire from the applicable Lima Parties (each, a "**Lima Seller**" and collectively, the "**Lima Sellers**"), all of such Lima Parties' respective rights, title and interest in the Real Property (including leasehold interests pursuant to the Assumed Lima Leases) and certain other Ancillary Assets (as defined herein) as further described herein;

WHEREAS, immediately thereafter, the applicable MPT Parties and the applicable Lessees shall enter into a Master Lease Agreement substantially in the form attached hereto as ***EXHIBIT C*** (the "**Master Lease**"), pursuant to which the applicable MPT Parties shall lease (or sublease, as applicable) the Real Property to the applicable Lessees; and

WHEREAS, in connection with the purchase, sale and lease transactions described above (collectively, the "**Sale/Leaseback Transaction**"), (i) Lima Holdco (the "**Guarantor**"), as direct and indirect owner of the Lima Subsidiaries (and, in the case of the Conemaugh Properties (other than Nason Medical Center), a direct or indirect owner of the applicable LifePoint JV Member), on each of the applicable Closing Dates, will enter into a guaranty agreement in favor of the MPT Parties substantially in the form attached hereto as ***EXHIBIT D*** (the "**Guaranty**"), pursuant to which Guarantor will guaranty the payment and performance of all of the Lima Parties' obligations and liabilities under the Master Lease and any other MPT Obligation Documents (as hereinafter defined), (ii) Lifepoint Health, Inc., a Delaware corporation ("**LifePoint**"), as direct owner of Lima HoldCo, LLC, on each of the applicable Closing Dates, will enter into a guaranty agreement in favor of the MPT Parties substantially in the form attached hereto as ***EXHIBIT E*** (the "**LifePoint Lease Guaranty**"), pursuant to which LifePoint will guaranty the payment and performance of all of the Lima Parties' obligations and liabilities under the Master Lease and any other MPT Obligation Documents (as hereinafter defined), and (ii) the Lima Parties and certain of their Affiliates (as herein defined) will enter into certain other MPT Obligation Documents, in each case as hereinafter described;

WHEREAS, MPT Operating Partnership, L.P., a Delaware limited partnership ("**MPT Op**"), as direct and indirect owner of the MPT Parties, contemporaneously herewith, is entering into a guaranty agreement in favor of the Lima Parties, pursuant to which MPT Op will guaranty the payment and performance of each of the MPT Parties' obligations and liabilities under this Agreement until the applicable closing with respect to each of the MPT Parties (the "**MPT Op APA Guaranty**").

NOW, THEREFORE, in consideration of the promises and mutual agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

ARTICLE I
DEFINED TERMS

Section 1.1 **Certain Defined Terms**. Capitalized terms used herein shall have the respective meanings ascribed to them in the attached ***Annex B***.

Section 1.2 **Interpretation; Terms Generally**. The definitions set forth in Section 1.1 and elsewhere in this Agreement shall apply equally to both the singular and plural forms of the terms defined. Whenever the context may require, any pronoun shall include the corresponding masculine, feminine and neuter forms. Unless otherwise indicated, the words "include", "includes" and "including" shall be deemed to be followed by the phrase "without limitation." The words "herein", "hereof" and "hereunder" and words of similar import shall be deemed to refer to this Agreement (including the Schedules, Annexes, and Exhibits) in its entirety and not to any part hereof, unless the context shall otherwise require. All references herein to parties, Articles, Sections, Schedules, Annexes, and Exhibits shall be deemed to refer to parties, Articles, Sections and Annexes and Schedules of, and Exhibits to, this Agreement, unless the context shall otherwise require. Unless the context shall otherwise require, any references to any agreement or other instrument or statute or regulation are to it as amended and supplemented from time to time (and, in the case of a statute or regulation, to any corresponding provisions of

successor statutes or regulations). Any reference in this Agreement to a "day" or number of "days" that does not refer explicitly to a "Business Day" or "Business Days" shall be interpreted as a reference to a calendar day or number of calendar days. If any action or notice is to be taken or given on or by a particular calendar day, and such calendar day is not a Business Day, then such action or notice shall be deferred until, or may be taken or given on, the next Business Day.

ARTICLE II
PURCHASE AND SALE OF REAL PROPERTY AND ANCILLARY ASSETS

Section 2.1 **Purchase and Sale**. Based upon the representations and warranties of the Lima Parties as set forth herein, and subject to the terms and conditions hereof, on the applicable Closing Date, each Lima Subsidiary listed on the attached ***EXHIBIT B***, in consideration for the payment of the Purchase Price in accordance with Section 3.1, shall grant, sell, assign, transfer, convey and deliver to the applicable MPT Party listed on the attached ***EXHIBIT B***, and the applicable MPT Party shall purchase and acquire from such Lima Party, free and clear of all Encumbrances, other than Permitted Encumbrances, the following assets of the Lima Parties (collectively, the "**MPT Acquired Assets**"):

(a) All Owned Real Property;

(b) All Assumed Lima Leases and all of the Lima Parties' rights, title and interests in and to the Leased Real Property subject thereto, including, without limitation, (i) any leasehold interests of any of the Lima Parties in the Leased Real Property and (ii) any ownership and/or leasehold interests of any of the Lima Parties in the Improvements located on the Leased Real Property;

(c) The MOB Ground Leases and all of the Lima Parties' rights, title and interests thereunder, including, without limitation (i) all rights as a landlord thereunder, and (ii) all reversionary interests contemplated therein; and

(d) All Ancillary Assets.

Section 2.2 **Excluded Assets**. Notwithstanding anything to the contrary contained herein, including Section 2.1 above, each of the Lima Parties, as applicable, shall retain all of its right, title and interest in and to and shall have no obligation to (and shall not be deemed to) sell, assign, convey, transfer, mortgage, pledge, hypothecate or otherwise deliver to any of the MPT Parties any or all of the Lima Parties' respective assets and properties other than the Real Property and the Acquired Assets (collectively, the "**Excluded Assets**"), which Excluded Assets shall include, without limitation the following:

(a) All cash, funds, accounts receivables, securities and investments of any of the Lima Parties;

(b) Any casualty, liability or other insurance policies of any of the Lima Parties with respect to the MPT Acquired Assets (subject from and after the applicable Closing Date, to the assignment to any of the applicable MPT Parties pursuant to the terms and conditions of the Master Lease of the proceeds of such policies in the event of a casualty);

(c) All personal property of any kind or nature, including without limitation, all inventories, supplies, books and records, licenses, permits and approvals (other than as expressly specified in Section 2.1);

(d) All healthcare compliance agreements, personal property leases, and any other assets of any of the Lima Parties (other than as expressly specified in Section 2.1);

(e) Other than the MOB Ground Leases (which are being assumed pursuant to Section 2.1 above), all leases, subleases, and other rental or occupancy agreements, whether written or oral, in effect (either on the date of this Agreement or on the applicable Closing Date), if any, pursuant to which any of the Lima Parties or its Affiliates grant or will grant a possessory interest in and to any portion of or space in the Real Property or that otherwise assign or convey rights with regard to the Real Property, including without limitation: (i) leases of land to third-party developers in connection with development/construction of health care related projects at the Facilities; (ii) medical office leases, parking lot agreements, subleases and occupancy agreements; (iii) leases, subleases and occupancy agreements for other medical uses, services or facilities; and (iv) leases, subleases and occupancy agreements for food services and other ancillary services at the Facilities, including as examples and not as limitations, wireless communication services, gift shops, pharmacies or florist shops (collectively, the "**Tenant Leases**");

(f) Other than the Assumed Lima Leases, all leases, subleases, and other rental or occupancy agreements, whether written or oral, in effect (either on the date of this Agreement or on the applicable Closing Date), if any, pursuant to which any of the Lima Subsidiaries holds a leasehold interest in any real property or improvements (and which are not being purchased or assumed by the MPT Parties pursuant to this Agreement), including without limitation, medical office leases, parking lot agreements, storage space leases, and any other leases, subleases and occupancy agreements relating to any real property or improvements ancillary to the operation of the Business (collectively, the "**Collateral Leases**"); provided, that, certain of the Collateral Leases shall be subject to the Collateral Assignments of Leases as hereinafter described;

(g) All Federal Communications Commission licenses and equipment used in operations thereunder; and

(h) Any assets and properties described on the attached ***Schedule 2.2***.

Section 2.3 Assumed Lima Leases; Assigned MOB Ground Leases; No Other Assumed Liabilities.

(a) Based upon the representations and warranties of the Lima Parties as set forth herein, and subject to the terms and conditions hereof, on the applicable Closing Date, the applicable Lima Parties and MPT Parties shall enter into an Assignment and Assumption of Lease Agreement, pursuant to which such Lima Parties shall assign to the applicable MPT Parties, and the applicable MPT Parties shall assume from the applicable Lima Parties, all of the lease agreements pursuant to which any of the Lima Parties leases, as tenant or lessee, from any third party landlord or lessor any of the Leased Real Property being sold, transferred, conveyed

any assigned as part of such Closing, all of which lease agreements are listed on the attached ***Schedule 2.3(a)*** (collectively, the "**Assumed Lima Leases**"), each of which shall be free and clear of all Encumbrances, other than Permitted Encumbrances, subject to the terms and conditions of this Agreement. ***Schedule 2.3(a)*** sets forth the current expiration date of each of the Assumed Lima Leases. The Parties acknowledge and agree that, pursuant to the Master Lease and notwithstanding any provision to the contrary in any Assignment and Assumption of Lease Agreement, the MPT Parties shall sublease the Leased Real Property to the Lessees, and the Lessees shall therein covenant and be obligated to comply with and perform during the term of the Master Lease all lessee and tenant obligations under the Assumed Lima Leases.

(b) Based upon the representations and warranties of the Lima Parties as set forth herein, and subject to the terms and conditions hereof, on the applicable Closing Date, the applicable Lima Parties and MPT Parties shall enter into an Assignment and Assumption of MOB Ground Lease Agreement, pursuant to which in connection with the sale of the fee simple interest in the applicable Real Property, such Lima Parties shall assign to the applicable MPT Parties, and the applicable MPT Parties shall assume from the applicable Lima Parties, all of the right, title, interest and obligations of the applicable Lima Parties as lessors under the MOB Ground Leases, each of which shall be free and clear of all Encumbrances, other than Permitted Encumbrances, subject to the terms and conditions of this Agreement. ***Schedule 2.3(b)*** sets forth the current expiration date of each of the MOB Ground Leases. The Parties acknowledge and agree that, pursuant to the Master Lease, and notwithstanding any provision to the contrary in any Assignment and Assumption of MOB Ground Lease Agreement, the Lessees shall therein covenant and be obligated to comply with and perform all lessor and landlord obligations under the MOB Ground Leases.

(c) Except as expressly set forth in Section 2.3(a) and Section 2.3(b) of this Agreement, the MPT Parties shall not assume or agree to pay, satisfy, discharge or perform, and shall not be deemed by virtue of the execution and delivery of this Agreement, or any other document delivered pursuant to this Agreement, or as a result of the consummation of the transactions contemplated by this Agreement, or such other document, to have assumed, or to have agreed to pay, satisfy, discharge or perform, and shall not be liable for, any liability, obligation, contract or indebtedness of any of the Lima Parties, their respective Affiliates or any other Person, whether primary or secondary, direct or indirect, including, without limitation, any liability or obligation relating to the ownership, use or operation of any of the MPT Acquired Assets or the Facilities prior to the applicable Closing, any liability or obligation arising out of or related to any breach, default, tort or similar act prior to the applicable Closing committed by any of the Lima Parties or any of their respective Affiliates, or for any failure of the Lima Parties or any of their respective Affiliates to perform any covenant or obligation for or during any period prior to the applicable Closing, and any liability arising out of the ownership and operation of such MPT Acquired Assets and the Facilities by the Lima Parties or any other Person prior to the applicable Closing (collectively, the "**Excluded Liabilities**").

Section 2.4 Damage, Destruction, or Condemnation of MPT Acquired Assets. If, prior to the applicable Closing Date, all or any material portion of the Real Property relating to any Facility is either damaged or destroyed by a fire or other casualty event, or taken by, or made subject to, condemnation, eminent domain or other governmental acquisition proceedings (and "material" in this context shall mean the amount of the damage or the value of the taking (in each

case, as determined by an independent third party contractor or engineer selected by the applicable Lima Parties and reasonably approved by the MPT Parties) or the amount of insurance proceeds or condemnation award shall exceed the sum of twenty-five percent (25%) of the aggregate applicable Individual Purchase Prices for the Real Property comprising the related Facility) (in either case, an "**Impacted Facility**"), the MPT Parties may elect by written notice to the Lima Parties, given not later than ten (10) Business Days prior to the applicable Closing Date (unless the damage or taking occurs less than thirty (30) Business Days prior to the applicable Closing Date, in which event such written notice may be given at any time prior to the applicable Closing Date), either:

(a) to terminate this Agreement with respect to such Impacted Facility (and related MPT Acquired Assets), in which event this Agreement shall remain in full force and effect with respect to the other Real Property and the aggregate Purchase Price shall be reduced by the amount of the Individual Purchase Price (provided, that, in the event that the Impacted Facility is any of the Conemaugh Properties, then the MPT Parties or the Lima Parties, in their sole discretion, may terminate this Agreement with respect to all of the Real Property), or

(b) to close the purchase of the Impacted Facility (and related MPT Acquired Assets) in accordance with this Agreement without any reduction or credit against the allocated Purchase Price, in which event (i) any insurance proceeds or awards related thereto which are received by any of the Lima Parties prior to the applicable Closing shall be utilized by the Lima Parties prior to Closing for the restoration of such Impacted Facility, and (ii) after the applicable Closing, all insurance proceeds and awards (including any such proceeds or awards received by the Lima Parties before the applicable Closing Date but not previously utilized for such restoration) shall be held and applied (and, if required thereunder, assigned to the MPT Parties) pursuant to and in accordance with the Master Lease.

ARTICLE III
PURCHASE PRICE

Section 3.1 **Purchase Price**. The aggregate purchase price (the "**Purchase Price**") for the MPT Acquired Assets shall be Seven Hundred Million Dollars ($700,000,000) (the "**Purchase Price**"), which Purchase Price shall be allocated among the Real Property as described in Section 3.4 hereof. The allocated Purchase Price for the MPT Acquired Assets of each individual Lima Seller shall be referred to herein as the "**Individual Purchase Price**" for the MPT Acquired Assets of such individual Lima Seller.

Section 3.2 **Payment of Purchase Price**. At each Closing, the applicable MPT Parties shall pay to the applicable Lima Sellers the Individual Purchase Price for each of the MPT Acquired Assets being sold, transferred, conveyed and assigned at such Closing.

Section 3.3 **Taxes, Rentals, Utilities**. The parties acknowledge that all utility charges and all real and personal property Taxes related to the Real Property and the other MPT Acquired Assets shall be the responsibility of the Lessees pursuant to the terms of the Master Lease. On the applicable Closing Date, there shall be no apportionment of taxes, rents, utility payments or other similar obligations.

Section 3.4 **Allocation of Purchase Price**. The Parties agree that the Purchase Price shall be allocated entirely to the Real Property as set forth on ***Schedule 3.4*** (the "**Allocation**") for purposes of Section 1060 of the Code and for all federal, state and local income tax purposes. The Parties agree to use, and to not take any position which is inconsistent with, the Allocation in the preparation and filing of any Tax Return, report, or information return or statement related to Taxes (including Form 8594) or accounting methods, unless required to do so by applicable Laws.

ARTICLE IV
REPRESENTATIONS AND WARRANTIES OF LIMA PARTIES

With the understanding that the MPT Parties shall rely hereon, and as a material inducement to the MPT Parties to enter into this Agreement and to consummate the transactions contemplated hereby, the Lima Parties, jointly and severally, hereby represent and warrant to the MPT Parties as of the date hereof and as of the applicable Closing as follows:

Section 4.1 **Organization**. Each Lima Party is a corporation or limited liability company, as the case may be, duly incorporated or organized, validly existing, and in good standing under the laws of the state of its incorporation or organization, and is qualified to do business in every jurisdiction where such qualification is necessary. ***Schedule 4.1*** sets forth the direct and indirect ownership of each Lima Party up through LifePoint (i.e., it does not show the direct and indirect ownership of LifePoint) on the date hereof, and also sets forth the direct and indirect ownership of each Lima Party up through LifePoint upon the consummation of the LifePoint Upper Tier Restructuring Transaction, which, the Parties agree, may occur prior to or after the Closing Date(s). Except as set forth on ***Schedule 4.1***, no other Person owns (or, after consummation of the LifePoint Upper Tier Restructuring Transaction, will own), and, except in connection with the LifePoint Upper Tier Restructuring Transaction, no Lima Party has offered to any Person, any equity interest in any of the Lima Parties or any option, warrant or other right to acquire the same. MPT Parties acknowledge and agree that prior to the consummation of the LifePoint Upper Tier Restructuring Transaction, LifePoint may make changes to the organizational chart that shows the ownership after the consummation of the LifePoint Upper Tier Restructuring Transaction, either to remove holding companies between Lima HoldCo and the Lima Subsidiaries or to include additional wholly-owned holding companies between Lima HoldCo and the Lima Subsidiaries, and the MPT Parties agree that any such changes shall not be deemed to violate this representation, if (i) such changes would not otherwise be in violation of Section 16.1(e) or Section 16.1(l) of the Master Lease if it were in effect and applicable to LifePoint, Lima HoldCo, and the Lima Subsidiaries as of the date thereof, and (ii) the Lima Parties promptly update ***Schedule 4.1*** accordingly.

Section 4.2 **Authorization and Enforceability**.

(a) Each Lima Party has the requisite corporate or limited liability company power and authority to conduct its business as it is now being conducted and as proposed to be conducted. Each applicable Lima Party has the requisite corporate or limited liability company power and authority to execute, deliver and carry out the terms of this Agreement, the other MPT Obligation Documents to which it is or will become a party and all documents and agreements

necessary to give effect to the provisions hereof and thereof and to consummate the transactions contemplated hereby and thereby.

(b) All actions required to be taken by each applicable Lima Party to authorize the execution, delivery and performance of this Agreement and the other MPT Obligation Documents, and all transactions contemplated hereby and thereby, in each case have been or will be when delivered duly and properly taken or obtained in accordance and in compliance with such applicable Lima Party's Constituent Documents. The Lima Parties have delivered to the MPT Parties true and correct copies of each Lima Party's Constituent Documents. No other action on the part of any applicable Lima Party, or its directors, managers or Equity Constituents (as applicable) is necessary to authorize the execution, delivery and performance of this Agreement, the other MPT Obligation Documents, or any transactions contemplated hereby and thereby.

(c) This Agreement, all other MPT Obligation Documents, and all other documents, agreements and instruments to which any applicable Lima Party is or will become a party hereunder or thereunder, are or will constitute when delivered the valid and legally binding obligations of such Lima Party, enforceable against such Lima Party in accordance with the respective terms hereof or thereof, except as enforceability may be restricted, limited or delayed by applicable bankruptcy, insolvency or other similar laws affecting creditors' rights generally and except as enforceability may be subject to and limited by general principles of equity (regardless of whether considered in a proceeding in equity or at law).

Section 4.3 **Absence of Conflicts**. Each applicable Lima Party's execution, delivery and performance of this Agreement and the other MPT Obligation Documents to which such Lima Party will become a party, and the consummation of the transactions contemplated hereby and thereby (including, without limitation, the LifePoint Upper Tier Restructuring Transaction and related LifePoint Upper Tier Distributions) will not, with or without the giving of notice and/or the passage of time, but subject to receipt of the consents and approvals set forth on ***Schedule 4.4*** hereto:

(a) violate or conflict with any provision of such Lima Party's Constituent Documents

(b) violate or conflict with any provision of any Law (including, without limitation, all applicable Laws regarding the paying, making, or declaring dividends or distributions to be made by the Lima Parties or any other Person in connection with the transactions contemplated hereby and thereby) to which such Lima Party or any of its Equity Constituents is subject;

(c) violate or conflict with any judgment, order, writ or decree of any court applicable to such Lima Party;

(d) result in or cause the creation of an Encumbrance (other than a Permitted Encumbrance) on any portion of the Real Property or any of the other MPT Acquired Assets; or

(e) result in the breach or termination of any provision of, or create rights of acceleration or constitute a default under, the terms of any material indenture, mortgage, deed of

trust, contract, agreement or other instrument of such Lima Party, other than pursuant to the MPT Obligation Documents (it being agreed that, for the purposes of this clause (e), a "material" agreement shall be deemed to mean any agreement requiring the payment of $1,000,000 or more per year).

Section 4.4 Consents and Approvals. Except as set forth in the attached ***Schedule 4.4***, no permit, consent, authorization, approval, registration, declaration or filing with any Governmental Authority or other Person is required to be made or obtained by or with respect to any applicable Lima Party in connection with the execution, delivery and performance of this Agreement, the MPT Obligation Documents, or the consummation of the transactions contemplated hereby or thereby with respect to which the failure to obtain such permit, consent or approval would result in a Material Adverse Effect.

Section 4.5 Real Property.

(a) The attached ***EXHIBIT A-1*** of this Agreement sets forth the addresses and legal descriptions for all Owned Real Property (but excluding any Excluded Assets); provided, that, with respect to the Conemaugh Properties, the attached ***EXHIBIT A-1*** sets forth only the addresses for such Conemaugh Properties. The applicable Lima Subsidiary specified in such Exhibit is the sole owner of the Owned Real Property, and such Lima Subsidiary has and, at the applicable Closing, will convey to the applicable MPT Party specified in such Exhibit fee simple title to such Owned Real Property related to the MPT Acquired Assets to be transferred at such Closing, free and clear of all Encumbrances other than the Permitted Encumbrances. The attached ***EXHIBIT A-2*** of this Agreement sets forth the addresses and legal descriptions for all Leased Real Property (but excluding any Excluded Assets and any real property subject to the Collateral Leases). The applicable Lima Subsidiary specified in such Exhibit is the sole lessee of such Leased Real Property, and such Lima Subsidiary has and, at Closing, will convey to the applicable MPT Party specified in such Exhibit a valid leasehold title to such Leased Real Property, free and clear of all Encumbrances other than the Permitted Encumbrances.

(b) Except as may be set forth in the Tenant Leases listed on the attached ***Schedule 4.5(b)***, there are no rights of first refusal, rights of first offer, options to purchase or lease, restriction to sale or transfer, or any similar rights or options to purchase or transfer any Facility or material portion of, or material rights in, any of the Real Property (collectively, the "**ROFR Purchase Rights**").

(c) ***Schedule 4.5(c)(i)*** of this Agreement lists all Tenant Leases and, except as set forth in the Tenant Leases, the applicable Lima Party has the right to assign certain rights under the Tenant Leases to the applicable MPT Parties pursuant to and as described in the Assignments of Rents and Leases, free and clear of all Encumbrances other than the Permitted Encumbrances. ***Schedule 4.5(c)(ii)*** of this Agreement lists all Collateral Leases and, except as set forth in ***Schedule 4.5(c)(ii)***, the applicable Lima Party has the right to collaterally assign the Collateral Leases to the applicable MPT Parties pursuant to the Collateral Assignments. The Lima Parties have delivered to the MPT Parties true, correct, and complete copies of all Tenant Leases and Collateral Leases (including all amendments, renewals, and extensions thereof).

(d) To the Knowledge of the Lima Parties, except as otherwise set forth on ***Schedule 4.5(d)(i)*** of this Agreement: (i) the lessors named in the respective Assumed Lima Leases and Collateral Leases are the fee owners of the real property and improvements leased thereunder, (ii) none of the Tenant Leases is subject to any option to renew, options to purchase, rights of first refusal, rights of first offer, restrictions to sale or transfer, or any similar rights except as set forth in the Tenant Leases, (iii) no tenant is entitled to any rebate, concession or free rent under any Tenant Lease or otherwise, (iv) no commitments have been made by any of the Lima Parties to any third party tenant for material repairs or improvements other than for normal repairs and maintenance in the future except as set forth in the Tenant Leases, and (v) no rents due under any Tenant Leases have been assigned or hypothecated to, or encumbered by, any Lima Party, as landlord. All of the Tenant Leases, Assumed Lima Leases, and Collateral Leases are in full force and effect and enforceable against the applicable Lima Parties and, to the Knowledge of the Lima Parties, the other parties thereto, in accordance with their terms, subject to bankruptcy, insolvency, reorganization, moratorium and similar Laws of general application relating to or affecting creditors' rights and to general principles of equity. Except as otherwise set forth on ***Schedule 4.5(d)(ii)***, there is no material default by any of the Lima Parties (or to the Knowledge of the Lima Parties, any other party) under any Tenant Lease, Assumed Lima Lease, or Collateral Lease and, to the Knowledge of the Lima Parties, no event has occurred which, whether with or without notice, lapse of time or both, would constitute a material default thereunder. No lessee party to any Tenant Lease, Assumed Lima Lease, or Collateral Lease is in a holdover status beyond the stated duration of the applicable term thereof. To the Knowledge of the Lima Parties, none of the Leased Real Property is subject to any Encumbrance (other than Permitted Encumbrances) which might reasonably be expected to materially impair the present and continued use thereof as contemplated in the applicable Assumed Lima Lease.

(e) There are no pending, or to the Knowledge of the Lima Parties, threatened Proceedings or actions to revoke, invalidate, rescind, or modify: (i) the zoning of the Facilities or any part thereof, or (ii) any building or other permits heretofore issued with respect to the Facilities or any part thereof, or asserting that any such zoning or permits do not permit the operation of the Hospitals or any part thereof, or that any Improvement located on the Real Property cannot be operated in accordance with its current use or is in violation of applicable use requirements.

(f) There is no pending or, to the Knowledge of the Lima Parties, threatened Public Taking (as defined below) affecting the Real Property or any portion thereof; or pending public improvements in, about or outside any of the Real Property which will in any manner materially and adversely affect access to or use of the Real Property or any part thereof, nor, to the Knowledge of the Lima Parties, any other threatened action, suit, Proceeding, or any special, general or other assessments, against or materially and adversely affecting the Real Property or any portion thereof, or relating to or arising out of the ownership, operation, management, use or maintenance of the Real Property or any portion thereof. As used herein, "**Public Taking**" shall mean any portion of the Land is subject to condemnation, requisition or other taking by any public authority.

(g) ***Schedule 4.5(g)*** of this Agreement: (i) describes all development and construction work, if any, which any of the Lima Parties has contracted for and which is presently in progress for any portion of the Real Property and is anticipated to cost in excess of

$7,500,000 (the "**Construction Projects**"); (ii) lists the general contractor agreements and architect agreements to which any of the Lima Parties or their Affiliates is a party with respect to any Construction Projects (together with any related warranties related to the Construction Projects, the "**Construction Documents**"); and (iii) sets forth the estimated maximum projected total development costs, including all hard and soft costs, relating to the completion of each Construction Projects (the "**Total Development Costs**"); and (iv) lists all other planned and approved facility and/or property improvements or capital projects (through December 31, 2023) that are anticipated to cost in excess of $15,000,000.

(h) Except as set forth on ***Schedule 4.5(h)*** of this Agreement, none of the Lima Parties has received any written notice of material noncompliance with (i) any material applicable Law, statutes, restrictions, regulations, ordinances, order or, injunction applicable thereto, including, but not limited to, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 with respect to the Real Property, or (ii) any restrictive covenant, deed restriction or ordinance (recorded or otherwise) adversely affecting the Real Property, including, without limitation, any applicable zoning, or building code, flood disaster law or health and environmental law or regulation or parking ordinances related to the Real Property.

(i) ***Schedule 4.5(i)*** of this Agreement list all Management Agreements to which any of the Lima Parties are parties with respect to the Hospitals or Facilities. MPT Parties acknowledge and agree that any Lima Parties may enter into Management Agreements and the MPT Parties agree that the same shall not be deemed to violate this representation, if (i) such Management Agreement would be with a "Qualified Manager" as defined in the Master Lease if it were in effect and applicable to the Lima Parties as of the date thereof, and (ii) the Lima Parties promptly update ***Schedule 4.5(i)*** accordingly.

(j) To the Knowledge of the Lima Parties, (i) the existing water, sewer, gas and electricity lines, storm sewer and other utility systems are adequate to serve the utility needs of the Real Property as currently used, (ii) all of said utilities are installed and operating, and (iii) all installation and connection charges have been paid in full.

(k) There is no action, claim, suit, audit, Proceedings or investigation pending or, to the Knowledge of the Lima Parties, threatened in writing, against or affecting all or any portion of the Real Property, that, if determined adversely to the applicable Lima Party, could have an adverse impact on the marketability of the applicable Real Property or the ability of such Lima Party to conduct its business in the manner conducted on the date hereof.

(l) Except as set forth in ***Schedule 4.5(l)***, the Lima Parties have not received written notice from any Governmental Authority or other Person asserting any facts or conditions which would result in the termination of the current access from the Real Property to any presently existing public highways and/or roads adjoining or situated on the Real Property or to sewer of other utility services to serve the Real Property.

(m) Except as otherwise disclosed in any zoning letters or reports obtained by the MPT Parties, to the Knowledge of the Lima Parties, the applicable Lima Seller owns or holds rights with respect to, parking for the Real Property and each Facility sufficient to satisfy in all material respects all applicable Laws, codes, requirements, rules and regulations, and, to the

Knowledge of the Lima Parties, such parking is adequate for the current uses of the Real Property.

Section 4.6 **Environmental Conditions**. Except as set forth on ***Schedule 4.6*** of this Agreement:

(a) The Lima Parties are and have been at all times during their respective ownership, use and operation of the Business, the Facilities and the Real Property, in compliance in all material respects with applicable Environmental Laws, except for any noncompliance that has been resolved without any further obligation for the Lima Parties and is not reasonably likely to reoccur.

(b) None of the Lima Parties nor any of their Affiliates nor, to the Knowledge of the Lima Parties, any other Person has stored or used any Hazardous Substances on any of the Real Property, except as necessary to the conduct of the Business, and then in material compliance with applicable Environmental Laws, except for any noncompliance that has been resolved without any further obligation for the Lima Parties and is not reasonably likely to reoccur.

(c) None of the Lima Parties nor any of their Affiliates nor, to the Knowledge of the Lima Parties, any other Person has disposed of, released or permitted the release of any Hazardous Substances on any of the Real Property, except in material compliance with applicable Environmental Laws or has been remedied without any further obligation for the Lima Parties and is not reasonably likely to reoccur.

(d) None of the Lima Parties has received any unresolved written communication from a Governmental Authority or any other Person that alleges that any of the Lima Parties is not in compliance with Environmental Laws or is otherwise subject to liability relating to Environmental Laws.

(e) None of the Lima Parties has been notified in writing that it is a potentially responsible party under any Environmental Laws with respect to any off-site location where any of the Lima Parties, with respect to the Business, has stored, disposed or arranged for the disposal of Hazardous Substances.

(f) None of the Lima Parties has assumed or undertaken or otherwise become subject to any liability or corrective, investigatory or remedial obligation of any other person relating to any Environmental Law.

(g) There are no Environmental Claims pending or, to the Knowledge of the Lima Parties, threatened against any of the Lima Parties.

(h) To the Knowledge of the Lima Parties, there are no underground storage tanks on the Real Property or any other property owned, leased or operated by any of the Lima Parties or with respect to any of the Facilities.

Section 4.7 **Litigation**. Except as set forth on ***Schedule 4.7***, there are no actions, claims, suits, audits, Proceedings or investigations pending or, to the Knowledge of the Lima

Parties, threatened against or affecting any Lima Party that has or would reasonably be expected to have a material and adverse effect on such Lima Party's ability to perform its obligations under this Agreement, the other MPT Obligation Documents, or any aspect of the transactions contemplated hereby or thereby.

Section 4.8 Healthcare Matters; Reimbursement; Accreditation.

(a) ***Schedule 4.8(a)*** contains a complete and accurate list, as of the date hereof, of all material Healthcare Licenses and, except as set forth in ***Schedule 4.8(a)***, the Lima Parties and/or the Facilities, as applicable, possess all material Healthcare Licenses, and such material Healthcare Licenses are in full force and effect.

(b) Except as set forth on ***Schedule 4.8(b)***, (i) the Lima Parties are in compliance, in all material respects, with the requirements of all material Healthcare Licenses, (ii) no suspension or cancellation of any such material Healthcare Licenses is pending or, to the Knowledge of the Lima Parties, threatened, and (iii) none of the Lima Parties have received any written notice from any Governmental Authority with respect to, as applicable, the threatened or pending denial, revocation, termination, or suspension of any of the material Healthcare Licenses.

Section 4.9 Compliance with Laws. Except as set forth on ***Schedule 4.9***: (i) each of the Lima Parties possess all material Licenses required under applicable Laws to own, lease and operate its properties and assets and to carry on its business as currently operated, (ii) there are no actions, claims, suits, audits, Proceedings or investigations pending or, to the Knowledge of the Lima Parties, threatened regarding the revocation, suspension, cancellation, withdrawing, material modification or limitation of any such material License or a declaration of any such material License as invalid. Except as set forth on ***Schedule 4.9***, each material License is in full force and effect, and each of the Lima Parties is in compliance in all material respects with each such material License (and its obligations with respect to such License) and with all Laws applicable to it or by or to which any of its properties or assets is bound or subject and none of the Lima Parties has received any written notice from any Governmental Authority alleging material non-compliance.

Section 4.10 [Intentionally Omitted]

Section 4.11 Taxes. Except as set forth on ***Schedule 4.11*** of this Agreement:

(a) Each of the Lima Parties has (i) filed or caused to be filed with the appropriate Governmental Authorities all income and other material Tax Returns required to be filed by it and (ii) paid all Taxes due and payable by it to the appropriate Governmental Authority, except to the extent such amounts are being contested in good faith and for which appropriate reserves have been established in accordance with sound and commercially reasonable accounting principles consistently applied by the Lima Parties. All such Tax Returns were correct and complete in all material respects solely in relation to the ultimate Tax liability calculated and reflected on such Tax Returns.

(b) There are no outstanding waivers or agreements regarding the application of the statute of limitations with respect to any material Taxes or material Tax Returns of any of the Lima Parties (other than pursuant to an extension of time to file).

(c) No unresolved federal, state, local or foreign audits or other administrative Proceedings have been formally commenced or are pending with regard to any Taxes or Tax Returns of any of the Lima Parties for which any of the Lima Parties has not made adequate provisions (in accordance with sound and commercially reasonable accounting principles consistently applied by the Lima Parties), and no written or, to the Knowledge of the Lima Parties, any other notification has been received by any of the Lima Parties that such an audit or other Proceeding has been proposed or, to the Knowledge of the Lima Parties, threatened.

(d) No unresolved written claim has been made by a Governmental Authority with respect to Taxes in a jurisdiction where any of the Lima Parties does not file Tax Returns that any of the Lima Parties is or may be subject to taxation by or required to file Tax Returns in that jurisdiction.

(e) There are no Encumbrances for Taxes (other than Permitted Encumbrances) upon any of the Real Property or the other MPT Acquired Assets.

(f) None of the Lima Parties are parties to any Tax abatement agreements relating to any of its properties or assets.

Section 4.12 Employee Benefit Plans/ERISA.

(a) ***Schedule 4.12(a)*** of this Agreement sets forth all "**Benefit Plans**".

(b) Except as disclosed in ***Schedule 4.12(b)***, all amounts that are required under the terms of any Collective Bargaining Agreement or participation agreement to be paid as contributions to a Multiemployer Plan, if any, on or prior to the applicable Closing Date have been paid. The funded status of each Benefit Plan subject to Accounting Standards Codification 715 is disclosed on ***Schedule 4.12(b)*** in a manner consistent with the Accounting Standards Codification 715. None of the transactions contemplated in this Agreement will subject any of the Lima Parties or any ERISA Affiliate to any withdrawal liability under Part 1 of Subtitle E of Title IV of ERISA as a "complete withdrawal" (as defined in ERISA Section 4203) or a "partial withdrawal" (as defined in ERISA Section 4205) from any Multiemployer Plan.

(c) Except as set forth on ***Schedule 4.12(c)***, the Benefit Plans have been administered in material compliance with the applicable provisions of ERISA, the Code, and all other applicable laws and regulations respecting such Benefit Plans. None of the Lima Parties or any ERISA Affiliate has any liability for (i) any lien imposed under Section 303(k) of ERISA or Section 430(k) of the Code, or (ii) for any interest payments required under Section 303(j) of ERISA or Section 430(j) of the Code.

(d) Except as set forth on ***Schedule 4.12(d)***, neither the execution and delivery of this Agreement or the other MPT Obligation Documents, nor the consummation of the transactions contemplated hereby and thereby, will (i) result in any "parachute payment" as defined in Section 280G of the Code, (ii) result any "change in control" or other payment under

any Benefit Plan or employment agreement or non-qualified deferred compensation plan or agreement, (iii) entitle any current or former director, officer, employee or consultant of any of the Lima Parties or any ERISA Affiliate to severance pay, termination pay, unemployment compensation or any other payment or benefit under any Benefit Plan, (iv) accelerate the time of payment or vesting of benefits, or increase the amount of compensation, due to any such director, officer, employee or consultant under any Benefit Plan, (v) trigger any funding obligation under any Benefit Plan, or (vi) impose any restrictions or limitations on the sponsoring employer's rights to administer, amend or terminate any Benefit Plan.

(e) Except as set forth on ***Schedule 4.12(e)***, no actions, suits, or claims (other than routine claims for benefits in the ordinary course of business) are pending or, to the Knowledge of the Lima Parties, threatened with respect to any Benefit Plan, and no audit or investigation, other than routine or random audits, by the Internal Revenue Service, the Department of Labor, or other Governmental Authority is pending with respect to any Benefit Plan, or, to the Knowledge of the Lima Parties, threatened, with respect to any Benefit Plan.

(f) No "reportable event" within the meaning of Section 4043 of ERISA has occurred with respect to any Benefit Plan in the prior three (3) years and with respect to the present Transactions, to the extent any portion of such Transaction is a reportable event, with respect to which the reporting requirement has not been waived, the Lima Parties have timely provided to the PBGC the required notice of such reportable event and the time period in which the PBGC has to comment or respond has expired with no response or comment from the PBGC.

(g) The Lima Parties have complied in all material respects with all applicable requirements of the Patient Protection and Affordable Care Act of 2010, as amended ("ACA"), including the shared responsibility provisions thereunder, such that no Lima Party could be subject to any liability under the ACA, including any penalty under Code Section 4980H.

Section 4.13 Labor Matters.

(a) Except as set forth on ***Schedule 4.13(a)***, none of the Lima Parties is a party to any Collective Bargaining Agreement.

(b) Except as set forth on ***Schedule 4.13(b)***: (i) no grievance, unfair labor practice charge, or arbitration proceeding arising out of or under any Collective Bargaining Agreement, which could reasonably be anticipated to result in liability in excess of One Million and No/100 Dollars ($1,000,000, is pending or, to the Knowledge of the Lima Parties, threatened, and (ii) since January 1, 2016, there has not been, nor is there, any pending or, to the Knowledge of the Lima Parties, any threatened (A) material labor dispute between any of the Lima Parties and any labor organization, or any material strike, work slowdown, work stoppage or other similar organized labor activity involving any employee of any of the Lima Parties, which could reasonably be anticipated to result in liability in excess of One Million and No/100 Dollars ($1,000,000) or (B) union organizing, or union election activity involving any employee of any of the Lima Parties with respect to their employment by any of the Lima Parties which could reasonably be anticipated to result in liability in excess of One Million and No/100 Dollars ($1,000,000).

(c) Each of the Lima Parties is, and has been since January 1, 2016, in compliance in all material respects with all Laws regarding labor, employment and employment practices, and conditions of employment, including occupational safety and health, immigration, discrimination, harassment, wrongful termination, misclassification of employees and independent contractors, and wages and hours, including any bargaining or other obligations under the National Labor Relations Act. Except as set forth on ***Schedule 4.13(c)***, there are no complaints, actions, suits, audits, Proceedings, investigations, or other litigation pending or, to the Knowledge of the Lima Parties, threatened against any of the Lima Parties or any of their respective Subsidiaries in connection with the employment of any current or former employee or temporary employee or current or former independent contractor that would reasonably be expected to result in material liability to, or have a material impact on, the Lima Parties, taken as a whole.

(d) Each of the Lima Parties has been since the January 1, 2016, and is, in material compliance with WARN and similar state Laws and has no material liabilities or obligations pursuant thereto. None of the Lima Parties has implemented a "mass layoff" or "plant closing" (as defined in WARN) within the last twelve months preceding the date hereof.

(e) Each of the Lima Parties has been, and is, in compliance and has not violated, the terms of the Immigration Reform and Control Act of 1988, as amended, and all related regulations promulgated thereunder and any other immigration laws, except, in each case, as would not reasonably be expected to result in any material liability or obligation for any of the Lima Parties. Since January 1, 2016, none of the Lima Parties has been warned, fined, or otherwise penalized by any Governmental Authority by reason of its failure to materially comply immigration laws.

Section 4.14 Solvency.

(a) Each of the Lima Parties is now Solvent and, immediately after giving effect to the transactions contemplated in this Agreement (including, without limitation, the LifePoint Upper Tier Restructuring Transaction and related LifePoint Upper Tier Distributions), each of the Lima Parties will be Solvent.

(b) No transfer of property is being made and no obligation is being incurred in connection with the transactions contemplated in this Agreement with the intent to hinder, delay, or defraud either present or future creditors of any of the Lima Parties.

(c) Any and all actions taken, or to be taken, by the Lima Parties in connection with the LifePoint Upper Tier Restructuring Transaction (and related LifePoint Upper Tier Distributions): (i) will be, properly authorized and approved in accordance with the applicable Constituent Documents of each of them prior to undertaking such LifePoint Upper Tier Restructuring Transaction (and related LifePoint Upper Tier Distributions), and (B) after giving effect to the transactions contemplated in this Agreement (including, without limitation, the LifePoint Upper Tier Restructuring Transaction (and related LifePoint Upper Tier Distributions)), will comply with all applicable Laws (including, without limitation, all applicable Laws regarding the paying, making, or declaring dividends or distributions).

(d) None of the Lima Parties are involved in any proceeding by or against it as a debtor before any Governmental Authority under Title 11 of the United States Bankruptcy Code or any other insolvency or debtors' relief act, whether state, federal or foreign, or for the appointment of a trustee, receiver, liquidator, assignee, sequestrator or other similar official for any part of any of the property or assets of any of the Lima Parties.

Section 4.15 Brokers. No broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission from any of the MPT Parties or their Affiliates in connection with the transactions contemplated in this Agreement based upon arrangements made by or on behalf of any of any of the Lima Parties or any of their respective Affiliates.

Section 4.16 Patriot Act Compliance.

(a) The Lima Parties have complied in all material respects with the International Money Laundering Abatement and Anti-Terrorist Financing Act of 2001, which comprises Title III of the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001 (the "**Patriot Act**") and the regulations promulgated thereunder, and the rules and regulations administered by the U.S. Treasury Department's Office of Foreign Assets Control ("**OFAC**"), to the extent the same are applicable to any Lima Party.

(b) No Lima Party is included on the List of Specially Designated Nationals and Blocked Persons maintained by the OFAC, or is a resident in, or organized or chartered under the laws of, (i) a jurisdiction that has been designated by the U.S. Secretary of the Treasury under Section 311 or 312 of the Patriot Act as warranting special measures due to money laundering concerns or (ii) any foreign country that has been designated as non-cooperative with international anti-money laundering principles or procedures by an intergovernmental group or organization, such as the Financial Action Task Force on Money Laundering, of which the United States is a member and with which designation the United States representative to the group or organization continues to concur.

Section 4.17 No Misrepresentation, Default or Waiver. All of the representations and warranties of the Lima Parties or their respective Affiliates in this Agreement and the other MPT Obligation Documents, and the statements made in or information contained on any schedules or certificates furnished by any of the Lima Parties or their respective Affiliates in connection herewith and therewith, do not contain as of the date hereof any untrue statement of a material fact.

ARTICLE V
REPRESENTATIONS AND WARRANTIES BY MPT PARTIES

With the understanding that the Lima Parties shall rely hereon, and as a material inducement to the Lima Parties to enter into this Agreement and to consummate the transactions contemplated hereby, the MPT Parties, jointly and severally, hereby represent and warrant to the Lima Parties as of the date hereof and as of the applicable Closing as follows:

Section 5.1 **Organization**. Each of the MPT Parties is a limited liability company organized, validly existing and in good standing under the laws of the State of Delaware and is qualified to do business in every jurisdiction where such qualification is necessary.

Section 5.2 **Authorization; Enforcement, Absence of Conflicts**.

(a) Each MPT Party has the requisite corporate or limited liability company power and authority to conduct its business as it is now being conducted and as proposed to be conducted. Each applicable MPT Party has the requisite corporate or limited liability company power and authority to execute, deliver and carry out the terms of this Agreement, the other MPT Obligation Documents to which it is or will become a party and all documents and agreements necessary to give effect to the provisions hereof and thereof and to consummate the transactions contemplated hereby and thereby.

(b) All actions required to be taken by each applicable MPT Party to authorize the execution, delivery and performance of this Agreement and the other MPT Obligation Documents, and all transactions contemplated hereby and thereby, in each case have been or will be when delivered duly and properly taken or obtained in accordance and in compliance with such applicable MPT Party's Constituent Documents. No other action on the part of any applicable MPT Party, or its directors, managers or Equity Constituents (as applicable) is necessary to authorize the execution, delivery and performance of this Agreement, the other MPT Obligation Documents, or any transactions contemplated hereby and thereby.

(c) This Agreement, all other MPT Obligation Documents, and all other documents, agreements and instruments to which any applicable MPT Party is or will become a party hereunder or thereunder, are or will constitute when delivered the valid and legally binding obligations of such MPT Party, enforceable against such MPT Party in accordance with the respective terms hereof or thereof, except as enforceability may be restricted, limited or delayed by applicable bankruptcy, insolvency or other similar laws affecting creditors' rights generally and except as enforceability may be subject to and limited by general principles of equity (regardless of whether considered in a proceeding in equity or at law).

Section 5.3 **Litigation**. There are no actions, claims suits, audits, Proceedings or investigations pending or, to the Knowledge of the MPT Parties, threatened against or affecting any MPT Party that has or would reasonably be expected to have a material and adverse effect on any MPT Party or on the ability to perform its obligations under this Agreement or any aspect of the transactions contemplated hereby.

Section 5.4 **Financing**. Each of the MPT Parties affirms that it is not a condition to any Closing or to any of its other obligations under this Agreement or the other MPT Obligation Documents that the MPT Parties or their Affiliates obtain financing for or related to any of the transactions contemplated hereby or thereby. The MPT Parties have access to sufficient funds to fulfill their respective obligations under this Agreement.

Section 5.5 **Brokers**. No broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission from any of the Lima Parties or their Affiliates in

connection with the transactions contemplated in this Agreement based upon arrangements made by or on behalf of any of any of the MPT Parties or any of their respective Affiliates.

ARTICLE VI
PRE-CLOSING COVENANTS

From and after the execution and delivery of this Agreement to and including the applicable Closing Date with respect to a particular Facility, the applicable party shall observe the following covenants with respect to all Facilities which have not yet been sold, transferred, conveyed or assigned pursuant to this Agreement:

Section 6.1 **Conduct of Business Prior to Closing**. Except as expressly provided or permitted hereunder, from the date of this Agreement until the applicable Closing, each of the applicable Lima Parties will use commercially reasonable efforts to conduct its business in the ordinary course of business consistent in all material respects with prior practices (it being understood that a reasonable good faith action taken solely to address an extraordinary or unusual event occurring after the date of this Agreement and outside of the ordinary course of business shall not be deemed a breach of this clause), except (a) if the MPT Parties shall have consented in writing (which consent will not be unreasonably withheld, conditioned or delayed), and (b) as otherwise contemplated or permitted by this Agreement; *provided*, *that*, notwithstanding the foregoing, (i) the Lima Parties and their Affiliates may use all available cash in any manner the Lima Parties determine, including to repay any mortgage indebtedness or to make cash distributions or pay bonuses or dividends on or prior to the applicable Closing, and (ii) no action by the Lima Parties or their Affiliates with respect to matters specifically addressed by any other provision of this Agreement shall be deemed a breach of this Section, unless such action would constitute a breach of one or more of such other provisions *provided, further, that* any actions taken by the Lima Parties in connection with the LifePoint Upper Tier Restructuring Transaction after the date hereof shall not be deemed a violation of this Section, if such actions would not otherwise violate the terms of the Master Lease to be executed and delivered at Closing if it were then in effect.

Section 6.2 **Access to Information**. Subject to the terms of the Confidentiality Agreement, the MPT Parties and their Representatives (including their designated engineer, architects, surveyors and/or consultants) may, upon reasonable notice and during times mutually convenient to the MPT Parties and senior management of the Lima Parties enter into and upon all or any portion of the Real Property in order to investigate and assess, as the MPT Parties deem necessary or appropriate in their reasonable discretion, the condition (including the structural and environmental condition) of the assets and properties of any of the Lima Parties, including such access as may be necessary to obtain the Title Commitments and any surveys or other necessary third party reports with respect to the MPT Acquired Assets; *provided, however*, that the MPT Parties shall indemnify, defend and hold harmless the Lima Parties from and against any and all loss, cost, expense and/or liability of any kind or nature incurred by the Lima Parties as the result of any such investigation and/or assessment and provided further that, in no event shall the MPT Parties and/or their Representatives undertake any intrusive testing of any kind without the prior written consent of the Lima Parties, which consent shall not be unreasonably, withheld, conditioned or delayed. Each of the Lima Parties shall reasonably cooperate with the MPT Parties and their Representatives in conducting such investigations, and shall allow the MPT

Parties and their Representatives reasonable access to the Real Property, the Facilities and the other assets and properties of the Lima Parties, together with permission to conduct such investigations, and shall provide to the MPT Parties and their Representatives all reasonably necessary information maintained by any of the Lima Parties in connection with the assets and properties of the Lima Parties.

Section 6.3 **No Shop.** None of the Lima Parties, nor any investment banker, attorney, accountant, representative or other person retained by or on behalf of any of the Lima Parties, shall directly or indirectly, initiate contact with, respond to, solicit or encourage any inquiries, proposals or offers by, or participate in any discussions or negotiations with, enter into any agreement with, disclose any information concerning the Lima Parties, the Real Property or the other MPT Acquired Assets, or the transactions contemplated herein to, afford any access to the properties, books or records of any Lima Party to, or otherwise assist, facilitate or encourage, any person, in each case, in connection with any possible proposal regarding a sale, lease, transfer, disposition or other similar transaction related to all or any portion of the Real Property or the other MPT Acquired Assets other than as contemplated in this Agreement. Nothing in this Agreement will be construed to prevent LifePoint or any of the Lima Parties from engaging in discussions to sell Lima HoldCo, any of Lima HoldCo's Subsidiaries or any of their respective assets in a transaction in which, upon completion of the sale transaction, the Real Property would remain subject to the Master Lease and no violation would occur under Section 16.1(e) or Section 16.1(l) of the Master Lease if it were in effect. The Lima Parties shall notify the MPT Parties immediately if any such discussions or negotiations are sought to be initiated, any inquiry or proposal is made, or any such information is requested. The restrictions contained herein shall not apply to disclosures, contact and/or discussions with the MPT Parties and their respective Affiliates or with existing lenders, new or prospective lenders to LifePoint or other direct and indirect Equity Constituents of the Lima Parties, or to disclosures, contact and/or discussions, in each case necessary to effect or otherwise consummate the transactions contemplated under this Agreement.

Section 6.4 **Schedule Updates.** From the date hereof until the applicable Closing Date, the Lima Parties shall promptly upon becoming aware advise the MPT Parties in writing of any additions or changes to any Schedule to this Agreement to reflect any deficiencies or inaccuracies in such Schedule or to reflect circumstances or matters which occur after the date of this Agreement which, if existing prior to such date, would have been required to be described on such Schedule. In the event that such supplemental disclosures reflect facts, circumstances or a state of affairs (when taken with all other facts, circumstances or the overall state of affairs) having, individually or in the aggregate, a Material Adverse Effect not disclosed in the original Schedules, or if not taken into account with respect to Article V, a material adverse effect on the MPT Parties' ability to consummate the transactions herein contemplated, as applicable, then the condition provided for in Section 7.1(a) or Section 7.2(a), as the case may be, shall be deemed not to have been satisfied. In the event that any of the Lima Parties or the MPT Parties determine that the condition provided for in Section 7.1(a) or Section 7.2(a), as the case may be, has not been or is likely not to be satisfied as a result of supplements or additions made to the original Schedules to this Agreement pursuant to this Section 6.4, such Party shall provide notice to the other Parties as soon as reasonably practicable to afford such other Parties the opportunity to attempt to cure the matter or circumstance rendering such condition unsatisfied.

Section 6.5 **Tenant Estoppels and Collateral Assignments of Leases**. The Lima Parties shall use their commercially reasonable efforts to obtain and provide to the MPT Parties: (a) all Tenant Estoppels described on the attached ***Schedule 6.5(a)***, and (b) all of the Collateral Assignments of Leases (and requisite landlord consents thereto) listed on the attached ***Schedule 6.5(b)***; *provided, that*, delivery of the foregoing shall not be a condition to any Party Closing the transactions contemplated in this Agreement, except as expressly specified in Section 7.2(e) hereof. In no event shall any Lima Party be under any obligation to pay any sums to any counterparty to obtain any Tenant Estoppel or consent to Collateral Assignment of Leases in order to obtain any such Tenant Estoppel or consent to Collateral Assignment of Leases, nor shall any Lima Party be obligated to commence any litigation or other proceeding against any counterparty in order to obtain any Tenant Estoppel or consent to Collateral Assignment of Leases.

Section 6.6 **ROFR and Other Notices**. The Lima Parties and MPT Parties acknowledge that certain portions of the Real Property being conveyed may be subject to the ROFR Purchase Rights. Promptly after the date hereof, the Lima Parties shall (a) send such notices and other information as may be necessary to obtain written releases or waivers from any applicable third party holders of any ROFR Purchase Rights that would be triggered as a result of the consummation of the Sale/Leaseback Transaction, (b) use commercially reasonable efforts to obtain such written releases or waivers as soon as possible, and (c) shall keep the MPT Parties reasonably informed of the status of all such waivers and releases, and any communications of the Lima Parties with any of such Persons. In no event shall any Lima Party be under any obligation to pay any sums to any third party holder of any ROFR Purchase Rights in order to obtain any such release or waiver, nor shall any Lima Party be obligated to commence any litigation or other proceeding against any third party holder of any ROFR Purchase Rights in order to obtain any such release or waiver; *provided, that*, the Lima Parties failure to obtain any release or waiver of any ROFR Purchase Rights that would be triggered as a result of the consummation of the Sale/Leaseback Transaction shall be deemed a failure of a condition to Closing under this Agreement.

Section 6.7 **[Intentionally Omitted]**.

Section 6.8 **Release of Encumbrances**. Simultaneous with the applicable Closing, the Lima Parties shall cause the release and discharge (including defeasance payments or penalty payments thereon, if applicable) of all mortgages, deeds of trust, security deeds, security agreements and other liens which are secured by any of the applicable MPT Acquired Assets, as set forth on ***Schedule 6.8*** attached hereto (collectively, the "**Mortgage Lien Releases**").

Section 6.9 **Regulatory Approvals**. As soon as reasonably practical, between the date of this Agreement and the applicable Closing Date, the Lima Parties and the MPT Parties will, to the extent required by Law, file all reports, applications, notices, or other documents required or requested by Government Authorities under any applicable Laws concerning the purchase and sale of the applicable MPT Acquired Assets, and comply promptly with any requests by any Governmental Authority for additional information concerning such transactions, so that such transactions will be approved by all necessary Government Authorities as soon as reasonably possible after the execution and delivery of this Agreement. The Lima Parties shall permit the MPT Parties and their representatives, upon request by the MPT Parties, to review and

provide comments to any such reports, applications, notices, or other material documents as they relate to the transactions contemplated herein prior to their submission.

Section 6.10 **Insurance**. Until the applicable Closing, the Lima Parties will use commercially reasonable efforts to keep in full force and effect all existing insurance policies of the Lima Parties which are presently in effect with respect to each applicable Facility and Lima Party, subject to the continuing availability of such insurance coverages on reasonable terms and conditions; provided, however, that no such insurance policies shall be voluntarily or consensually terminated by the Lima Parties without MPT's prior written consent.

Section 6.11 **Construction Projects Affecting Real Property**. As of the date hereof, there are various ongoing Construction Projects at the Real Property. The Parties acknowledge and agree that during the period commencing the date hereof and ending on the applicable Closing Date, the applicable Lima Party will (or may) incur certain obligations and/or expenditures with respect to the Construction Projects, which obligations and/or expenditures may be incurred to, among other things: (a) acquire certain land, buildings or other improvements and/or (b) engage in certain capital and other improvements (including both so-called hard costs and soft costs, including costs of architects and other contractors with respect to the Construction Projects). On the applicable Closing Date, the applicable Lima Party shall convey the Construction Projects and related properties and assets of the type that are described in the definition of the MPT Acquired Assets to the applicable MPT Party as part of and included with such MPT Acquired Assets at no additional cost to the MPT Parties, and the completion of such Construction Projects shall be at the sole cost and expense of the Lima Parties. The Lima Parties shall use their commercially reasonably efforts to complete the Construction Projects in accordance with the timeline specified on ***Schedule 6.11***, it being agreed that it shall not be a condition to any Closing that the Construction Projects (or any one (1) or more of the Construction Projects) is completed prior to such Closing.

Section 6.12 **Mutual Covenants**. The Parties shall use their commercially reasonable efforts to satisfy the conditions to the applicable Closings of the transactions contemplated hereby subject to the terms and conditions hereof. Without limiting the generality of the foregoing, the respective Parties shall execute and/or deliver, or use their respective commercially reasonable efforts to cause to be executed and/or delivered, the documents contemplated to be executed and/or delivered by them and their respective Affiliates at the applicable Closing.

Section 6.13 **Title and Survey Review**.

(a) Prior to the date hereof, the MPT Parties have ordered Title Commitments from the Title Company, surveys, zoning reports, and other desired third party reports relating to the title to the Real Property. The Lima Parties shall be responsible for and shall pay the reasonable costs of such commitments, surveys and reports (collectively, the "**Title Expenses**").

(b) The MPT Parties shall provide the Lima Parties with written notice of any objections (each, an "**Objection**") to any matters shown in the Title Commitments, surveys, zoning reports, and other third party reports that are not Permitted Encumbrances (any such matters raised by the MPT Parties, the "**Objectionable Matters**"). Such notice shall specify the exact nature of the Objection and shall include copies of the applicable Title Commitment,

underlying title objection document, survey, zoning report of other third party report that relate to the Objection. If the MPT Parties fail to raise any Objections in the manner provided above within the later of (i) the date that is fifteen (15) days after the date of this Agreement, or (ii) as applicable, fifteen (15) days after the date of MPT Parties' receipt of the applicable Title Commitment (including legible copies of all listed title exception documents) with respect to matters shown thereon, fifteen (15) days after the MPT Parties' receipt of the survey with respect to matters shown thereon, or fifteen (15) days after the MPT Parties' receipt of the zoning report with respect to matters shown thereon, in each case, then the applicable matter shall be deemed to be within the definition of Permitted Encumbrances; *provided, however*, in no event shall tax liens or Encumbrances securing Indebtedness be deemed Permitted Encumbrances. If any Encumbrance (other than a Permitted Encumbrance) not revealed in any Title Commitment or survey is discovered by the MPT Parties or by the Title Company and is added to the Title Commitment by the Title Company (or to any subsequent survey, if applicable) at or prior to the applicable Closing with respect to a particular Facility, the MPT Parties shall have until the earlier of (i) ten (10) days after the MPT Parties' receipt of the updated, revised Title Commitment (or subsequent survey, if applicable) showing such new title exception, together with a legible copy of any such new matter, or (ii) the date of the applicable Closing, to provide the Lima Parties with an Objection to any such new title exception.

(c) The MPT Parties and the Lima Parties shall reasonably cooperate and work together in good faith to resolve each Objection raised by the MPT Parties to the extent same is not a Permitted Encumbrance. If the Lima Parties do not remove or cure any Encumbrance which is not a Permitted Encumbrance prior to the applicable Closing Date, or if the Title Company is unable to issue at the applicable Closing an owner's (or lender's, as the case may be) title insurance policy insuring good and marketable title to any portion of the Real Property free and clear of all Encumbrances other than the Permitted Encumbrances, the Lima Parties shall have the right to adjourn the scheduled Closing Date for up to thirty (30) days in order to eliminate or endeavor to eliminate such Encumbrance which is not a Permitted Encumbrance, provided, that, once such matters are eliminated, the Lima Parties shall provide the MPT Parties at least five (5) Business Days' notice before such newly scheduled Closing Date. In no event shall any Lima Party be under any obligation to pay any sums to resolve any Objection or remove or cure any Encumbrance (except that the Lima Parties shall be obligated to pay any unpaid real property tax liens or materialman's liens and to remove Encumbrances securing Indebtedness of such Lima Party), nor shall any Lima Party be obligated to commence any litigation or other proceeding to resolve any Objection or remove or cure any encumbrance that is not a Permitted Encumbrance; *provided, that*, failure to remove any Encumbrance that is not a Permitted Encumbrance shall be deemed a failure to satisfy a condition to Closing.

(d) If after such thirty (30) day adjournment, the applicable Lima Seller does not remove or cure any Encumbrance which is not a Permitted Encumbrance prior to the applicable Closing Date, or if the Title Company is unable to issue at the applicable Closing an owner's (or lender's, as the case may be) title insurance policy insuring good and marketable title to any portion of the Real Property free and clear of all Encumbrances other than the Permitted Encumbrances, then the MPT Parties shall have the right, exercisable by written notice to the Lima Parties, at the MPT Parties' option, to terminate this Agreement as to the applicable Real Property that is affected by such Objectionable Matter; *provided, that*, if any such Objectionable

Matter pertains to any of the Conemaugh Properties, then the MPT Parties and the Lima Parties shall each have the option to terminate this Agreement.

Section 6.14 Intentionally Omitted.

Section 6.15 Tenant Estoppels; Consents with Respect to Collateral Assignment of Collateral Leases. Promptly after execution of this Agreement, the Lima Parties will send such notices and other information as may be necessary to obtain (i) the Tenant Estoppels with respect to any Tenant Leases identified on ***Schedule 6.5(a)***, and (ii) any counterparties' consent under the Collateral Leases with respect to the Collateral Assignment of Leases. The Lima Parties shall use commercially reasonable efforts to obtain such Tenant Estoppels and counterparty consents as quickly as possible and, upon request by the MPT Parties, will keep the MPT Parties reasonably informed of the status of all such consents and any communications of the Lima Parties with any of such Persons; *provided, however*, that the failure to receive any consents shall impose no liability on the Lima Parties and shall not constitute the failure of a condition to Closing, other than as specifically provided in Section 7.2(e) hereof. In no event shall any Lima Party be under any obligation to pay any sums to any counterparty under any Assumed Lima Lease, Tenant Lease, or Collateral Lease in order to obtain any such Tenant Estoppel, consent, approval or waiver, nor shall any Lima Party be obligated to commence any litigation or other proceeding against any such landlord in order to obtain any such Tenant Estoppel, consent, approval or waiver.

ARTICLE VII
CLOSING CONDITIONS

Section 7.1 Conditions to the Obligations of the Lima Parties. With respect to each Closing, the obligations of the Lima Parties to effect the transactions contemplated hereby with respect to the MPT Acquired Assets to be sold, transferred, conveyed and assigned on such Closing Date shall be further subject to the fulfillment of the following conditions, any one or more of which may be waived by the Lima Parties:

(a) All of the representations and warranties of the MPT Parties set forth in this Agreement shall be true and correct when made and shall remain true and correct in all material respects as of the applicable Closing Date as if made on such Closing Date (other than those representations and warranties that address matters only as a particular date or only with respect to a specific period of time, which need only be true and correct as of such date or with respect to such period), except, solely in the case of representations and warranties that are not Fundamental Representations, for such inaccuracies in such representations and warranties that do not have a Material Adverse Effect.

(b) The MPT Parties shall have delivered, performed, observed and complied with all of the items, instruments, documents, covenants, agreements and conditions required by this Agreement to be delivered, performed, observed and complied with by it prior to, or as of, the applicable Closing.

(c) The MPT Parties shall have executed, where applicable, and delivered to the Lima Parties the documents referenced in Section 8.3 hereof that pertain to the MPT Acquired Assets being sold, transferred, conveyed or assigned at the applicable Closing.

(d) There shall not have been instituted by any creditor of the MPT Parties, any Governmental Authority or any other third party, a suit, action or Proceeding which would affect any material portion of the MPT Acquired Assets to be sold, transferred, conveyed or assigned on the applicable Closing Date or seek to restrain, enjoin or invalidate the transactions contemplated in this Agreement.

(e) The MPT Parties shall have paid the Individual Purchase Price with respect to each of the MPT Acquired Assets that are being sold, transferred, conveyed and assigned on such Closing Date in accordance with Section 3.2 hereof.

(f) With respect to the MPT Acquired Assets to be sold, transferred, conveyed or assigned on the applicable Closing Date, the Lima Parties shall have received any written releases or waivers from any applicable third party holders of the ROFR Purchase Rights to the extent the same are required to be delivered pursuant to this Agreement; *provided, however*, that the parties agree that the ROFR Purchase Rights contained in the Leases at the Johnstown ROFR Properties are not triggered by the Sale/Leaseback Transaction, and the Lima Parties shall not be required to seek written releases or waivers from the applicable third party holders of ROFR Purchase Rights relating to the Johnstown ROFR Properties.

Section 7.2 Conditions to the Obligations of the MPT Parties. With respect to each Closing, the obligations of the MPT Parties to effect the transactions contemplated hereby shall be further subject to the fulfillment of the following conditions, any one or more of which may be waived by the MPT Parties:

(a) All of the representations and warranties of the Lima Parties set forth in this Agreement shall be true and correct when made and shall remain true and correct in all material respects as of the applicable Closing Date as if made on the applicable Closing Date (other than those representations and warranties that address matters only as a particular date or only with respect to a specific period of time, which need only be true and correct as of such date or with respect to such period); except, solely in the case of representations and warranties that are not Fundamental Representations, for such inaccuracies in such representations and warranties that do not have a Material Adverse Effect.

(b) The Lima Parties shall have delivered, performed, observed and complied with all of the items, instruments, documents, covenants, agreements and conditions required by this Agreement to be delivered, performed, observed and complied with by any of them prior to, or as of, the applicable Closing with respect to the MPT Acquired Assets being sold, transferred, conveyed or assigned at the applicable Closing.

(c) The Lima Parties shall have delivered or caused to be delivered to the Title Company satisfactions, discharges and releases with respect to any mortgages, assignments of leases or other security instruments recorded against the MPT Acquired Assets being sold, transferred, conveyed or assigned at the applicable Closing (or shall have otherwise delivered

payoff letters or other documentation sufficient to enable the Title Company to remove any such mortgages, assignments of leases or other security instruments from the public records), it being understood and agreed that nothing herein contained shall require the Lima Parties to deliver satisfactions, discharges or releases in connection with any security instrument permitted under the Existing Intercreditor Agreement (but in no event shall leasehold mortgages be permitted exist or remain).

(d) The Lima Parties shall have executed where applicable and delivered to the MPT Parties the documents referenced in Section 8.2 hereof that pertain to the MPT Acquired Assets being sold, transferred, conveyed or assigned at the applicable Closing.

(e) With respect to the MPT Acquired Assets to be sold, transferred, conveyed and assigned on the applicable Closing Date, the Lima Parties shall have received, as applicable:

(i) if the Leased Land is being sold, transferred, conveyed and assigned on such Closing Date, the Assignment and Assumption of Lease Agreements relating to the Assumed Lima Lease at the Leased Land;

(ii) if the Conemaugh Properties are being sold, transferred, conveyed and assigned on such Closing Date, all counterparty consents required to enter into the Collateral Assignment of Leases with respect to the Collateral Leases listed on ***Schedule 7.2(e)(ii)***;

(iii) if the Southwestern/Lawton Ground Leased Property is being sold, transferred, conveyed and assigned on such Closing Date, (A) all counterparty consents, if any, required to enter into a Collateral Assignment of Lease with respect to each of the Southwestern MOB Master Leases, and (B) an Assignment and Assumption of MOB Ground Lease Agreements relating to each Southwestern MOB Ground Lease;

(iv) if the Ottumwa Ground Leased Property is being sold, transferred, conveyed and assigned on such Closing Date, (A) all counterparty consents, if any, required to enter into the Collateral Assignment of Lease with respect to the Ottumwa MOB Master Lease, and (B) the Assignment and Assumption of MOB Ground Lease Agreement relating to the Ottumwa MOB Ground Lease;

(v) if the Nason/Roaring Springs Ground Leased Property is being sold, transferred, conveyed and assigned on such Closing Date, the Assignment and Assumption of MOB Ground Lease Agreement relating to the Nason/Roaring Springs Ambulance Facility Lease; and

(vi) all other third party consents and approvals required for the applicable Lima Parties to consummate the Sale/Leaseback Transaction and otherwise to enter into the Master Lease and the other MPT Obligation Documents with respect to such MPT Acquired Assets; *provided*, *however*, that nothing in this clause (vi) shall be construed to require the Lima Parties to seek or obtain consents or approvals with respect to commercial third-party payor

participation or reimbursement agreements to which the applicable Lima Parties are a party which agreements may require consent or approval from a third party as a condition to consummating the Sale/Leaseback Transaction and otherwise to enter into the Master Lease and the other MPT Obligation Documents with respect to such MPT Acquired Assets, it being agreed that the decision whether to seek such consent with respect to such commercial third-party payor participation or reimbursement agreements shall be made on a case-by-case basis by the Lima Parties in their good faith discretion.

(f) With respect to the MPT Acquired Assets to be sold, transferred, conveyed or assigned on the applicable Closing Date, the Lima Parties shall have received any written releases or waivers from any applicable third party holders of the ROFR Purchase Rights to the extent the same are required to be delivered pursuant to this Agreement; *provided, however*, that the parties agree that the ROFR Purchase Rights contained in the Leases at the Johnstown ROFR Properties are not triggered by the Sale/Leaseback Transaction, and the Lima Parties shall not be required to seek written releases or waivers from the applicable third party holders of ROFR Purchase Rights relating to the Johnstown ROFR Properties.

(g) There shall not have been instituted by any Governmental Authority any suit, action or Proceeding which would seek to restrain, enjoin or invalidate the transactions contemplated by this Agreement or the transactions contemplated hereby, which action, suit, investigation or Proceeding, in the reasonable opinion of the MPT Parties, may result in a decision, ruling or finding that has or would reasonably be expected to have a Material Adverse Effect on the validity or enforceability of this Agreement, or on the ability of the Lima Parties to perform their obligations under this Agreement.

ARTICLE VIII
CLOSING

Section 8.1 Closing.

(a) The closing of the Sale/Leaseback Transaction with respect to each Facility pursuant to this Agreement (each, a "**Closing**") shall occur as promptly as practicable (but in no event later than the tenth (10th) Business Day) after all of the conditions precedent for closing set forth in Article VII of this Agreement have been satisfied with respect to such Facility (other than conditions which by their terms are required to be satisfied at the applicable Closing) or, if permissible, waived in writing by the Parties entitled to the benefit of the same (as applicable with respect to each Facility, the "**Closing Date**"); *provided, that*, unless the Parties shall otherwise agree in writing, in no case shall the final Closing occur later than March 31, 2020 (the "**Outside Closing Date**").

(b) Each Closing shall be handled through deliveries to the Title Company into escrow with the Title Company receiving and distributing proceeds in accordance with the terms of this Agreement and any Closing Statement among the Parties, or in such other manner and at such other place as agreed to by the Parties hereto. At each Closing, (i) the applicable Lima Parties shall deliver the documents to be delivered by each of them and their Affiliates pursuant to Article VIII this Agreement, as well as possession of the applicable MPT Acquired

Assets, and the applicable MPT Parties shall pay the Purchase Price (subject to the Mortgage Lien Releases) for the applicable MPT Acquired Assets as provided in this Agreement and deliver the documents required to be delivered by the MPT Parties and their Affiliates pursuant to Article VIII of this Agreement.

(c) At the Lima Parties' election, Closings may occur in up to three (3) tranches (each such Closing, a "**Tranche**"). If the Lima Parties elect to have more than one (1) Closing: (i) the Lima Parties shall give the MPT Parties notice of such election not later than ten (10) Business Days prior to the first scheduled Closing Date, and such notice shall set forth: (x) the proposed Closing Date for each Closing, and (y) a list of the MPT Acquired Assets to be include in such each such Closing, (ii) the first Tranche will include all of the Conemaugh Properties, together with any other Real Property relating to the Facilities specified by the Lima Parties in such notice delivered by the Lima Parties; (ii) the second Tranche will include the Real Property with respect to the Facilities specified by the Lima Parties in such notice delivered by the Lima Parties, and (iii) the third Tranche will include the remaining balance of the Real Property.

Section 8.2 Lima Parties' Deliverables. On each applicable Closing Date, the applicable Lima Parties shall execute and deliver, or cause to be executed and delivered by the applicable Persons, the following with respect to the MPT Acquired Assets being sold, transferred, conveyed and assigned on such Closing Date:

(a) The Deeds;

(b) In the case of the sale, transfer, conveyance and assignment of the Leased Land, the related Assignment and Assumption of Lease Agreements;

(c) In the case of the sale, transfer, conveyance and assignment of the Ottumwa Ground Leased Property, the Southwestern/Lawton Ground Leased Property, and/or the Nason/Roaring Springs Ground Leased Property, the related Assignment and Assumption of MOB Ground Lease Agreements;

(d) The Bills of Sale and Assignment;

(e) The Master Lease;

(f) The Memoranda of Lease;

(g) The Guaranty;

(h) The LifePoint Lease Guaranty;

(i) The Environmental Indemnification Agreement;

(j) The Assignments of Rents and Leases;

(k) The Lima Noncompetition Agreement and the LifePoint Noncompetition Agreement;

(l) The Joinder to the Existing Intercreditor Agreement;

(m) Any Tenant Estoppels received by the Lima Parties with respect to the applicable MPT Acquired Assets for such Closing;

(n) If and to the extent Lima Parties have received the requisite counterparty consents or approvals thereto, any Collateral Assignment of Leases received by the Lima Parties with respect to the applicable MPT Acquired Assets for such Closing;

(o) Any written releases or waivers from any applicable third party holders of the ROFR Purchase Rights;

(p) All satisfactions, discharges or releases required by the Title Company with respect to (i) any mortgages, assignments of leases or other security instruments recorded against the MPT Acquired Assets being sold, transferred, conveyed or assigned at the applicable Closing (or shall have otherwise delivered payoff letters or other documentation sufficient to enable the Title Company to remove any such mortgages, assignments of leases or other security instruments from the public records) and (ii) Encumbrances that are not Permitted Encumbrances;

(q) Terminations of any leases of the Real Property by any Affiliate of the Lima Parties, as landlord, to any Lessee, as tenant;

(r) Certificates dated the applicable Closing Date signed by the Chief Executive Officer, Chief Financial Officer, or Chief Operating Officer (or other office reasonably acceptable to the MPT Parties) of LifePoint, Lima HoldCo and each of the Lima Parties that owns any of the Facilities being sold, transferred, conveyed or assigned on such Closing Date:

(i) certifying to the MPT Parties that: (A) all of the representations and warranties of such Lima Parties contained in this Agreement (considered collectively) and each of these representations and warranties (considered individually) remain true and correct in all material respects as of the applicable Closing Date as if made on such date, and (B) the applicable Lima Parties have performed and satisfied all covenants and conditions required by this Agreement to be performed or satisfied by such Lima Parties on or prior to such Closing; and

(ii) including a certified copy of the resolutions or consents of the applicable governing body of each of the applicable Lima Parties, dated as of applicable Closing Date, and authorizing such Person's execution, delivery and performance of this Agreement and the other MPT Obligation Documents; and

(iii) designating the officers or managers of the applicable Lima Parties (or their Affiliates) who are authorized to execute and deliver such documents on behalf of such Lima Parties, together with a certificate of incumbency with respect to such officers or managers, in each case in form and substance reasonably satisfactory to the MPT Parties;

(s) Certificates of existence and good standing of each of the Lima Parties and any of their respective Affiliates that will be parties to any of the MPT Obligation Documents being executed and delivered at the applicable Closing from the secretary of state of their respective states of incorporation or formation, dated the most recent practical date prior to the applicable Closing Date, and certificates of good standing from the respective states in which they are qualified to do business, dated the most recent practical date prior to the applicable Closing Date;

(t) The Title Commitment and an irrevocable commitment from Title Company to issue the Title Policies with respect to the Real Property being sold, transferred, conveyed or assigned at the applicable Closing to the MPT Parties following the applicable Closing Date;

(u) A duly executed Closing Statement; and

(v) Such other instruments and documents as the MPT Parties or Title Company reasonably deem necessary to effect the transactions contemplated hereby.

Section 8.3 **MPT Parties' Deliverables**. On the Closing Date (or the Closing Date for the applicable tranche of Facilities), the applicable MPT Parties shall execute and deliver, or cause to be executed and delivered by the applicable Persons, the following with respect to the Facilities being sold, transferred, conveyed and assigned on such Closing Date:

(a) In the case of the sale, transfer, conveyance and assignment of the Leased Land, the related Assignment and Assumption of Lease Agreements;

(b) In the case of the sale, transfer, conveyance and assignment of the Ottumwa Ground Leased Property, the Southwestern/Lawton Ground Leased Property, and/or the Nason/Roaring Springs Ground Leased Property, the related Assignment and Assumption of MOB Ground Lease Agreements;

(c) The Bills of Sale and Assignment;

(d) The Master Lease;

(e) The Memoranda of Lease;

(f) The Environmental Indemnification Agreement;

(g) The Assignments of Rents and Leases;

(h) The Lima Noncompetition Agreement and the LifePoint Noncompetition Agreement;

(i) The Joinder to the Existing Intercreditor Agreement;

(j) Certificates dated the applicable Closing Date signed by the Chief Executive Officer, Chief Financial Officer, or Chief Operating Officer (or other office

reasonably acceptable to the Lima Parties) of the sole member of each of the MPT Parties (i) certifying to the Lima Parties that (A) all of the representations and warranties of the MPT Parties contained in this Agreement (considered collectively) and each of these representations and warranties (considered individually) remain true and correct in all material respects as of the applicable Closing Date as if made on such date, and (B) the MPT Parties have performed and satisfied all covenants and conditions required by this Agreement to be performed or satisfied by the MPT Parties on or prior to the applicable Closing; (ii) including a certified copy of the resolutions or consents of the applicable governing body of each of the applicable MPT Parties, dated as of the applicable Closing Date, and authorizing such Person's execution, delivery and performance of this Agreement and the other MPT Obligation Documents; and (iii) designating the officers or managers of the sole member of each of the MPT Parties (or their Affiliates) who are authorized to execute and deliver such documents on behalf of the MPT Parties, together with a certificate of incumbency with respect to such officers or managers, in each case in form and substance reasonably satisfactory to the Lima Parties;

(k) Certificates of existence and good standing of the MPT Parties from the secretary of state of the State of Delaware, dated the most recent practical date prior to the applicable Closing Date, and certificates of good standing from the Secretary of State of Washington, dated the most recent practical date prior to the applicable Closing Date;

(l) A duly executed Closing Statement; and

(m) Such other instruments and documents as the Lima Parties reasonably deem necessary to effect the transactions contemplated hereby.

ARTICLE IX
TERMINATION

Section 9.1 **Termination**. Notwithstanding anything to the contrary in this Agreement, the obligations of the Parties hereunder may be terminated and the transactions contemplated hereby abandoned with respect to any of the Facilities at any time prior to the applicable Closing for such Facility: (i) by mutual written consent of the Parties, (ii) by any Party at any time following the Outside Closing Date, or (iii) as otherwise expressly set forth in this Agreement.

Section 9.2 **Notice and Effect**. In the event of the termination of this Agreement pursuant to Section 9.1, the provisions of this Agreement shall immediately become void and of no further force and effect (other than this Article IX, Article XII and Section 13.10), and there shall be no liability on the part of the Lima Parties or the MPT Parties to one another. In the event of the termination of this Agreement pursuant to this Article IX, the Party terminating this Agreement shall give prompt written notice thereof to the other Parties, and the transactions contemplated hereby shall be abandoned, without further action by any Party. Promptly following the termination of this Agreement, each filing, application and other submission relating to the transactions contemplated hereby shall, to the extent practicable, be withdrawn from the Person to whom it was made.

Section 9.3 **Termination as Remedy**. In the event of a breach of this Agreement by any Party hereto, notwithstanding any provision hereof (or the substance of any Law applicable to the transaction described herein), it is agreed that no damages or other sums shall be paid as a result of such breach of this Agreement, other than the Lima Parties shall pay the MPT Parties out-of-pocket costs and expenses in accordance with Section 13.9 hereof.

ARTICLE X
CERTAIN POST-CLOSING COVENANTS

Section 10.1 **Tenant Estoppels and Collateral Assignments**. To the extent the Lima Parties were unable to obtain and provide to the MPT Parties at or prior to the applicable Closing any of the Tenant Estoppels and the Collateral Assignments of Leases (together with the requisite counterparty consents thereto) that are described in Section 6.5 hereof, the Lima Parties shall continue for sixty (60) days after the applicable Closing Date to use their good faith efforts to obtain and provide to the MPT Parties such Tenant Estoppels and Collateral Assignment of Leases (together with the requisite counterparty consents thereto). In no event shall any Lima Party be under any obligation to pay any sums to any tenant under any Tenant Lease in order to obtain any such Tenant Estoppel or to any landlord under any Collateral Lease in order to obtain any such consent, approval or waiver, nor shall any Lima Party be obligated to commence any litigation or other proceeding against any landlord under any Tenant Lease in order to obtain any Tenant Estoppel or under any Collateral Lease in order to obtain any such consent, approval or waiver. If, despite such good faith efforts, the Lima Parties are unsuccessful in obtaining any Tenant Estoppels or the requisite counterparty consents to any Collateral Assignment of Leases, then the Lima Parties shall be released from their responsibility hereunder to obtain such Tenant Estoppels (subject to the terms of the Master Lease) and to obtain such consents and delivering the related Collateral Assignments.

ARTICLE XI
INDEMNIFICATION

Section 11.1 **Survival**. The Fundamental Representations shall survive the applicable Closing for a period of three (3) years, and all representations and warranties (excluding the Fundamental Representations) and the covenants and agreements (except for covenants or agreements solely to the extent requiring performance by such party prior to the applicable Closing) of the Parties set forth in this Agreement will terminate effective immediately as of the applicable Closing (other than to the extent they relate to the Facilities to be sold, transferred, conveyed and assigned at prospective Closings). Each covenant and agreement solely to the extent requiring performance after the applicable Closing, will, in each case, expressly survive the applicable Closing in accordance with its terms for a period of three (3) years, and nothing in this Section 11.1 will be deemed to limit any rights or remedies of any Person for breach of any such surviving covenant or agreement or any Fundamental Representation.

Section 11.2 **Lima Parties' Agreement to Indemnify**. Notwithstanding the existence of any insurance or self-insurance provided for in this Agreement or the Master Lease and without regard to the policy limits of any such insurance or self-insurance, the Lima Parties, jointly and severally, shall indemnify, defend and hold harmless the MPT Parties, their respective Affiliates and their respective officers, managers, members, (general and limited) partners, shareholders,

employees, agents and representatives (collectively, the "**MPT Indemnified Parties**") from and against any demands, claims, actions, losses, damages, liabilities, penalties, Taxes, costs and expenses (including, without limitation, reasonable attorneys' and accountants' fees, settlement costs, arbitration costs and any other reasonable expenses for investigating or defending any action or threatened action, but excluding punitive, incidental, consequential, special or indirect damages (including loss of revenue, diminution in value and any damages based on any type of multiple)) actually incurred by the MPT Indemnified Parties or any of them as a result of or arising from (a) any breach of any Fundamental Representation, (b) any third party claims asserted against or damages suffered by any of the MPT Indemnified Parties as a result of any breach by any of the Lima Parties of their Fundamental Representations; or (c) any Excluded Assets or Excluded Liabilities.

Section 11.3 MPT Parties' Agreement to Indemnify. The MPT Parties, jointly and severally, shall indemnify, defend and hold harmless Lifepoint, the Lima Parties, their respective Affiliates and their respective officers, managers, members, (general and limited) partners, shareholders, employees, agents and representatives (collectively, the "**LifePoint Indemnified Parties**") from and against any demands, claims, actions, losses, damages, liabilities, penalties, Taxes, costs and expenses (including, without limitation, reasonable attorneys' and accountants' fees, settlement costs, arbitration costs and any reasonable other expenses for investigating or defending any action or threatened action, but excluding punitive, incidental, consequential, special or indirect damages (including loss of revenue, diminution in value and any damages based on any type of multiple)) actually incurred by any of the LifePoint Indemnified Parties or any of them as a result of or arising from (a) any breach of any Fundamental Representation; or (b) any third party claims asserted against or damages suffered by any of the LifePoint Indemnified Parties as a result of any breach by any of the MPT Parties of their Fundamental Representations.

Section 11.4 Notification and Defense of Claims.

(a) Any Person entitled to be indemnified pursuant to this Article XI (the "**Indemnified Party**") shall notify the party liable for such indemnification (the "**Indemnifying Party**") in writing of any claim or demand which the Indemnified Party has determined has given or could give rise to a right of indemnification under this Agreement, as soon as possible after the Indemnified Party becomes aware of such claim or demand; *provided, that*, the Indemnified Party's failure to give such notice to the Indemnifying Party in a timely fashion shall not result in the loss of the Indemnified Party's rights with respect thereto except to the extent the Indemnifying Party is materially prejudiced by the delay.

(b) If the Indemnified Party shall notify the Indemnifying Party of any claim or demand pursuant to the provisions hereof, and if such claim or demand relates to a claim or demand asserted by a third party against the Indemnified Party in writing (a "**Third Party Claim**"), the Indemnifying Party shall have the obligation either (i) to pay such claim or demand, or (ii) defend any such Third Party Claim with counsel reasonably satisfactory to the Indemnified Party. After the Indemnifying Party has assumed the defense of such Third Party Claim, the Indemnifying Party shall not be liable to the Indemnified Party under this Article XI for any legal or other expenses subsequently incurred by the Indemnified Party in connection with the defense thereof other than reasonable costs of investigation, provided that the Indemnified Party shall

have the right to employ counsel, at the Indemnifying Party's expense, to represent it if (A) in the Indemnified Party's reasonable opinion the Indemnifying Party is not diligently prosecuting the defense of such Third Party Claim, (B) such Third Party Claim involves remedies other than monetary damages and such remedies against the Indemnified Party, in the Indemnified Party's reasonable judgment, could reasonably be expected to have a material and adverse effect on such Indemnified Party, (C) the Indemnified Party may have available to it one or more defenses or counterclaims that are inconsistent with one or more defenses or counterclaims that may be alleged by the Indemnifying Party, or (D) the Indemnified Party believes in its reasonable discretion that a conflict of interest exists between the Indemnifying Party and the Indemnified Party with respect to such Third Party Claim or action, and in any such event the reasonable fees and expenses of such separate counsel for the Indemnified Party shall be paid by the Indemnifying Party. The Indemnified Party shall make available to the Indemnifying Party or its agents all records and other materials in the Indemnified Party's possession reasonably required by the Indemnifying Party for its use in contesting any Third Party Claim or demand.

(c) No Indemnified Party may settle or compromise any claim or consent to the entry of any judgment with respect to which indemnification is being sought hereunder without the prior written consent of the Indemnifying Party, unless (i) the Indemnifying Party fails to assume and diligently prosecute the defense of such claim or (ii) such settlement, compromise or consent includes an unconditional release of the Indemnifying Party from all liability arising out of such claim and does not contain any equitable order, judgment or term which includes any admission of wrongdoing or could result in any liability (including regulatory liability) of the Indemnifying Party or which would otherwise in any manner affect, restrain or interfere with the business of the Indemnifying Party or any Affiliate of the Indemnifying Party. An Indemnifying Party may not, without the prior written consent of the Indemnified Party, settle or compromise any claim or consent to the entry of any judgment with respect to which indemnification is being sought hereunder unless such settlement, compromise or consent includes an unconditional release of the Indemnified Party from all liability arising out of such claim and does not contain any equitable order, judgment or term which includes any admission of wrongdoing or could result in any liability (including regulatory liability) of the Indemnified Party or which would otherwise in any manner affect, restrain or interfere with the business of the Indemnified Party or any of the Indemnified Party's Affiliates.

Section 11.5 Investigations. The right to indemnification based upon breaches or inaccuracies of representations, warranties and covenants will not be affected by any investigation conducted with respect to, or knowledge acquired (or capable of being acquired) at any time, whether before or after the execution and delivery of this Agreement or the applicable Closing Date, whether as a result of disclosure by a party pursuant to this Agreement or otherwise, with respect to the accuracy or inaccuracy of or compliance with any such representation, warranty or covenant. The waiver of any condition based on the accuracy of any representation or warranty, or on the performance of or compliance with any covenant, will not affect a party's right to indemnification, payment of damages or other remedies based on such representations, warranties and covenants.

Section 11.6 Exclusive Remedy. THE PARTIES AGREE AND ACKNOWLEDGE THAT, FROM AND AFTER THE APPLICABLE CLOSING WITH RESPECT TO A PARTICULAR FACILITY, THE INDEMNIFICATION RIGHTS PROVIDED IN THIS

ARTICLE SHALL BE THE SOLE AND EXCLUSIVE REMEDY OF THE PARTIES TO THIS AGREEMENT WITH RESPECT TO SUCH FACILITY FOR BREACHES OF THIS AGREEMENT AND FOR ALL DISPUTES ARISING UNDER OR RELATING TO SUCH FACILITY UNDER THIS AGREEMENT AND ANY ADDITIONAL AGREEMENTS OR DOCUMENTS EXECUTED OR DELIVERED IN OR ARISING OUT OF THE TRANSACTIONS CONTEMPLATED HEREBY WITH RESPECT TO SUCH FACILITY, EXCEPT: (A) FAILURE TO PERFORM POST-CLOSING COVENANTS, (B) IN CASES WHERE SPECIFIC PERFORMANCE IS AVAILABLE AS A REMEDY, AND (C) IN CASES OF FRAUD.

Section 11.7 **Treatment of Indemnification Payments.** All indemnification payments made pursuant to this Article shall be treated by the parties for income Tax purposes as adjustments to the Purchase Price, unless otherwise required by applicable Law.

ARTICLE XII
DISPUTE RESOLUTION

Section 12.1 **Governing Law**.

(a) THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF DELAWARE APPLICABLE TO CONTRACTS EXECUTED AND PERFORMED IN SUCH STATE, WITHOUT GIVING EFFECT TO CONFLICTS OF LAW PRINCIPLES; *PROVIDED, THAT*, WITH RESPECT TO MATTERS RELATING TO THE TRANSFER AND CONVEYANCE OF THE REAL PROPERTY OR THE OTHER MPT ACQUIRED ASSETS, OR PROCEDURES RELATING TO THE ENFORCEMENT OF THE DEEDS OR OTHER PROPERTY CONVEYANCE DOCUMENTS, SUCH MATTERS OR PROCEDURES SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE IN WHICH THE APPLICABLE REAL PROPERTY IS LOCATED.

(b) NOTWITHSTANDING THE FOREGOING, EACH OF THE PARTIES HEREBY AGREES THAT IT WILL NOT BRING OR SUPPORT ANY ACTION, CAUSE OF ACTION, CLAIM, CROSS-CLAIM OR THIRD-PARTY CLAIM OF ANY KIND OR DESCRIPTION, WHETHER IN LAW OR IN EQUITY, WHETHER IN CONTRACT OR IN TORT OR OTHERWISE, AGAINST ANY FINANCING SOURCE, OR ANY OF ITS REPRESENTATIVES, IN ANY WAY RELATING TO THIS AGREEMENT OR ANY OF THE TRANSACTIONS CONTEMPLATED HEREBY, INCLUDING ANY DISPUTE ARISING OUT OF OR RELATING IN ANY WAY TO ANY FINANCING OR THE PERFORMANCE THEREOF, IN ANY FORUM OTHER THAN THE SUPREME COURT OF THE STATE OF NEW YORK, NEW YORK COUNTY, OR, IF UNDER APPLICABLE LAW EXCLUSIVE JURISDICTION IS VESTED IN THE FEDERAL COURTS, THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK, LOCATED IN THE BOROUGH OF MANHATTAN (AND APPELLATE COURTS THEREOF), AND THAT THE PROVISIONS OF SECTION 12.3 RELATING TO THE WAIVER OF JURY TRIAL SHALL APPLY TO ANY SUCH ACTION, CAUSE OF ACTION, CLAIM, CROSS-CLAIM OR THIRD-PARTY CLAIM.

Section 12.2 Jurisdiction and Venue. EACH OF THE PARTIES CONSENTS TO PERSONAL JURISDICTION IN THE STATE OF DELAWARE. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION 12.2, EACH OF THE PARTIES AGREES THAT ANY ACTION OR PROCEEDING ARISING FROM OR RELATED TO THIS AGREEMENT SHALL BE BROUGHT AND TRIED EXCLUSIVELY IN THE STATE OR FEDERAL COURTS OF DELAWARE. EACH OF THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY OBJECTION TO THE LAYING OF VENUE OF ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. EACH OF THE PARTIES EXPRESSLY ACKNOWLEDGES THAT DELAWARE IS A FAIR, JUST AND REASONABLE FORUM AND AGREES NOT TO SEEK REMOVAL OR TRANSFER OF ANY ACTION FILED BY THE OTHER PARTIES IN SAID COURTS. FURTHER, EACH OF THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY CLAIM THAT SUCH SUIT, ACTION OR PROCEEDING HAS BEEN BROUGHT IN AN INCONVENIENT FORUM. SERVICE OF ANY PROCESS, SUMMONS, NOTICE OR DOCUMENT BY CERTIFIED MAIL ADDRESSED TO A PARTY AT THE ADDRESS DESIGNATED PURSUANT TO SECTION 13.2 SHALL BE EFFECTIVE SERVICE OF PROCESS AGAINST SUCH PARTY FOR ANY ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. A FINAL JUDGMENT IN ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT MAY BE ENFORCED IN ANY OTHER COURT TO WHOSE JURISDICTION ANY OF THE PARTIES IS OR MAY BE SUBJECT.

Section 12.3 Waiver of Jury Trial. EACH PARTY TO THIS AGREEMENT HEREBY WAIVES, TO THE FULLEST EXTENT PERMITTED BY LAW, ANY RIGHT TO TRIAL BY JURY OF ANY CLAIM, DEMAND, ACTION, OR CAUSE OF ACTION (A) ARISING UNDER THIS AGREEMENT OR (B) IN ANY WAY CONNECTED WITH OR RELATED OR INCIDENTAL TO THE DEALINGS OF THE PARTIES HERETO IN RESPECT OF THIS AGREEMENT OR ANY OF THE TRANSACTIONS RELATED HERETO, IN EACH CASE WHETHER NOW EXISTING OR HEREAFTER ARISING, AND WHETHER IN CONTRACT, TORT, EQUITY, OR OTHERWISE. EACH PARTY TO THIS AGREEMENT HEREBY AGREES AND CONSENTS THAT ANY SUCH CLAIM, DEMAND, ACTION, OR CAUSE OF ACTION SHALL BE DECIDED BY COURT TRIAL WITHOUT A JURY, AND THAT THE PARTIES TO THIS AGREEMENT MAY FILE A COPY OF THIS AGREEMENT WITH ANY COURT AS WRITTEN EVIDENCE OF THE CONSENT OF THE PARTIES HERETO TO THE WAIVER OF THEIR RIGHT TO TRIAL BY JURY.

Section 12.4 Specific Performance and Remedies. Each of the Parties hereto acknowledges that the rights of each party to consummate the transactions contemplated in this Agreement are unique and recognizes and affirms that in the event of a breach of this Agreement by any party, money damages may be inadequate and the non-breaching party may have no adequate remedy at law. Accordingly, the Parties agree that such non-breaching Party shall have the right, as its sole and exclusive remedy for any breach of or default with respect to any of the terms of this Agreement (other than to the extent expressly set forth to the contrary in Article XI), to enforce its rights and the other Parties' obligations hereunder by an action or actions for specific performance, injunctive and/or other equitable relief (without posting of bond or other security), and, except to the extent expressly set forth to the contrary in Article XI, that neither Party shall be entitled to seek damages or any other remedy in connection with any such breach or default of this Agreement, except as provided in this Section 12.4. Notwithstanding the

foregoing, the Parties agree that any Party's breach or alleged breach of this Agreement shall not constitute grounds for any objection or opposition to such Party's right to specific performance. The Parties agree not to assert that a remedy of specific performance or other equitable relief is unenforceable, invalid, contrary to law or inequitable for any reason, and not to assert that a remedy of monetary damages would provide an adequate remedy or that the Parties otherwise have an adequate remedy at law. The Parties acknowledge and agree that any Party pursuing an injunction or injunctions to prevent breaches of this Agreement and to enforce specifically the terms and provisions of this Agreement in accordance with this Section 12.4 will not be required to provide any bond or other security in connection with seeking any such injunction or injunctions.

ARTICLE XIII
MISCELLANEOUS

Section 13.1 **Binding Effect; Assignment**. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns, except that neither this Agreement nor any of the rights, interests or obligations hereunder may be assigned or delegated by any party without the prior written consent of the other parties. Notwithstanding the foregoing, the MPT Parties may at any time and without the consent of the other Party assign all of their respective rights and obligations hereunder to their Affiliate.

Section 13.2 **Notices**. All notices, demands and other communications to be given or delivered under or by reason of the provisions of this Agreement shall be in writing and shall be deemed to have been given (a) when personally delivered, (b) when transmitted via telecopy (or other facsimile device) to the number set out below if the sender on the same day sends a confirming copy of such notice by a recognized overnight delivery service (charges prepaid), (c) the day following the day (except if not a Business Day then the next Business Day) on which the same has been delivered prepaid to a reputable national overnight air courier service or (d) the third Business Day following the day on which the same is sent by certified or registered mail, postage prepaid. Notices, demands and communications, in each case to the respective parties, shall be sent to the applicable address set forth below, unless another address has been previously specified in writing:

If to any Lima Party:
c/o LifePoint Health, Inc.
330 Seven Springs Way
Brentwood, TN 37027
Attention: General Counsel
Fax: [redacted]

with a copy to:
Sidley Austin LLP
787 Seventh Avenue
New York, NY 10019
Attn: [redacted]

with a copy to:
Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700

Nashville, TN 37219
Attn: [redacted]
Fax: [redacted]

If to any MPT Party: c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, AL 35242
Attention: Legal Department
Phone: [redacted]
Fax: [redacted]

with a copy to: Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
420 20th Street North, Suite 1400
Birmingham, AL 35203
Attention: [redacted]
Phone: [redacted]
Fax: [redacted]

or to such other address with respect to a party as such party notifies the other in writing as above provided.

Section 13.3 Calculation of Time Period. When calculating the period of time before which, within which or following which any act is to be done or step taken, the date that is the reference date in calculating such period shall be excluded. If the last day of such period is not a Business Day, the period in question shall end of the next succeeding Business Day.

Section 13.4 Captions. The section and paragraph headings or captions appearing in this Agreement are for convenience only, are not a part of this Agreement, and are not to be considered in interpreting this Agreement.

Section 13.5 Entire Agreement; Modification. This Agreement, including each Exhibit, Annex, and Schedule attached hereto, and other written agreements executed and delivered in connection herewith by the Parties, embody and constitute the entire understanding between the Parties with respect to the transactions contemplated herein and shall be interpreted in such manner as to be effective and valid under applicable law, and all prior agreements, understandings, representations and statements (oral or written) are merged into this Agreement. The Parties have not relied upon, and shall not be entitled to rely upon, any prior or contemporaneous agreements, understandings, representations or statements (oral or written) other than this Agreement in effecting the transactions contemplated herein or otherwise. If any provision of this Agreement is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Agreement, unless the severance of such provision would be in opposition to the parties' intent with respect to such provision. Neither this Agreement, any Exhibit, Annex, or Schedule attached hereto, nor any provision hereof or thereof may be modified or amended except by an instrument in writing signed by the Parties; *provided, that*, notwithstanding anything to the contrary in this Agreement, Sections 12.1, 12.2, 13.1, 13.5, 13.11, and 13.18 and the definitions of "Financing Sources",

"Financing" and "Non-Recourse Party" (such sections and definitions, collectively, the "**Financing Source Protection Provisions**"), solely to the extent applicable to the Financing Sources, cannot be amended, waived or otherwise modified in a manner materially adverse to the Financing Sources, without the written consent of the Financing Sources.

Section 13.6 Schedules and Exhibits. All Schedules and Exhibits referred to in this Agreement shall be deemed a part of this Agreement and are hereby incorporated herein by reference. The statements in the Schedules referred to in this Agreement, and those in any supplement thereto, relate to the provisions in the Section of this Agreement to which they expressly relate; *provided, however*, that any information set forth in one section of the Schedules shall also be deemed to apply to any other section to which its relevance is reasonably apparent on its face.

Section 13.7 Necessary Action. Each party shall perform any further acts and execute and deliver any documents that may be reasonably necessary to carry out the provisions of this Agreement.

Section 13.8 Counterparts. This Agreement may be executed in multiple counterparts, any one of which need not contain the signature of more than one party, but all such counterparts taken together shall constitute one and the same instrument.

Section 13.9 Expenses. The Lima Parties are jointly and severally responsible for, and shall pay or reimburse to the MPT Parties upon demand for, all reasonable expenses (including but not limited to legal, accounting, brokerage and other fees and expenses) which may be incurred by the MPT Parties or its Affiliates with respect to the negotiation, execution and delivery of this Agreement, the MPT Obligation Documents, and the consummation of the transactions contemplated hereby and thereby. In addition, the Lima Parties are jointly and severally responsible for, and shall pay to the MPT Parties or the applicable third parties upon demand, the costs of all surveys, inspections, title policies and other third party reports required by the MPT Parties in connection with the consummation of the transactions contemplated hereby, recording fees, and all other expenses incurred in the consummation of the transactions contemplated hereby. For the avoidance of doubt, the MPT Parties may submit to the Lima Parties after the applicable Closing copies of additional invoices relating to costs and expenses, and the Lima Parties, jointly and severally, shall reimburse the MPT Parties within ten (10) days after receipt thereof.

Section 13.10 Public Announcements. No press release or public announcement related to this Agreement or the transactions contemplated herein shall be issued or made by any party hereto (or any Affiliate to a party hereto) without the joint approval of the other parties hereto, unless required by Law (in the reasonable opinion of counsel) in which case the other parties shall have the right to review such press release, announcement or communication prior to issuance, distribution or publication. Notwithstanding the foregoing, a party may, without the prior consent of the other parties hereto, (i) issue or cause publication of any such press release or public announcement to the extent that such party reasonably determines, after consultation with outside legal counsel, such action to be required by Law or by the rules of any applicable self-regulatory organization (including, without limitation, federal and state securities laws and the rules and regulations of the NYSE or NASDAQ), in which event such party will use its

commercially reasonable efforts to allow the other parties hereto reasonable time to comment on such press release or public announcement in advance of its issuance, (ii) disclose that it has entered into this Agreement and the other MPT Obligation Documents, and may provide and disclose information regarding this Agreement, the parties to this Agreement and the other MPT Obligation Documents, the Real Property, the Facility and the other assets and properties subject hereto and thereto, and such additional information which such party may reasonably deem necessary, to its proposed investors in connection with a public offering or private offering of securities, or any current or prospective lenders with respect to its financing, and to investors, analysts and other parties in connection with earnings calls and other normal communications with investors, analysts and other parties, or (iii) include any information in a prospectus, prospectus supplement or other offering circular or memorandum in connection with public or private capital raising or other activities undertaken by such party.

Section 13.11 No Third Party Beneficiaries. Nothing expressed or referred to in this Agreement will be construed to give any Person other than the Parties to this Agreement (and any Non-Recourse Party with respect to Section 13.18 hereof) any legal or equitable right, remedy, or claim under or with respect to this Agreement or any provision of this Agreement; *provided, that*, notwithstanding anything to the contrary in this Agreement, the Financing Sources, if any, shall be third party beneficiaries of, and shall have the right to enforce their rights and remedies under, the Financing Source Protection Provisions.

Section 13.12 Joint Drafting. The parties hereto and their respective counsel have participated in the drafting and redrafting of this Agreement and the general rules of construction which would construe any provisions of this Agreement in favor of or to the advantage of one party as opposed to the other as a result of one party drafting this Agreement as opposed to the other or in resolving any conflict or ambiguity in favor of one party as opposed to the other on the basis of which party drafted this Agreement are hereby expressly waived by all parties to this Agreement.

Section 13.13 Joint and Several Obligations.

(a) Each Lima Party shall be jointly and severally liable for all of the liabilities and obligations of the Lima Parties under this Agreement. Additionally, each Lima Party acknowledges and agrees that all of the representations, warranties, covenants, obligations, conditions, agreements and other terms contained in this Agreement shall be applicable to and shall be binding upon and enforceable against any one or more of the Lima Parties. The MPT Parties may, in their sole discretion, seek satisfaction of liabilities and obligations of the Lima Parties from any or all of the Lima Parties under this Agreement (including, without limitation, with respect to Article XI hereof).

(b) Each MPT Party shall be jointly and severally liable for all of the liabilities and obligations of the MPT Parties under this Agreement. Additionally, each MPT Party acknowledges and agrees that all of the representations, warranties, covenants, obligations, conditions, agreements and other terms contained in this Agreement shall be applicable to and shall be binding upon and enforceable against any one or more of the MPT Parties. The Lima Parties may, in their sole discretion, seek satisfaction of liabilities and obligations of the MPT

Parties from any or all of the MPT Parties under this Agreement (including, without limitation, with respect to Article XI hereof).

Section 13.14 No Waiver. No waiver of any provision hereunder or any breach or default thereof shall extend to or affect in any way any other provision or prior or subsequent breach or default.

Section 13.15 Severability. Whenever possible, each provision of this Agreement shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Agreement, unless the severance of such provision would be in opposition to the parties' intent with respect to such provision.

Section 13.16 Delivery by Electronic Transmission. This Agreement and any signed agreement entered into in connection herewith or contemplated hereby, and any amendments hereto or thereto, to the extent signed and delivered by means of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail, shall be treated in all manner and respects as an original contract and shall be considered to have the same binding legal effects as if it were the original signed version thereof delivered in person. At the request of any party hereto or to any such contract, each other party hereto or thereto shall re-execute original forms thereof and deliver them to all other parties. No party hereto or to any such contract shall raise the use of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail to deliver a signature or the fact that any signature or contract was transmitted or communicated through the use of facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail as a defense to the formation of a contract and each such party forever waives any such defense.

Section 13.17 Representatives of the Parties.

(a) Each of the Lima Parties hereby appoints Lima HoldCo as its duly authorized agent and representative (the "**Lima Parties' Representative**") to take all actions and enforce all rights of the Lima Parties under this Agreement, including, without limitation, (i) giving and receiving any notice or instruction permitted or required under this Agreement; (ii) interpreting all of the terms and provisions of this Agreement; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with the MPT Parties under this Agreement; (v) conducting negotiations and dealing with the MPT Parties under this Agreement; and (vi) taking any other actions on behalf of the Lima Parties relating to the Lima Parties' rights, claims, duties and obligations under this Agreement. In the performance of the MPT Parties' respective duties and obligations hereunder, the MPT Parties shall be authorized and permitted to correspond and transact with Lima Parties' Representative on behalf of all the Lima Parties and shall be entitled to rely upon any document or instrument executed and delivered by the Lima Parties' Representative.

(b) The MPT Parties hereby appoint MPT of Johnstown-Lima, LLC as its duly authorized agent and representative (the "**MPT Representative**") to take all actions and enforce all rights of the MPT Parties under this Agreement, including, without limitation, (i)

giving and receiving any notice or instruction permitted or required under this Agreement; (ii) interpreting all of the terms and provisions of this Agreement; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with the Lima Parties under this Agreement; (v) conducting negotiations and dealing with the Lima Parties under this Agreement; and (vi) taking any other actions on behalf of the MPT Parties relating to the MPT Parties' rights, claims, duties and obligations under this Agreement. In the performance of the Lima Parties' respective duties and obligations hereunder, the Lima Parties shall be authorized and permitted to correspond and transact with the MPT Representative on behalf of all the MPT Parties and shall be entitled to rely upon any document or instrument executed and delivered by the MPT Representative.

Section 13.18 Non-Recourse. Notwithstanding anything in this Agreement or any of the MPT Obligation Documents to the contrary, each of the Parties, by its acceptance, directly or indirectly, of the benefits of this Agreement, expressly covenants, acknowledges and agrees that (a) no Person other than the Parties hereto shall have any obligation hereunder (and with respect thereto, only to the extent expressly provided herein) and that no recourse hereunder shall be had against, and no personal liability whatsoever shall attach to, be imposed on or otherwise be incurred by (i) any of the Parties' former, current and future direct or indirect equity holders, controlling persons, directors, officers, employees, agents, Affiliates, advisors, members, managers, general or limited partners, assignees, or representatives, (ii) any Financing Sources, or (iii) any former, current or future direct or indirect equity holders, controlling persons, directors, officers, employees, agents, Affiliates, advisors, members, managers, general or limited partners or assignees, or representatives of any of the foregoing (each of the foregoing referred to in clause (i), (ii) or (iii) above being referred to as a "**Non-Recourse Party**"), for any obligations of the Parties under this Agreement, or for any claim (whether in tort, contract or otherwise) based on, in respect of, or by reason of any such obligations or their creation or the transactions contemplated in this Agreement, through any of the Parties or otherwise, whether by or through attempted piercing of the corporate veil, by or through a claim by or on behalf of any of the Parties hereto against any of the other Parties or any Non-Recourse Party, by the enforcement of any judgment or assessment or by any legal or equitable proceeding, by virtue of any law, statute, or regulation, or otherwise, and (b) in no event shall any Lima Party or any other Person shall have any right to, nor shall any MPT Party or any of its Representatives have any obligation to, enforce specifically or otherwise seek specific performance of any debt or equity commitment letter described in the definition of "Financing" or any other agreements with any Financing Source relating to the Financing. Each of the Parties hereby covenants and agrees that it shall not institute, and shall cause each of its Affiliates and its equity holders and representatives not to attempt to assign or institute, directly or indirectly, any claim, suit or proceeding or bring, or attempt to assign, any other claim arising under, or in connection with, this Agreement or the transactions contemplated in this Agreement against any Non-Recourse Party. Notwithstanding the foregoing, nothing in this Section 13.18 shall in any way limit or modify any Financing Source's obligations to MPT Operating Partnership, L.P., Medical Properties Trust, Inc. or any MPT Party, as applicable, pursuant to any written agreement between such Financing Source, on the one hand, and MPT Operating Partnership, L.P., Medical Properties Trust, Inc. or such MPT Party, as applicable, on the other hand, with respect to any Financing. Furthermore, for the avoidance of doubt, (a) no Party to this Agreement will be considered a Non-Recourse Party and (b) nothing herein is intended or shall be deemed to limit or modify in any respect any the MPT Parties' or their Affiliates' respective rights and remedies under the Master Lease or any other

MPT Obligation Documents (including, without limitation, the Guaranty or any other guaranty agreement entered into by any of the Lima Parties or their Affiliates in connection therewith).

Section 13.19 Certain Waivers.

(a) Each of the Parties knowingly, willingly, irrevocably and expressly acknowledge and agree, on their own behalf and on behalf of their respective Affiliates, that, from and after the applicable Closing (other than with respect to prospective Closings), to the fullest extent permitted under applicable Law (including under Environmental Laws), any and all rights, claims and causes of action it may have against any other party to this Agreement or any of such other Party's Affiliates solely relating, as applicable, to the operation of any of the Lima Parties or the Lima Subsidiaries, any of the MPT Parties or their respective businesses or relating to the subject matter of this Agreement or any other document contemplated hereby, and the Transactions (other than, and solely with respect to, any of the representations, warranties and covenants herein that in accordance with the express term hereof survive the applicable Closing or with respect to claims for fraud, bad faith, or similar claims), whether or not arising under, or based upon, any Law (including any right, whether arising at law or in equity, to seek indemnification, contribution, cost recovery, damages, or any other recourse or remedy) are hereby irrevocably waived. Furthermore, without limiting the generality of this Section 13.19, no action, suit, claim, investigation or proceeding will be brought, encouraged, supported or maintained by, or on behalf of, any Party to this Agreement (or such party's Affiliates) against any of the other Parties to this Agreement (or their respective Affiliates), and no recourse will be sought or granted against any of them, by virtue of, or based upon, any alleged misrepresentation or inaccuracy in, or breach of, any of the representations, warranties, covenants or agreements of such other Party or its Affiliates set forth or contained in this Agreement or any other document contemplated hereby or any certificate, instrument, opinion, agreement or other document of such party, its Affiliates or any other Person delivered hereunder (other than, and solely with respect to, any of the representations, warranties and covenants herein that in accordance with the express term hereof survive the applicable Closing or with respect to claims for fraud, bad faith, or similar claims), the subject matter of this Agreement or any other document contemplated hereby, the business, the ownership, operation, management, use or control of the business of, as applicable, the Lima Parties, any of the Lima Subsidiaries, any of the MPT Parties, any of their respective assets, or any actions or omissions at, or prior to, the applicable Closing. Furthermore, without limiting the generality of this Section 13.19, none of the Parties will be entitled to rescind this Agreement or, subject to Article IX, treat this Agreement as terminated by reason of any breach of this Agreement, and all of the Parties knowingly, willingly, irrevocably and expressly waive any and all rights of rescission it may have in respect of any such matter; provided, that such waiver of recission rights shall not apply in the case of fraud, bad faith, or similar claims.

(b) Notwithstanding the foregoing subsection, nothing herein shall be deemed a waiver or relinquishment by any of the MPT Parties (or their Affiliates) of their rights and remedies under the Master Lease or other MPT Obligations Documents.

[Signatures Appear on the Following 6 Pages.]

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized officers on the date first written above.

MPT PARTIES:

MPT OF JOHNSTOWN-LIMA, LLC
MPT OF MEYERSDALE-LIMA, LLC
MPT OF HASTINGS-LIMA, LLC
MPT OF ROARING SPRINGS-LIMA, LLC
MPT OF LAWTON-LIMA, LLC
MPT OF PALESTINE-LIMA, LLC
MPT OF DODGE CITY-LIMA, LLC
MPT OF OTTUMWA-LIMA, LLC
MPT OF RIVERTON-LIMA, LLC
MPT OF LANDER-LIMA, LLC

BY: MPT OPERATING PARTNERSHIP, L.P.
ITS: SOLE MEMBER

By: _____
Name: R. Steven Hamner
Title: Executive Vice President & CFO

LIMA PARTIES:

LIMA HOLDCO, LLC

By: Kathy Teague
Name: Kathy Teague
Title: AVP, Secretary

DODGE CITY HEALTHCARE GROUP, LLC
d/b/a Western Plains Medical Complex

By: Kathy Teague
Name: Kathy Teague
Title: AVP, Secretary

NASON MEDICAL CENTER, LLC

By: Kathy Teague
Name: Kathy Teague
Title: AVP, Secretary

SOUTHWESTERN MEDICAL CENTER, LLC

By: Kathy Teague
Name: Kathy Teague
Title: AVP, Secretary

RCHP-OTTUMWA, LLC,
d/b/a Ottumwa Regional Health Center

By: Kathy Teague
Name: Kathy Teague
Title: AVP, Secretary

[Signature Page to Real Property Asset Purchase Agreement]

PALESTINE PRINCIPAL HEALTHCARE LIMITED PARTNERSHIP
d/b/a Palestine Regional Medical Center

By: Palestine-Principal G.P., Inc.,
its general partner

By: Kathy Teague
Name: Kathy Teague
Title: AVP, Corporate Secretary

PALESTINE-PRINCIPAL G.P., INC.

By: Kathy Teague
Name: Kathy Teague
Title: AVP, Secretary

DLP CONEMAUGH MEMORIAL MEDICAL CENTER, LLC

By: Kathy Teague
Name: Kathy Teague
Title: AVP, Secretary

DLP CONEMAUGH MINERS MEDICAL CENTER, LLC

By: Kathy Teague
Name: Kathy Teague
Title: AVP, Secretary

RIVERTON MEMORIAL HOSPITAL, LLC
d/b/a SageWest Health Care – Riverton Campus and
SageWest Health Care – Lawton Campus

By: Kathy Teague
Name: Kathy Teague
Title: AVP, Secretary

[Signature Page to Real Property Asset Purchase Agreement]

DLP CONEMAUGH MEYERSDALE MEDICAL CENTER, LLC

By: _____
Name: Kathy Teague
Title: AVP, Secretary

[Signature Page to Real Property Asset Purchase Agreement]

ANNEX A

Lima Subsidiaries and MPT Parties

LIMA SUBSIDIARIES

1. NASON MEDICAL CENTER, LLC
2. DODGE CITY HEALTHCARE GROUP, LLC
3. SOUTHWESTERN MEDICAL CENTER, LLC
4. PALESTINE PRINCIPAL HEALTHCARE LIMITED PARTNERSHIP (D/B/A PALESTINE REGIONAL MEDICAL CENTER)
5. PALESTINE-PRINCIPAL G.P., INC.
6. RCHP-OTTUMWA, LLC (D/B/A OTTUMWA REGIONAL HEALTH CENTER)
7. RIVERTON MEMORIAL HOSPITAL, LLC (D/B/A SAGEWEST HEALTH CARE-RIVERTON AND SAGEWEST HEALTH CARE – LANDER)
8. DLP CONEMAUGH MEMORIAL MEDICAL CENTER, LLC
9. DLP CONEMAUGH MINERS MEDICAL CENTER, LLC
10. DLP CONEMAUGH MEYERSDALE MEDICAL CENTER, LLC

MPT PARTIES

1. MPT OF JOHNSTOWN-LIMA, LLC
2. MPT OF MEYERSDALE-LIMA, LLC
3. MPT OF HASTINGS-LIMA, LLC
4. MPT OF ROARING SPRINGS-LIMA, LLC
5. MPT OF LAWTON-LIMA, LLC
6. MPT OF PALESTINE-LIMA, LLC
7. MPT OF DODGE CITY-LIMA, LLC
8. MPT OF OTTUMWA-LIMA, LLC
9. MPT OF RIVERTON-LIMA, LLC
10. MPT OF LANDER-LIMA, LLC

ANNEX B

Defined Terms

"**Affiliate**" means, with respect to any Person (i) any Person that, directly or indirectly, controls or is controlled by or is under common control with such Person or (ii) any other Person that owns, beneficially, directly or indirectly, 10% or more of the outstanding capital stock, shares or equity interests of such Person; provided that Affiliate shall not include (x) any officer, director, employee, shareholder, partner, member, manager or trustee of such Person or (y) any Person that directly or indirectly owns equity securities of LifePoint or any portfolio company or Affiliate of such Person other than LifePoint and its subsidiaries. For the purposes of this definition, "control" (including the correlative meanings of the terms "controlled by" and "under common control with"), as used with respect to any Person, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, through the ownership of voting securities or otherwise.

"**Agreement**" has the meaning set forth in the preamble hereof.

"**Ancillary Assets**" means, collectively, the following: (a) to the extent assignable, all rights in all intangible property relating exclusively to the Real Property, including, but not limited to, zoning rights, permits and indemnification or similar rights and all warranties, representations and guaranties affecting or inuring to the benefit of the Real Property or the owner thereof (including, without limitation, any indemnification or similar rights and warranties, representations and guaranties related to the Real Property); (b) to the extent assignable, all right, title and interest in and to site plans, surveys, soil and substrata studies, architectural drawings, plans and specifications, inspection reports, engineering and environmental plans and studies, title reports, floor plans, landscape plans and other plans relating to the Real Property; and (c) all right, title and interest of any Lima Party in and to all causes of action, claims and rights in litigation (or which could result in litigation against any party) pertaining or relating to the Real Property. Notwithstanding the foregoing, Ancillary Assets shall not include any assets included the Excluded Assets (as herein defined).

"**Assignment and Assumption of Lease Agreement**" means each Assignment and Assumption of Lease Agreement to be entered into by each of the applicable Lima Subsidiaries and MPT Parties at the applicable Closing, which shall be substantially in the form attached hereto as ***EXHIBIT F***, and pursuant to which such Lima Subsidiaries shall assign to the such MPT Parties, and such MPT Parties shall assume from such Lima Subsidiaries, all of the Assumed Lima Leases relating to the Leased Real Property intended to be transferred on such Closing Date.

"**Assignment and Assumption of MOB Ground Lease Agreement**" means each Assignment and Assumption of Lease Agreement to be entered into by each of the applicable Lima Subsidiaries and MPT Parties at the applicable Closing, which shall be substantially in the form attached hereto as ***EXHIBIT G***, and pursuant to which such Lima Subsidiaries shall assign to the such MPT Parties, and such MPT Parties shall assume from such Lima Subsidiaries, all of the Assumed Lima Leases relating to the Leased Real Property intended to be transferred on such Closing Date.

"**Assignments of Rents and Leases**" means the assignments of rents and leases (each in recordable form) to be entered into by each of the applicable Lima Subsidiaries and the MPT Parties at the applicable Closing, which shall be substantially in the form attached hereto as ***EXHIBIT H***.

"**Assumed Lima Leases**" has the meaning set forth in Section 2.3(a) hereof.

"**Benefit Plans**" means each employee benefit plan within the meaning of Section 3(3) of ERISA to which any Lima Party is a party or is bound or under which it may have any liability or obligation and under which any employees of any Lima Party are eligible to participate or derive a benefit.

"**Business**" means the business and operation of the Facilities by the applicable Lima Subsidiaries.

"**Business Day**" means a day other than Saturday, Sunday, or any day on which the principal commercial banks in the State of New York are authorized or obligated to close under the Laws of such state.

"**Bills of Sale and Assignment**" means that certain bill of sale and assignment to be entered into by each of the applicable Lima Parties and MPT Parties at the applicable Closing, transferring the Ancillary Assets relating to the MPT Acquired Assets to be transferred on such Closing Date from each of the Lima Parties to the applicable MPT Parties, and which shall be substantially in the form of ***EXHIBIT I*** attached hereto.

"**Closing**" has the meaning set forth in Section 8.1 hereof.

"**Closing Date**" has the meaning set forth in Section 8.1 hereof.

"**Code**" means the United States Internal Revenue Code of 1986, as amended through the date hereof, and all regulations thereunder. Any reference herein to a specific section or sections of the Code shall be deemed to include a reference to any corresponding provision of future law.

"**Collateral Assignments of Leases**" means collateral assignments from each of the applicable Lima Parties of the Collateral Leases listed on ***Schedule 6.5(b)*** and/or ***Schedule 8.2(l)*** attached hereto, substantially in the form of ***EXHIBIT J*** attached hereto.

"**Collateral Leases**" has the meaning set forth in Section 2.2 hereof.

"**Collective Bargaining Agreement**" means any collective bargaining agreement or similar Contract with any labor organization or other employee representative body.

"**Conemaugh Properties**" means, collectively, all of the Real Property on which the following Facilities are located: (i) Conemaugh Memorial Medical Center, (ii) Conemaugh Meyersdale Medical Center, (iii) Conemaugh Miners Medical Center, and (iv) Nason Medical Center.

"**Confidentiality Agreement**" means that certain confidentiality letter agreement, dated July 16, 2019, by and among MPT Op, DSB Holdings, Inc., and the other party thereto.

"**Constituent Documents**" means, for any corporation, partnership, limited partnership, limited liability company or other organization, its charter, articles of incorporation, certificate of incorporation, bylaws, partnership agreement, operating agreement, certificate of limited partnership, certificate of formation and other similar formation and governance documents, each as amended to the relevant date.

"**Construction Documents**" has the meaning set forth in Section 4.5(g) hereof.

"**Construction Projects**" has the meaning set forth in Section 4.5(g) hereof.

"**Contract**" means all written contractual agreements relating to or affecting the assets or the operation of the Facilities to which any of the Lima Parties is a party, and all contracts or agreements with regard to the development and construction of any additional healthcare facilities.

"**Damages**" means actual out-of-pocket losses, damages, claims, costs, fines, fees, expenses, penalties, interest obligations and deficiencies (including reasonable attorneys' fees and other expenses of litigation); provided, that Damages shall not include punitive, incidental, consequential, special or indirect damages (including loss of revenue, diminution in value and any damages based on any type of multiple).

"**Deeds**" means one or more special warranty deeds (each in recordable form) from the applicable Lima Subsidiaries conveying to the applicable MPT Parties fee simple title to (a) the applicable Owned Real Property, and (b) any owned Improvements (as applicable) located on any of the Leased Real Property, in each case subject only to the Permitted Encumbrances, and which shall be substantially in the form attached hereto as ***EXHIBIT K***.

"**Encumbrance**" means any mortgage, pledge, assessment, security interest, lease, sublease, lien, adverse claim, levy, right of way, easement, encroachment, covenant, charge, restriction, variance, liability or other encumbrance of any kind, or any conditional sale contract, title retention contract, or other agreement, arrangement or understanding to give or to refrain from giving any of the foregoing.

"**Environmental Claim**" means any claim, action, cause of action, investigation alleging potential liability (including, without limitation, potential liability for investigatory costs, cleanup costs, governmental response costs, natural resources damages, property damages, personal injuries or penalties) arising out of or based on Environmental Law, or resulting from the violation of any Environmental Law.

"**Environmental Indemnification Agreement**" means the Environmental Indemnification Agreement to be entered into at the applicable Closing by Lima Holdco, each of the applicable Lima Subsidiaries, and the MPT Parties, and which shall be substantially in the form attached hereto as ***EXHIBIT L***.

"**Environmental Laws**" means Laws relating to the use, refinement, handling, treatment, removal, storage, production, manufacture, transportation or disposal, emission, discharge, release or threatened release of Hazardous Substances, or otherwise relating to protection of worker health (with respect to exposure to Hazardous Substances) or the environment (including, without limitation, ambient air, surface water, ground water, land surface or subsurface strata), as the same may be amended or modified to the date hereof and as of the applicable Closing Date, including, but not limited to Comprehensive Environmental Response, Compensation and Liability Act , 42 U.S.C. § 9601 *et seq.*, Resource Conservation and Recovery Act, 42 U.S.C. § 6901 *et seq.*, Toxic Substances Control Act, 15 U.S.C. § 2601 *et seq.*, Occupational Safety and Health Act, 29 U.S.C. *§* 651 et seq., the Clean Air Act, 42 U.S.C. § 7401 *et seq.*, the Clean Water Act, 33 U.S.C. § 1251 *et seq.*, each as may have been amended or supplemented, and any applicable environmental transfer statutes or laws.

"**Equity Constituents**" means, with respect to any Person, as applicable, the members, general or limited partners, shareholders, stockholders or other Persons, however designated, who are the owners of the issued and outstanding equity or ownership interests of such Person.

"**ERISA**" shall mean the United States Employee Retirement Income Security Act of 1974, as amended, and the rules and regulations promulgated thereunder.

"**ERISA Affiliate**" shall mean any other corporation or trade or business controlled by, controlling, or under common control with any Lima Party (within the meaning of Code Section 414 or Section 400(a)(14) or 4001(b) of ERISA).

"**Excluded Liabilities**" has the meaning set forth in Section 2.3.

"**Excluded Assets**" has the meaning set forth in Section 2.2.

"**Existing Intercreditor Agreement**" means that certain Intercreditor Agreement, dated as of April 29, 2016, by and among certain Affiliates of the MPT Parties, on the one hand, and Wilmington Trust, National Association (as notes collateral agent), Royal Bank of Canada (as administrative agent and collateral agent under the Asset-Based Revolving Credit Agreement (as defined therein), and Cantor Fitzgerald Securities, as collateral agent under the First Lien Credit Agreement (as defined therein), with respect to certain leasing and financing arrangements with Regionalcare Hospital Partners Holdings, Inc., a Delaware corporation d/b/a RCCH Healthcare Partners, and its indirect subsidiaries that are MPT Operators (as defined therein), as the same has been amended, modified or supplemented from time to time.

"**Facilities**" has the meaning set forth in the recitals of the Agreement.

"**Financing**" shall mean, as applicable, any offering or private placement of any debt or equity securities or any bank loan or other debt financing issued or incurred, or proposed to be issued or incurred, by Medical Properties Trust, Inc. or any of its Affiliates (i) to finance, in whole or in part, any of the transaction contemplated by this Agreement and related fees and expenses to be incurred by the MPT Parties and their Affiliates in connection therewith, and/or (ii) to refinance, in whole or in part, any such debt financing referred to in clause (i) above.

"**Financing Source Protection Provisions**" shall have the meaning set forth in Section 13.5 hereof.

"**Financing Sources**" shall mean, collectively, any lender, underwriter, financing source, placement agent, arranger, bookrunner, and other agent for all or any portion of any Financing, and each other entity that has committed to provide, or otherwise agreed to place, purchase, underwrite, syndicate or arrange, all or any portion of any Financing, including any financial institution from time to time party to the commitment letter referred to in the definition of "Financing" (in each case, together with their respective Affiliates, and the respective current, former or future officers, directors, employees, agents and representatives of the foregoing, and their respective successors and assigns).

"**Fixtures**" shall mean all permanently affixed non-medical equipment, machinery, fixtures, and other items of real property, including all components thereof, now and hereafter located in, on or used in connection with, and permanently affixed to or incorporated into the Improvements, including, without limitation, all affixed furnaces, boilers, heaters, electrical equipment, heating, plumbing, lighting, ventilating, refrigerating, incineration, air and water pollution control, waste disposal, air-cooling and air-conditioning systems and apparatus, sprinkler systems and fire and theft protection equipment, and built-in vacuum, cable transmission, oxygen and similar systems, all of which, to the greatest extent permitted by law, are hereby deemed by the parties to constitute real estate, together with all replacements, modifications, alterations and additions thereto.

"**Fundamental Representations**" means (i) with respect to the representations and warranties of the Lima Parties, the representations and warranties set forth in Sections 4.1, 4.2, 4.3, 4.4, 4.14, and with respect to the representations and warranties of the MPT Parties, the representations and warranties set forth in Sections 5.1 and 5.2.

"**Governmental Authority**" means any national, state or local government; any political subdivision thereof; any other governmental, quasi-governmental, judicial, public or statutory instrumentality, authority, body, agency, department, bureau, commission or entity (to the extent that the rules, regulations or orders of such organization or authority have the force of Law); or any arbitrator with authority to bind a party at law.

"**Ground Leased MOB Property**" means, collectively, the Southwestern/Lawton Ground Leased Property, the Ottumwa Ground Leased Property, and the Nason/Roaring Springs Ground Leased Property.

"**Guarantor**" has the meaning set forth in the recitals hereof.

"**Guaranty**" has the meaning set forth in the recitals hereof.

"**Hazardous Substances**" means any Medical Waste and any toxic or hazardous waste, pollutants or substances listed as a "hazardous substance," "toxic substance," "toxic pollutant" or similarly identified substance or mixture, in or pursuant to any Environmental Law, including

friable asbestos, polychlorinated biphenyls and petroleum, petroleum products and byproducts or other hydrocarbon substances.

"**Healthcare Licenses**" means all applicable federal, state and local governmental Licenses, approvals, qualifications, variances, certificates of need, franchises, accreditations, certificates, certifications, consents, permits, provider agreements and other authorizations, which may be (a) necessary for the operation of each of the Hospitals as a general acute care or critical access hospital facility (and for such other legal ancillary uses as may be necessary in connection with or incidental to such uses), or (b) required for certification and participation under Medicare and Medicaid legislation and regulations, the provider programs of any Governmental Authority for each particular Facility, the United States Department of Health and Human Services, and the Centers for Medicare and Medicaid Services, and/or state or federal Title XVIII and/or Title XIX provider programs applicable for each such Facility.

"**Hospitals**" has the meaning set forth in the recitals hereof.

"**Impacted Facility**" has the meaning set forth in Section 2.4.

"**Improvements**" means the Facilities and all other buildings, improvements, structures and Fixtures located on the Land (either on the date of this Agreement or on the applicable Closing Date), including without limitation, landscaping, parking lots and structures, roads, drainage and all above ground and underground utility structures, equipment systems and other so-called "infrastructure" improvements.

"**Indemnified Party**" has the meaning set forth in Section 11.4(a).

"**Indemnifying Party**" has the meaning set forth in Section 11.4(a).

"**Individual Purchase Price**" has the meaning set forth in Section 3.1.

"**Johnstown ROFR Properties**" means, collectively, (i) certain the Real Property located at 1440 Scalp Avenue, Lot 11, Johnstown, Pennsylvania, and (ii) certain the Real Property located at 1440 Scalp Avenue, Lots 12 and 17, Johnstown, Pennsylvania.

"**Joinder to the Existing Intercreditor Agreement**" means a joinder and amendment to Existing Intercreditor Agreement to be executed and delivered at the applicable Closing, pursuant to which the applicable Parties hereto join or cause to be joined to the Existing Intercreditor Agreement: (i) the Sale/Leaseback Transaction as a "Future MPT/Holdings Transaction" thereunder, (ii) the applicable MPT Parties as "MPT Lessor" thereunder, and (iii) the applicable Lima Subsidiaries as "MPT Operators" thereunder, and which joinder and amendment shall be in substantially in the form of ***EXHIBIT M*** attached hereto (unless otherwise agreed by the MPT Parties, in their sole discretion).

"**Knowledge of MPT Parties**" (and any similar expression, including "MPT Parties' Knowledge") means, as to a particular fact or matter, the actual knowledge of R. Steven Hamner,

after reasonable inquiry, by such Person of officers, directors, employees and agents of the MPT Parties or of any Affiliate of the MPT Parties with respect to the matters at hand.

"**Knowledge of the Lima Parties**" (and any similar expression, including "Lima's Knowledge") means, as to a particular fact or matter, the actual knowledge of any of the Person specified with respect to any of the Lima Parties on ***EXHIBIT N*** as of the date hereof, after reasonable inquiry by such Person of officers, directors, employees and agents of the applicable Lima Parties or their Affiliates with respect to the matters at hand.

"**Land**" has the meaning set forth in the recitals hereof.

"**Law**" means any statute, law, ordinance, rule, regulation, code, resolution, order, writ, injunction, judgment, decree, ruling or treaty issued by any Governmental Authority.

"**Leased Land**" has the meaning set forth in the recitals hereof.

"**Leased Real Property**" has the meaning set forth in the recitals hereof.

"**Lessees**" has the meaning set forth in the recitals hereof.

"**Licenses**" shall mean all accreditations, licenses, permits, franchises, certificates and certifications (including certificates of need), approvals, exemptions, classifications, registrations and other similar documents and authorizations issued by any Governmental Authority (including, without limitation, all Healthcare Licenses), and amendments and modifications of any of the foregoing.

"**LifePoint**" has the meaning set forth in the recitals hereof, it being understood that in the event that LifePoint is converted to a Delaware limited liability company, the term "LifePoint" shall be deemed to refer to such converted entity.

"**LifePoint Indemnified Parties**" has the meaning set forth in Section 11.2.

"**LifePoint JV Members**" means, collectively, the direct and indirect members in the entities that own the Conemaugh Properties.

"**LifePoint Lease Guaranty**" has the meaning set forth in the recitals hereof.

"**LifePoint Noncompetition Agreement**" means the Noncompetition Agreement to be entered into by LifePoint at the applicable Closing, which shall be substantially in the form attached hereto as ***EXHIBIT O***.

"**LifePoint Upper Tier Distributions**" means the collective distributions by any of the Lima Sellers or LifePoint, DSB Holdings, Inc., or any of its Subsidiaries of any portion of their Affiliates of the proceeds received directly or indirectly by the Lima Sellers in connection with the Sale/Leaseback Transaction to (directly or indirectly) any of LifePoint or its Subsidiaries.

"**LifePoint Upper Tier Restructuring Transaction**" means any distributions, contributions or other transfers of (i) the equity interests of DLP Conemaugh Holding Company, LLC (and indirectly its Subsidiaries and minority investments) to (a) LifePoint or any of its wholly-owned subsidiaries and (b) Duke Quality Network, Inc. and its Subsidiaries (the "Conemaugh Separation"), (ii) any direct or indirect equity interests of the Lima Parties held directly by LifePoint or any of its wholly-owned Subsidiaries (including following the Conemaugh Separation, their equity interest in DLP Conemaugh Holding Company, LLC) within LifePoint and its wholly-owned Subsidiaries whether prior to, on, or after any Closing; *provided that*, without consent from the MPT Parties, which consent shall not be unreasonably withheld, the LifePoint Upper Tier Restructuring Transaction will not result in any change in the entities that own the Real Property.

"**Lima Party**" and "**Lima Parties**" have the respective meanings set forth in the preamble hereof.

"**Lima Indemnified Parties**" has the meaning set forth in Section 11.3 hereof.

"**Lima Parties' Representative**" has the meaning set forth in Section 13.17(a) hereof.

"**Lima Seller**" and "**Lima Sellers**" have the respective meanings set forth in the recitals hereof.

"**Lima Subsidiaries**" has the meaning set forth in the preamble hereof.

"**Lima Holdco**" has the meaning set forth in the preamble hereof.

"**Lima Noncompetition Agreement**" means the Noncompetition Agreement to be entered into by Lima Holdco at the initial Closing, which shall be substantially in the form attached hereto as ***EXHIBIT P***.

"**Management Agreements**" means any contract or agreement for the provision of whole-hospital management services to any of the Lima Subsidiaries with respect to the operation of any Hospital on any of the Real Property, whether now existing or hereafter entered into (but shall not be construed to cover management agreements or similar agreements relating to only a small portion of a Facility, such as an inpatient psychiatric unit or a wound care facility (as opposed to the management and operation of the Hospital).

"**Master Lease**" has the meaning set forth in the recitals hereof.

"**Material Adverse Effect**" means any change, effect, event, occurrence, state of facts or development, whether direct or indirect, that, both before and after giving effect to the transactions contemplated by this Agreement, individually or in the aggregate, has or could reasonably be expected to have a material adverse effect to the financial condition or results of operations of the Lima Parties taken as a whole, the cost of which exceeds or could reasonably be expected to exceed Seventy-Five Million Dollars ($75,000,000); *provided, however*, that none of the following shall be deemed in themselves, either alone or in combination, to constitute, and

none of the following shall be taken into account in determining whether there has been or will be, a Material Adverse Effect: any change, effect, event, occurrence, state of facts or development attributable to (a) the announcement or pendency of the transactions contemplated by this Agreement; (b) conditions affecting the general acute care hospital industry, the U.S. economy as a whole, or the financial or capital markets in general (including currency fluctuations) or the markets in which the Lima Parties operate; (c) compliance with the terms of, or the taking of any action required, contemplated or permitted by, this Agreement; (d) any change in, or proposed or potential change in, applicable Laws or the interpretation thereof; (e) actions required to be taken under applicable Laws, contracts or agreements; (f) any change in generally accepted accounting principles or other accounting requirements or principles or the interpretation thereof; (g) the failure of the Lima Parties to meet or achieve the results set forth in any projection or forecast (*provided*, that this clause (g) shall not prevent a determination that any change or effect underlying such failure to meet projections or forecasts has resulted in a Material Adverse Effect (to the extent such change or effect is not otherwise excluded from this definition of Material Adverse Effect)); (h) the commencement, continuation or escalation of a war, cyberattack, material armed hostilities or other material international or national calamity or act of terrorism; (i) any of the matters disclosed on the disclosure Schedules attached to this Agreement; or (j) the effect of any action taken by the MPT Parties with respect to the transactions contemplated by this Agreement or the financing thereof; *provided* that, in the case of clauses (b), (d), (e) and (h) above, if such change, effect, event, occurrence, state of facts or development disproportionately affects the Lima Parties as compared to other Persons or businesses that operate in the industry in which the Lima Parties operate, then the disproportionate aspect of such change, effect, event, occurrence, state of facts or development may be taken into account in determining whether a Material Adverse Effect has or will occur.

"**Medicaid**" shall mean the medical assistance program established by Title XIX of the Social Security Act (42 U.S.C. Sections 1396 *et seq.*) and any statute succeeding thereto.

"**Medical Waste**" means (a) pathological waste, (b) blood, (c) sharps, (d) wastes from surgery or autopsy, (e) dialysis waste, including contaminated disposable equipment and supplies, (f) cultures and stocks of infectious agents and associated biological agents, (g) contaminated animals, (h) isolation wastes, (i) contaminated equipment, (j) laboratory waste and (k) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings or animals. "Medical Waste" also includes any substance, pollutant, material, or contaminant listed or regulated under the Medical Waste Tracking Act of 1988, 42 U.S.C. § 6992, *et seq.* ("**MWTA**"), and applicable state Law.

"**Medicare**" shall mean the health insurance program for the aged and disabled established by Title XVIII of the Social Security Act (42 U.S.C. Sections 1395 *et seq.*) and any statute succeeding thereto.

"**Memoranda of Lease**" means one or more memoranda of lease (each in recordable form for the applicable jurisdiction) between each of the Lessees and each of the applicable MPT Parties with respect to the Master Lease, in form and substance reasonable satisfactory to the Parties.

"**MOB Ground Leases**" means, individually and collectively, each of the Southwestern/Lawton MOB Ground Leases, the Ottumwa MOB Ground Lease, and the Nason/Roaring Springs Ambulance Facility Lease.

"**Mortgage Lien Releases**" has the meaning set forth in Section 6.8 hereof.

"**MPT Acquired Assets**" has the meaning set forth in in Section 2.1(a) hereof.

"**MPT Indemnified Parties**" has the meaning set forth in Section 11.1 hereof.

"**MPT Obligation Documents**" means, collectively, this Agreement, the Master Lease, the Guaranty, the LifePoint Lease Guaranty, the MPT Op APA Guaranty, the Assignments of Rents and Leases, the Environmental Indemnification Agreement, the Lima Noncompetition Agreement, the LifePoint Noncompetition Agreement, and all other guarantees, security agreements, pledge agreements, assignments of rents and leases, and other documents, instruments, or certificates entered into by any of the Parties or their Affiliates in connection with the transactions contemplated in this Agreement or as may be necessary to give effect to the provisions hereof or to evidence or secure the payment and performance of the Lima Parties' and their Affiliates' respective obligations and liabilities under this Agreement, the Master Lease, and any other documents and instruments entered into in connection therewith, as each of the same may be amended, modified or restated from time to time.

"**MPT Op**" has the meaning set forth in the recitals hereof.

"**MPT Op APA Guaranty**" has the meaning set forth in the recitals hereof.

"**MPT Parties**" has the meaning set forth in the preamble hereof.

"**MPT Representative**" has the meaning set forth in Section 13.17(b) hereof.

"**Multiemployer Plan**" means each "multiemployer plan" as defined in Section 3(37) of ERISA to which any of the Lima Parties or ERISA Affiliates is obligated to contribute as of the Closing Date or has been so obligated within the preceding six (6) years pursuant to a Collective Bargaining Agreement or participation agreement.

"**Nason/Roaring Springs Ambulance Facility Lease**" means that certain Lease Agreement dated June 1, 1992, by and between Nason Hospital, as landlord, and Altoona-Logan Township Mobile Medical Emergency Department Authority f/k/a Roaring Spring Ambulance Service, Inc., as tenant, as the same has been or may be amended, modified, or restated from time to time.

"**Nason/Roaring Springs Ground Leased Property**" means that certain real property leased under the Nason/Roaring Springs Ambulance Facility Lease.

"**Non-Recourse Party**" has the meaning set forth in Section 13.18.

"**Objection**" has the meaning set forth in Section 6.13 hereof.

"**Objectionable Matters**" has the meaning set forth in Section 6.13 hereof.

"**OFAC**" has the meaning set forth in Section 4.16(a) hereof.

"**Ottumwa MOB Ground Lease**" means that certain Ground Lease, dated as of November 22, 2010, between RCHP-Ottumwa, LLC, a Delaware limited liability company (f/k/a RCHP-Ottumwa, Inc.), as lessor, and Ottumwa Medical Properties, LLC, an Iowa limited liability company (as successor by assignment to Ottumwa MOB, LLC, a Georgia limited liability company), as lessee, as the same has been or may be amended, modified, or restated from time to time.

"**Ottumwa Ground Leased Property**" means that certain real property ground leased under the Ottumwa MOB Ground Lease.

"**Ottumwa MOB Master Lease**" means that certain Master Lease Agreement, dated as of November 22, 2010, between Ottumwa Medical Properties, LLC, an Iowa limited liability company (as successor by assignment to Ottumwa MOB, LLC, a Georgia limited liability company), as lessor, and RCHP-Ottumwa, LLC, a Delaware limited liability company (f/k/a RCHP-Ottumwa, Inc.), as lessee, relating to real property located at 1011-1013 Pennsylvania Avenue, Ottumwa, Iowa, as the same has been or may be amended, modified, or restated from time to time.

"**Outside Closing Date**" has the meaning set forth in Section 8.1(a) hereof.

"**Owned Land**" has the meaning set forth in the recitals hereof.

"**Owned Real Property**" has the meaning set forth in the recitals hereof.

"**Patriot Act**" has the meaning set forth in Section 4.16(a) hereof.

"**PBGC**" means the Pension Benefit Guaranty Corporation, together with its successors and assigns.

"**Permitted Encumbrance**" means (a) any Encumbrance for Taxes or other governmental charges or assessments which are not due and payable as of the applicable Closing Date (*provided, that*, Encumbrances arising under Section 430(k) of the Code, ERISA, or otherwise with respect to the Benefit Plans are not Permitted Encumbrances), (b) any Encumbrance of any landlord, carrier, warehouseman, mechanic or materialman and any like Encumbrance arising in the ordinary course of business for sums that are not delinquent more than thirty (30) days, (c) Laws regulating the use or enjoyment of the applicable portion of the Real Property, provided such Laws do not materially adversely affect the marketability of the Real Property or the use or operation of any Facility in accordance with the manner it is currently being used or operated, (d) all existing Tenant Leases, (e) with respect to any Leased Real Property, Encumbrances which encumber the fee interest in such property, which do not

materially adversely affect the marketability of the Real Property or the use or operation of any Facility in accordance with the manner it is currently being used or operated and (f) all Encumbrances, including, without limitation, all matters shown on the title insurance policies or surveys obtained by the MPT Parties, which do not materially adversely affect the marketability of the Real Property or the use or operation or occupancy of the Facilities in accordance with the manner currently being used or operated.

"**Person**" means an individual, a corporation, a limited liability company, a partnership, an unincorporated association, a joint venture, a Governmental Authority or another entity or group.

"**Present Fair Salable Value**" means, with respect to any Person, the amount that may be realized if the aggregate assets of such Person are sold as an entirety with reasonable promptness in an arm's length transaction under then-present conditions for the sale of comparable business enterprises.

"**Public Taking**" has the meaning set forth in Section 4.5(f) hereof.

"**Purchase Price**" has the meaning set forth in Section 3.1 hereof.

"**Proceedings**" means any audit, examination, injunction, or other proceeding.

"**Real Property**" has the meaning set forth in the recitals hereof.

"**Representatives**" shall mean the directors, officers, employees, Affiliates, agents, investment bankers, financial advisors, attorneys, accountants, advisors, brokers, finders, consultants or representatives of the MPT Parties, the Lima Parties, or any of their respective Affiliates, as the case may be.

"**ROFR Purchase Rights**" has the meaning set forth in Section 4.5(b) hereof.

"**Sale/Leaseback Transaction**" has the meaning set forth in the recitals hereof.

"**Solvent**" means, with respect to any Person, that as of the applicable date of determination, (i) the Present Fair Salable Value of the assets of such Person will, as of such date, exceed all of its debts, as of such date, (ii) such Person will not have, or have access to, as of such date, an unreasonably small amount of capital for the business in which it is engaged or will be engaged, and (iii) such Person is able to pay its debts as they become absolute and mature, in the ordinary course of business, taking into account the timing of and amounts of cash to be received by it and the timing of and amounts of cash to be payable on or in respect of its indebtedness, in each case after giving effect to the Sale/Leaseback Transaction and the LifePoint Upper Tier Restructuring Transaction. The term "Solvency" shall have a correlative meaning. For purposes of this definition: (A) "debt" means liability on a "claim"; and (B) "claim" means (1) any right to payment, whether or not such a right is reduced to judgment, liquidated, unliquidated, fixed, contingent, matured, unmatured, disputed, undisputed, secured or unsecured, or (2) the right to an equitable remedy for breach of performance if such breach gives

rise to a right to payment, whether or not such right to an equitable remedy is reduced to judgment, liquidated, unliquidated, fixed, contingent, matured, unmatured, disputed, undisputed, secured or unsecured.

"**Southwestern/Lawton Ground Leased Property**" means that certain real property ground leased under the Southwestern/Lawton MOB Ground Leases.

"**Southwestern/Lawton MOB Ground Leases**" means, collectively, (i) that certain Amended and Restated Ground Lease, dated as of January 7, 2008, between Southwestern Medical Center, LLC, a Delaware limited liability company), as lessor, and G&E HC REIT II Lawton MOB Portfolio LLC, a Delaware limited liability company (as successor by assignment to Southwestern MOB I, LLC, a Delaware limited liability company), as lessee, relating to real property located at 5606 SW Lee Blvd. in Lawton, Oklahoma and (ii) that certain Ground Lease, dated as of January 7, 2008, between Southwestern Medical Center, LLC, a Delaware limited liability company), as lessor, and G&E HC REIT II Lawton MOB Portfolio LLC, a Delaware limited liability company (as successor by assignment to Southwestern MOB I, LLC, a Delaware limited liability company), as lessee, relating to real property located at 5604 SW Lee Blvd. in Lawton, Oklahoma, as the same has been or may be amended, modified, or restated from time to time, as each of the foregoing has been or may be modified, amended or restated from time to time.

"**Southwestern/Lawton MOB Master Leases**" means, collectively, (i) that certain Master Lease Agreement, dated January 7, 2008, between Southwestern Medical Center, LLC, a Delaware limited liability company), as lessee, and G&E HC REIT II Lawton MOB Portfolio LLC, a Delaware limited liability company (as successor by assignment to Southwestern MOB I, LLC, a Delaware limited liability company), as lessor, relating to real property located at 5606 SW Lee Blvd. in Lawton, Oklahoma and (ii) that certain Master Lease Agreement, dated as of January 7, 2008, between Southwestern Medical Center, LLC, a Delaware limited liability company), as lessee, and G&E HC REIT II Lawton MOB Portfolio LLC, a Delaware limited liability company (as successor by assignment to Southwestern MOB I, LLC, a Delaware limited liability company), as lessor, relating to real property located at 5604 SW Lee Blvd. in Lawton, Oklahoma, as the same has been or may be amended, modified, or restated from time to time, as each of the foregoing has been or may be modified, amended or restated from time to time.

"**Subordination of Management Agreements**" means the Subordination of Management Agreements to be entered into on each Closing Date by each of the applicable MPT Parties, the applicable Lima Subsidiaries, and the Management Company in connection with the Sale/Leaseback Transaction, which shall be substantially in the form attached hereto as ***EXHIBIT Q***, and pursuant to which any and all Management Agreements shall be made subject.

"**Survey**" means a current "as-built" ALTA survey, certified to ALTA requirements, prepared by an engineer or surveyor licensed in the applicable States in which the Real Properties are located and acceptable to the MPT Parties in their sole discretion.

"**Tax**" or "**Taxes**" means any federal, state, local or foreign income, gross receipts, license, business, payroll, employment, excise, severance, stamp, occupation, premium, windfall

profits, environmental, customs duties, capital stock, franchise, profits, hospital provider, hospital franchise fee, unrelated business income, withholding, social security (or similar), unemployment, disability, real property, personal property, sales, use, transfer, registration, value added, alternative or add-on minimum, unclaimed/abandoned property, estimated, or other tax of any kind whatsoever, including any interest, penalty, or addition thereto.

"**Tax Returns**" shall mean any report, return, document or other filing (including any additional or supporting material and any amendments or supplements) required to be supplied to any Governmental Authority with respect to Taxes.

"**Tenant Estoppels**" means the estoppels from the underlying lessees or tenants of the Tenant Leases, in form and substance required by the underlying lease or otherwise as reasonably satisfactory to the MPT Parties.

"**Tenant Leases**" has the meaning set forth in Section 2.2 hereof.

"**Third Party Claim**" has the meaning set forth in Section 11.4(b).

"**Title Commitment**" means a current commitment issued by the Title Company to the applicable MPT Parties pursuant to the terms of which the Title Company shall commit to issue the Title Policies to the applicable MPT Parties in accordance with the provisions of this Agreement, and reflecting all matters which would be listed as exceptions to coverage on the Title Policy.

"**Title Company**" means Fidelity National Title Insurance Company, or such other title company as may be mutually acceptable to the parties.

"**Title Expenses**" has the meaning set forth in Section 6.13 hereof.

"**Title Policies**" means a title insurance policies for the Real Property from the Title Company in form and substance satisfactory to the MPT Parties, in their sole discretion, including zoning endorsements and such other endorsements as the MPT Parties may require, subject only to the Permitted Encumbrances.

"**Total Development Costs**" has the meaning set forth in Section 4.5(g) hereof.

"**Tranche**" has the meaning set forth in Section 8.1(c) hereof.

"**WARN**" means the Worker Adjustment and Retraining and Notification Act, and all regulations promulgated thereunder.

Exhibit A-1

Legal Descriptions of Owned Land

Dodge City Owned Land

PARCEL 1: (Medical Office Building)
Lots Five (5), Six (6), and Seven (7), Block Four (4), Candletree Addition to the City of Dodge City, Ford County, Kansas, according to the Plat recorded in Plat Book "D" at Pages 65-67, inclusive.

PARCEL 2: (Hospital Land)
Lot Twenty-one (21), Block One (1), Ross Addition, an addition to the City of Dodge City, Ford County, Kansas, according to the recorded Plat thereof, formerly described as follows: A tract of land in the Southeast Quarter (SE ¼) of Section Fourteen (14), Township Twenty-six (26) South, Range Twenty-five (25) West, Ford County, Kansas, more fully described as follows: Commencing at the Northeast corner of the Southeast Quarter of Section 14, Township 26 South, Range 25 West, Ford County, Kansas; thence West along the North boundary line of the Southeast Quarter of said Section 14 for 25.00 feet to a point of beginning; thence continuing West along the North boundary line of the Southeast Quarter of said Section 14 for 1196.70 feet; thence South parallel with the East boundary line of the Southeast Quarter of said Section 14 for 724.60 feet; thence East parallel with the South boundary line of the Southeast Quarter of said Section 14 for. 1196.70 feet to a point 25.00 feet west of the East boundary line of the Southeast Quarter of said Section 14; thence North parallel with and 25.00 west of the East boundary line of the Southeast Quarter of said Section 14 for 731.40 feet to the point of beginning.

PARCEL 3: (Occupational Therapy Human Resources)
Lots Eight (8) and Nine (9), Block Four (4), Candletree Addition to the City of Dodge City, Ford County, Kansas, according to the Plat recorded in Plat Book "D" at Pages 65-67, inclusive.

PARCEL 4: (Women's Center)
Tract 1:
The East 80.00 feet of Lot 11 and all of Lot 12, Block 4, Candletree Addition, Dodge City, Ford County, Kansas.

Tract 2:
The South 68.00 feet of Lots 13 and 14, Candletree Courts, a Replat of Portions of Block 4, Candletree Addition, Dodge City, Ford County, Kansas, according to the Plat recorded in Plat Book "D" at Page 122A.

Tract 3:
Part of Lot 15, Candletree Courts, a Replat of Portions of Block 4, Candletree Addition, Dodge City, Ford County, Kansas, according to the Plat recorded in Plat Book "D" at Page 122A, more fully described as follows: Beginning at the Southeast corner of said Lot 15, Candletree Courts, thence North 89°36'40" West along the South line of said Lot 15 for 43.75 feet; thence North 00°23'20" East at right angles to the South line of said Lot 15 for 68.00 feet; thence South

89°36'40" East parallel with the South line of said Lot 15 for 42.74 feet to the east line of said Lot 15; thence South 00°28' East along the east line of said Lot 15 for 68.00 feet to the point of beginning.

Tract 4:

The North 87.00 feet of Lot 13, Candletree Courts, a Replat of Portions of Lot 13, Block 4, Candletree Addition, Dodge City, Ford County, Kansas, according to the Plat recorded in Plat Book "D" at Page 122A.

Tract 5:

Part of Lot 14, Candletree Courts, a Replat of Portions of Lot 13, Block 4, Candletree Addition, Dodge City, Ford County, Kansas, according to the Plat recorded in Plat Book "D" at Page 122A, more fully described as follows: Beginning at the Northeast corner of said Lot 14, Candletree Courts; thence South 00°28' East along the east line of said Lot 14 for 87.00 feet; thence North 89°36'40" West parallel with the north line of said Lot 14 for 74.74 feet; thence North 00°23'20" East at right angles with the north line of said Lot 14 for 86.99 feet; thence South 89°36'40" East along the north line of said Lot 14 for 73.44 feet to the point of beginning.

Tract 6:

The portion of Candletree Court (vacated), a platted street in Candletree Courts, a Replat of portions of Lot 13, Block 4, Candletree Addition, Dodge City, Ford County, Kansas, according to the Plat recorded in Plat Book "D" at Page 122A, as now established, more fully described as follows:

Beginning at the Northeast corner of Lot 13, Candletree Courts Replat, the same being the point of intersection of the south line of Candletree Court, a platted street, with the west line of Avenue A, thence North 89°36'40" West along the south line of Candletree Court, the platted street, for 173.44 feet; thence North 00°23'20" East for 60.00 feet; thence South 89°36'40" East along the north line of Candletree Court, the platted street, for 172.57 feet; thence South 00°28 East along the west line of

Avenue A for 60.01 feet to the point of beginning.

Tract 7:

Part of Lot 13, Block 4, Candletree Addition, Dodge City, Ford County, Kansas, according to the Plat recorded in Plat Book "D" at Page 65-67, more fully described as follows: Beginning at the Northeast corner of Candletree Courts, a replat of portions of Lot 13, Block 4, Candletree Addition, the same being the point of intersection of the north line of Candletree Court, the platted street, with the west line of Avenue A; thence North 89°36'40" West along the north line of said Candletree Courts replat for 172.57 feet; thence North 00°23'20" East for 38.01 feet; thence South 89°36'40" East for 172.00 feet; thence South 00°28' East along the west line of Avenue A for 38.01 feet to the point of beginning.

Tax Parcel Numbers:
086-14-0-10-03-016.00-0
086-14-0-40-01-001.00-0
086-14-0-10-03-018.00-0
086-14-0-10-03-019.00-0
086-14-0-10-03-019.02-0

Hastings Owned Land

290 Haida Avenue, Hastings, PA

Johnstown Owned Land

1086 Franklin	Johnstown	PA
Franklin Street-Rear	Johnstown	PA
1020 Franklin Street	Johnstown	PA
130 W. Osborne Street	Johnstown	PA
127 Flinn Street	Johnstown	PA
1015 Franklin Street	Johnstown	PA
1017 Franklin Street	Johnstown	PA
1097-1098 Franklin Street	Johnstown	PA
1111 Franklin Street	Johnstown	PA
Southmont Blvd	Johnstown	PA
Southmont Blvd - Rear	Johnstown	PA
1105 Otto Court	Johnstown	PA

Milford Street (West side)	Johnstown	PA
Milford Street (East side)	Johnstown	PA
113 Mayer Avenue	Johnstown	PA
150 Skelly Street (East of Esty St)	Johnstown	PA
Mulberry Street Parking (North side)	Johnstown	PA
Mulberry Street Parking (South side)	Johnstown	PA
Mulberry Street Parking (South side)	Johnstown	PA
Esty Street (East side)	Johnstown	PA
Esty Street (East and West sides)	Johnstown	PA
147 Skelly Street	Johnstown	PA
145 Skelly Street	Johnstown	PA
1063 Sunny Court	Johnstown	PA

Franklin Street - Rear (Actually Flynn St)	Johnstown	PA
Franklin Street / Otto Court (between F & MOB 1111 Franklin St)	Johnstown	PA
1141 Franklin Street	Johnstown	PA
1135-1137 Franklin Street	Johnstown	PA
Franklin Street (Between Moyer and Anstead Pl)	Johnstown	PA
Franklin Street (between Baker's Loaf & Ameriserv)	Johnstown	PA
Otto Court (Westside)	Johnstown	PA
17 Rose Street -corner of Otto Court	Johnstown	PA
46 Valley Pike	Johnstown	PA
50 Valley Pike	Johnstown	PA
Barnett Street (chiiler area)	Johnstown	PA
968 Fritz Street	Johnstown	PA
Franklin Street	Johnstown	PA
One Tech Park Drive	Johnstown	PA

415 Napoleon Place	Johnstown	PA
425 Napoleon Place (On Tax Map as 433 Benton St)	Johnstown	PA
320 Main St.	Johnstown	PA
Market St	Johnstown	PA
112 Walnut St. (Corner Walnut St & Washington St)	Johnstown	PA
SE corner of Morrell St & Locust St	Johnstown	PA
Corner of Seigh Pl and Marion Pl	Johnstown	PA
231 Locust Street Z231	Johnstown	PA
1440 Scalp Ave (HI Expess) 1450 Scalp Ave (CEH Outpatient)	Johnstown	PA
1450 Scalp Avenue	Johnstown	PA
Rt 22, 139 Cook Road	Ebensburg	PA
1060 Lloyd St	Nanty Glo	PA
1068 Lloyd St	Nanty Glo	PA
564 Theatre Road	St. Benedict	PA

105 Pine Haven Dr	Somerset	PA
105 Pine Haven Dr	Somerset	PA
2 Celestte Drive (927 Menoher Blvd)	Johnstown	PA
123 Mayer Avenue	Johnstown	PA

Lawton Owned Land

TRACT B:

Beginning at a point 70.0 feet S00°13'14"W and 414.26 feet S89°43'40"E of the Northwest Corner of the Northeast Quarter (NE/4) of Section Four (4), Township One (1) North, Range Twelve (12) West, I.M., Comanche County, Oklahoma, according to the U.S. Government Survey thereof; this point being on the South Right of Way line of State Highway No. 7; THENCE S89°43'40"E along said South Right of Way line a distance of 864.20 feet; THENCE S00°16'20"W a distance of 205.0 feet; THENCE Southeast along a curve to the left having a radius of 626.392 feet a distance of 273.315 feet; THENCE S24°43'40"E a distance of 25.0 feet; THENCE Southerly on a curve to the right having a radius of 254.138 feet a distance of 288.311 feet; THENCE S40°16'20"W a distance of 120 feet; THENCE Southwesterly on a curve to the left having a radius of 370.0 feet a distance of 218.230 feet; THENCE N89°43'40"W a distance of 2.168 feet; THENCE Northwesterly on a curve to the right having a radius of 1384.386 feet a distance of 847.294 feet; THENCE N35°20'22"E a distance of 106.645 feet; THENCE N00°16'20"E a distance of 714.317 feet to the point of beginning.

LESS AND EXCEPT the following described tract of land:

Commencing at the Northwest Corner of the Northeast Quarter (NE/4) of Section Four (4), Township One (1) North, Range Twelve (12) West, I.M., Comanche County, Oklahoma, according to the U.S. Government Survey thereof; THENCE S00°13'14"W a distance of 70.0 feet; THENCE S89°43'40"E a distance of 424.26 feet for the point of beginning, this point being on the South Right of Way line of State Highway No. 7 and 10.0 feet S89°43'40"E on the East Right of Way line of Mark Edward Drive; THENCE S89°43'40"E on said South Right of Way Line of State Highway No. 7 for a distance of 230.0 feet; THENCE S00°16'20"W a distance of 155.0 feet; THENCE N89°43'40"W a distance of 230.0 feet to a point 10.0 feet S89°43'40"E of the East line of said Mark Edward Drive; THENCE N00°16'20"E parallel with said East Right of Way of Mark Edward Drive for a distance of 155.0 feet to the point of beginning.

TRACT D:

Tract 1
Beginning at a point on the West line of the Northwest Quarter (NW/4) of Section Five (5), Township One (1) North, Range Twelve (12) West, I.M., Comanche County, Oklahoma, according to the U.S. Government Survey thereof, and 1318.289 feet S0°38'23"W of the Northwest Corner of said Northwest Quarter (NW/4); THENCE East parallel to the North line of said Northwest Quarter (NW/4) a distance of 660.00 feet; THENCE South parallel to the West line of said Northwest Quarter (NW/4) a distance of 660.00 feet; THENCE West parallel to the North line of said Northwest Quarter (NW/4) a distance of 660.00 feet to a point on the West line of said Northwest Quarter (NW/4); THENCE North along said West line a distance of 660.00 feet to the point of beginning.

Tract 2
Beginning at a point 1318.289 feet S00°38'23"W along the Section line from the Northwest Corner of the Northwest Quarter (NW/4) of Section Five (5), Township One (1) North Range Twelve (12) West, I.M., Comanche County, Oklahoma, according to the U.S. Government Survey thereof; THENCE S89°40'37"E parallel to the North Section line for a distance of 660.00 feet; THENCE N00°38'23"E a distance of 176.00 feet; THENCE N89°40'37"W a distance of 660.00 feet; THENCE S00°38'23"W a distance of 176.00 feet to the point of beginning.

Tract 3
Beginning at a point 2148.289 feet S00°38'23"W along the Section line from the Northwest Corner of the Northwest Quarter (NW/4) of Section Five (5), Township One (1) North, Range Twelve (12) West, I.M., Comanche County, Oklahoma, according to the U.S. Government Survey thereof; THENCE S89°40'37"E parallel to the North Section line for a distance of 660.00 feet; THENCE N00°38'23"E a distance of 170.00 feet; THENCE N89°40'37"W a distance of 660.00 feet; THENCE S00°38'23"W a distance of 170.00 feet to the point of beginning.

Tax Map ID(s):
43089, 43088, 39684 and 26744

Meyersdale Owned Land

7160 Mason Dixon Hwy	Meyersdale	PA
7160 Mason Dixon Hwy	Meyersdale	PA
7160 Mason Dixon Hwy	Meyersdale	PA

Second Ave	Meyersdale	PA
Second Ave	Meyersdale	PA
Fourth Ave	Meyersdale	PA
Sherman St	Meyersdale	PA
Second Ave	Meyersdale	PA
200 Hospital Drive	Meyersdale	PA
602 Fourth Ave	Meyersdale	PA

Ottumwa Owned Land

Real property in the City of Ottumwa, County of Wapello, State of lowa, described as follows:

Tract 1 (Marack Property):

Parcel 4:
A part of the North Half of the Southwest Quarter of Section 17, Township 72 North, Range 13 West of the 5th P.M. in Wapello County, Iowa, described as follows, to wit:

Beginning at a point on the North line of the said North Half of the SW 1/4 of Section 17 that is 1,384.1 feet East of the West One-quarter corner of said Section 17; thence at an angle to the right of 88 degrees 15 minutes from the said North line of the North Half of the SW 1/4 of Section 17 in a Southerly direction, a distance of 134.5 feet; thence at an angle to the right of 13 degrees 23 minutes, a distance of 215 feet; thence at an angle to the right of 56 degrees 00 minutes a distance of 40 feet; thence at an angle to the right of 45 degrees 47 minutes a distance of 163.8 feet; thence at an angle to the right of 15 degrees 50 minutes, a distance of 46 feet; thence at an angle to the right of 22 degrees 00 minutes a distance of 30 feet to a point on the East line of the now dedicated Birchwood Drive as found in a Quit-Claim Deed to the City of Ottumwa, Iowa dated the 21st day of April, 1975, and found in Book 387, Pages 611 and 614 in the Office of the Recorder, Wapello County, Iowa; thence South 1 degree 43 minutes 20 seconds East along the said East line of Birchwood Drive, a distance of 93.23 feet to a point on the Northerly line of the James W. and Barbara M. Garman property as described and found of Record in Book 394, Page 71, in the Office of the Recorder, Wapello County, Iowa, said point also being 22.68 feet Southeast of the Northwest corner of said Garman property; thence Southeasterly along the said Northerly line of the Garman

property a distance of 35.47 feet; thence at an angle of 10 degrees 19 minutes 20 seconds to the left along the Northerly line of the Garman property, a distance of 179.71 feet to the Northwest corner of the William N. Cramblit property as described in Book 369, Page 75, in the Office of the Recorder, Wapello County, Iowa; thence Northeasterly along the Northerly line of the said William N. Cramblit property, a distance of 70 feet; thence at an angle of 20 degrees 01 minutes to the left, a distance of 85 feet; thence at an angle of 100 degrees 00 minutes to the right, a distance of 175 feet; thence at an angle of 39 degrees 29 minutes to the right, a distance of 95 feet; thence at an angle of 82 degrees 30 minutes to the right, a distance of 220 feet to the Southwest corner of the said William N. Cramblit property; thence Northwesterly along the Southwesterly line of that property as described in said Book 394, Page 71, a distance of 125 feet; thence at an angle of 56 degrees 31 minutes to the left, a distance of 132 feet to a point on the said East line of Birchwood Drive; thence South 1 degrees 03 minutes East along the said East line of Birchwood Drive, a distance of 289.77 feet; thence South 77 degrees 57 minutes West along the Southerly line of Birchwood Drive, a distance of 178.41 feet; thence North 64 degrees 03 minutes West along the Southerly line of Birchwood Drive, a distance of 82.56 feet; thence South 30 degrees 1 minutes West a distance of 253.37 feet; thence South 59 degrees 35 minutes West, a distance of 161.1 feet to the Southwest corner of the Mary Helen Anderson property as found of record in Book 275, Page 564, in the Office of the Recorder, Wapello County, Iowa; thence South 16 degrees 46 minutes East along the Easterly line of the Mary Helen Anderson property as found of record in Book 272, Page 250, in the Office of the Recorder, Wapello County, Iowa, to the Southeast corner of said property; thence South 54 degrees 46 minutes West, a distance of 45.31 feet; thence South 44 degrees 19 minutes East, a distance of 123.4 feet; thence South 2 degrees 20 minutes West to a point on the South line of the said North Half of the SW 1/4 of Section 17; thence East along the said South line of the said North Half of the SW 1/4 of Section 17 to the Southeast corner of the said North Half of the SW 1/4 of Section 17; thence North along the East line of the North Half of the SW 1/4 of Section 17 as the same is now evidenced by an old existing boundary line fence to a point that is South 0 degrees 48 minutes East from the center of said Section 17, a distance of 250 feet; thence North 83 degrees 09 minutes 40 second West, a distance of 783.63 feet; thence North 16 degrees 06 minutes 40 seconds West, a distance of 105 feet; thence North 83 degrees 19 minutes West, a distance of 428.15 feet to the point of beginning, containing 43.5 acres more or less, and being subject to that part of the private roadway (now being called Birchwood Lake Drive) along the Northerly side of the James W. and Barbara M. Garman property and the William N. Cramblit property now being used for ingress and egress to said property and for utilities serving said property; Except those portions of the above described property contained within the plat of Ackley's Birchwood First Subdivision, filed September 1, 1979, in Book 1A, Page 123, and the Deeds filed in Book 408, Page 430; Book 525, Page 903; and Book 531, Page 1092, of the Records of the Wapello County, Iowa Recorder.

Tax Property Identification No. 007411560044000

Parcel 5:

A part of the North Five (5) Acres of the West Half of the Southwest Quarter of the Southwest Quarter of Section 17, Township 72 North, Range 13 West of the 5th P.M., in the City of Ottumwa, Wapello County, Iowa, described as follows, to-wit:

Beginning at a point on the West line of the said West Half of the SW 1/4 of the SW 1/4 of Section 17 that is 990 feet North of the Southwest corner of said Section 17; thence North along the said West line of the West Half of the SW 1/4 of the SW 1/4 of Section 17, to a point on the South line of the now dedicated Pike Road as found of record in a Quit-Claim Deed to the City of Ottumwa, Iowa dated the 21st day of April 1975, and found in Book 387, Pages 611 and 614, in the Office of the Recorder, Wapello County, Iowa; thence East along the said South line of Pike Road, a distance of 30 feet; thence South 0 degrees 02 minutes West a distance of 38.15 feet; thence South 37 degrees 33 minutes East, a distance of 65.6 feet; thence South 89 degrees 57 minutes East, a distance of 239 feet; thence South 62 degrees 05 minutes East, a distance of 162.8 feet; thence North 69 degrees 33 minutes East, a distance of 212.15 feet to a point on the East line of the said West Half of the SW 1/4 of the SW 1/4 of Section 17; thence South along the said East line of the West Half of the SW 1/4 of the SW 1/4 of Section 17 to a point on the South line of the said North Five (5) Acres of the West Half of the SW 1/4 of the SW 1/4 of Section 17; thence West along the said South line of the North Five (5) Acres of the West Half of the SW 1/4 of the SW 1/4 of Section 17, to the point of beginning;
EXCEPT

Parcel "A" described as a part of the North 5 acres of the Northwest Quarter (NW 1/4) of the Southwest Quarter (SW 1/4) of the Southwest Quarter (SW 1/4) of Section Seventeen (17) and a part of Auditors Lot Four (4) of the Southeast Quarter (SE 1/4) of the Southeast Quarter (SE 1/4), Section Eighteen (18), all in Township Seventy-two (72) North, Range Thirteen (13) West of the 5th P.M., in the City of Ottumwa, Wapello County, Iowa and more particularly described as follow: Beginning at a found 112" iron rebar at the intersection of the South line of Pike Road and the West line of said Northwest Quarter (NW 1/4) of the Southwest Quarter (SW 1/4) of the Southwest Quarter (SW 1/4) Section 17; thence North 87 degrees, 18 minutes 31 seconds East 29.90 feet along the South line of Pike Road to a found 1/2" iron rebar; thence South 00 degrees 23 minutes 20 seconds East 38.15 feet along the West line of Lot 17 of Birchwood Hills Addition to found 5/8" iron rebar with Cap No. 11420; thence South 37 degrees 56 minutes 35 seconds East 65.35 feet along the Southwest line of said Lot 17 to a found 1/2" iron rebar; thence South 83 degrees 37 minutes 58 seconds West 70.32 feet to the West line of said North 5 acres, marked by a found iron 1/2: pipe over an iron 1/2" rebar; thence North 38 degrees 01 minutes 40 seconds West 48.78 feet to a found 5/8" rebar with Cap No. 11420; thence North 00 degrees 23 minutes 17 seconds West 57.73 feet to the South line of Pike Road to a found 1/2" iron rebar; thence South 89 degrees 42 minutes 37 seconds East 30.05 feet along said South line to the point of beginning, containing 0.144 acres, and subject to any and all easements and/or restrictions of record. The West line of the North 5 acres of the NW 1/4 SW 1/4 SW 1/4 Section 17 is North 00 degrees 18 minutes 00 seconds West for this description;

AND EXCEPT

A parcel of land described as Parcel "D" and described by Plat of Survey dated July 13, 2010, as follows:

Parcel "D" of the North five (5) acres of the Northwest Quarter (NW 1/4) of the Southwest Quarter (SW 1/4) of the Southwest Quarter (SW 114) of Section Seventeen (17), Township Seventy-two (72) North, Range Thirteen (13) West of the 5th P.M., in the City of Ottumwa, Wapello County,

Iowa and more particularly described as follows: Commencing at a found 1/2" rebar at the intersection of the South line of Pike Road and the West line of said NW I/4 of the SW 1/4 of the SW 1/4 Section 17; thence South 00 degrees, 18 minutes 00 seconds East 96.00 feet along the West line thereof to a found 1/2" pipe over found 1/2" rebar; thence North 83 degrees 37 minutes 58 seconds East 34.32 feet to the point of beginning for this description; thence continuing North 83 degrees 37 minutes 58 seconds East 36.00 feet to a found 1/2" rebar at the Southwest corner of Lot Seventeen (17) of Birchwood Hills Addition; thence North 89 degrees 39 minutes 58 seconds East 103.00 feet along the South line of said Lot 17; thence South 40 degrees 09 minutes 12 seconds West 95.75 feet; thence North 48 degrees 18 minutes 10 seconds West 103.18 feet to the point of beginning, containing 0.118 acres or 5130.04 square feet, and subject to any and all easements and/or restrictions of record. The West line of the North 5 acres of the NW 1/4 of the SW 1/4 of the SW 1/4 Section 17 is North 00 degrees 18 minutes 00 seconds West for this description.

Tax Property Identification No. 007411560046030
Parcel 6:

The West Half of the Southwest Quarter of the Southwest Quarter of Section 17, Township 72 North, Range 13 West of the 5th P.M., in the City of Ottumwa , Wapello County, Iowa, except the North Five (5) acres.

Tax Property Identification No. 007411560045000

Tract 2:

Parcel B:

The Southwest Quarter (SW 1/4) of the Southeast Quarter (SE 1/4) of the Southwest Quarter (SW 1/4) of Section Seventeen (17), Township Seventy-two (72) North, Range Thirteen (13) West of the 5th P.M. in Wapello County, Iowa, except part quit-claimed to Richard C. Bauerle and Jane M. Bauerle, husband and wife, by Quit Claim Deed 439 Page 426, filed in Recorder's Office of Wapello County, Iowa on May 9, 1984.

Tax Property Identification No. 007131740477000
Tract 3: (Pennsylvania Main Campus)

Parcel 1:

The Northwest Quarter (NW 1/4) of the Northwest Quarter (NW 1/4) of Section Twenty (20), and the East Half(E 1/2) of the Southwest Quarter (SW 1/4) of the Southwest Quarter (SW1/4) of Section Seventeen (17), all in Township Seventy-two (72) North of Range Thirteen (13) West of the 5th P.M., in Wapello County, Iowa, Except, a part of the Southwest Quarter of the Southwest Quarter of Section 17, Township 72 North, Range 13 West of the 5th P.M., and a part of the Northwest Quarter of the Northwest Quarter of Section 20, Township 72, North 13, West of the 5th P.M., described as follows, to-wit:

Beginning at the Northeast corner of the said NW 1/4 of the NW 1/4 of Section 20; thence North, a distance of 42.45 feet; thence South 89 degrees 37 minutes 10 seconds West along a line that is parallel to the North line of the said NW 1/4 of the NW 1/4 of Section 20, a distance of 595.38 feet; thence South a distance of 42.45 feet to a point on the said North line of the NW 1/4 of the NW 1/4 of Section 20; thence South 13 degrees 02 minutes 30 seconds East, a distance of 611.32 feet; thence South 66 degrees 23 minutes 40 seconds West, a distance of 500 feet; thence South 23 degrees 36 minutes 20 seconds East, a distance of 536.52 feet to a point on the North line of Pennsylvania Avenue in the said City of Ottumwa, Iowa; thence North 89 degrees 39 minutes 40 seconds East along the said North line of Pennsylvania Avenue, a distance of 697.51 feet to a point on the East line of the said NW 1/4 of the NW 1/4 of Section 20 that is 30 feet North 0 degrees 08 minutes 50 seconds East, from the Southeast corner of the said NW 1/4 of the NW 1/4 of Section 20; thence North 0 degrees 08 minutes 50 seconds East, along the said East line of the NW 1/4 of the NW 1/4 of Section 20, a distance of 1287.32 feet to the point of beginning.

Also Except, A parcel of land in the NW 1/4 NW 1/4 of Section 20 T72N, R13W of the 5th P.M. Wapello County, Iowa. More particularly described as follows: Commencing at the SW corner of the NW 1/4 of the NW 1/4 of said Section 20, thence North 0 degrees 00 minutes 00 seconds East 30.00 feet; thence North 89 degrees 39 minutes 40 seconds East 609.07 feet; thence North 23 degrees 36 minutes 20 seconds West 505.52 feet to the point of beginning. Thence North 23 degrees 36 minutes 20 seconds West 31.00 feet; thence North 66 degrees 23 minutes 40 seconds East 210.28 feet; thence North 23 degrees 36 minutes 20 seconds West 19.02 feet; thence South 66 degrees 23 minutes 40 seconds West 105.66 feet; thence North 23 degrees 36 minutes 20 seconds West 0.83 feet, thence South 66 degrees 23 minutes 40 seconds West 41.35 feet, thence South 23 degrees 36 minutes 20 seconds East 1.35 feet; thence South 66 degrees 23 minutes 40 seconds West 23.34 feet, thence North 23 degrees 36 minutes 20 seconds West 5.76 feet; thence South 66 degrees 23 minutes 40 seconds West 0.33 feet, thence North 23 degrees 36 minutes 20 seconds West 6.15 feet; thence South 66 degrees 23 minutes 40 seconds West 71.00 feet; thence South 23 degrees 36 minutes 20 seconds East 7.00 feet; thence South 66 degrees 23 minutes 40 seconds West 4.50 feet; thence South 23 degrees 36 minutes 20 seconds East 54.41 feet, thence North 66 degrees 23 minutes 40 seconds East 35.90 feet to the point of beginning, containing 0.15 acres.

EXCEPT those portions of the above described properties contained within the Warranty Deeds filed June 30, 2011, in Book 2011, Page 2792; Book 2011, Page 2793 and Book 2011, Page 2794, all in the Records of the Wapello County, Iowa Recorder.

Tax Property Identification No. 007411560021000
Tax Property Identification No. 007411590001030

Parcel 2:

A parcel of land in the NW 1/4 NW 1/4 of Section 20 Township 72 North, Range 13 West and the SW 1/4 SW 1/4 Section 17 Township 72 North, Range 13 West of the 5th P.M. Wapello County, Iowa. More particularly described as follows: Commencing at the NW corner of said Section 20; thence North 89 degrees 37 minutes 10 seconds East 715.38 to the point of beginning; thence North 0 degrees 00 minutes 00 seconds 42.45 feet; thence North 89 degrees 37 minutes 10 seconds

East 165.00 feet; thence South 33 degrees 26 minutes 15 seconds West 235.22 feet; thence North 13 degrees 02 minutes 30 seconds West 156.79 feet, point of beginning, containing 0.39 acres.

EXCEPT those portions of the above described properties contained within the Warranty Deeds filed June 30, 2011, in Book 2011, Page 2792; Book 2011, Page 2793 and Book 2011, Page 2794, all in the Records of the Wapello County, Iowa Recorder.

Tax Property Identification No. 007411590010010

Parcel 3:

A part of the Southeast Quarter (SE 1/4) of the Southeast Quarter (SE 1/4) of Section Eighteen (18), Township Seventy-two (72) North, Range Thirteen (13) West of the 5th P.M., in the City of Ottumwa, Wapello County, Iowa, being more particularly described as follows, to-wit:
Beginning at the Southeast Corner of the said SE 1/4 of the SE 1/4 of Section 18; thence West along the South line of the said SE 1/4 of the SE 1/4 of Section 18, a distance of 528.00 feet to a point on the East End of East Highland Avenue in the said City of Ottumwa, Iowa; thence North along the said East End of East Highland Avenue, a distance of 30.00 feet to the North Corner of the said East End of Highland Avenue; thence East on a line that is 30.00 feet North of and parallel with the said South line of the SE 1/4 of the SE 1/4 of Section 18, a distance of 207.43 feet; thence North on a line that is the East line of the Property heretofore conveyed by the Ottumwa Regional Health Center, Incorporated to George J. Evans and Jayne A. Evans, a distance of 630.00 feet; thence East on a line that is parallel with the said South line of the SE 1/4 of the SE 1/4 of Section 18, a distance of 320.57 feet to a point on the East line of the said SE 1/4 of the SE 1/4 of Section 18; thence South along the said East line of the SE 1/4 of the SE 1/4 of Section 18, a distance of 660.00 feet to the point of beginning, containing 5.00 Acres more or less and being subject to a permanent Easement for the purposes of Ingress and Egress and for the construction, placement and maintenance of the necessary Utilities to serve the above said George J. Evans and Jayne A. Evans Property, which said Easement being subject to any improvements and Utilities that the above said Ottumwa Regional Health Center, Incorporated, their heirs or assigns may deem necessary for the servicing of their Property lying East and South of the said Evans Property, said Easement being 30.00 feet wide North and South and 207.43 feet long East and West and is lying immediately South of and adjoining the South line of the said Evans Property.

Tax Property Identification No. 007411570146000

Parcel 4:

The East 4 Acres of the following tract of land, a part of the Southeast Quarter (SE 1/4) of the Southeast Quarter (SE1/4) of Section 18, Township 72, Range 13 described as follows:
Commencing at the Southeast corner of said Section 18; thence West 528 feet; thence North 660 feet; thence East 528 feet; thence South 660 feet to beginning, situated in the County of Wapello, State of lowa, said tract of land being known as Auditor's Lot 7 of the Southeast Quarter of Section 18, Township 72, Range 13, Wapello County, Iowa.

Tax Property Identification No. 007411570040000

Parcel 5:

That part of Auditor 's Lot 2 in the NE 1/4 of the NE 1/4 of Section 19, Township 72 North, Range 13 West of the 5th P.M., in the City of Ottumwa, Wapello County, Iowa, described as follows: Beginning at a point 453.42 feet West of the NE Corner of said Section 19; thence West along the Section line a distance of 74.58 feet; thence South at right angles 16 1/2 feet; thence Southeasterly to a point 72 feet South of the place of beginning; thence North 72 feet to the point of beginning.

Tax Property Identification No. 007411580110000

Parcel 6:

One Acre of ground in the Northeast corner of Section Nineteen (19), Township Seventy-two (72), Range Thirteen (13), in Wapello County, Iowa, described as follows:

Beginning Thirty-three (33) feet South and Thirty-three (33) feet West of the Northeast corner of said Section 19, Township 72, Range 13; thence South 208 feet; thence West 208 feet; thence North 208 feet; thence East 208 feet to the place of beginning. The 33 feet North thereof to be used for street purposes.

The acre of ground herein described is designated on the Plat Book in the County Auditor's Office, as Auditor's Lot 5 of the Northeast Quarter (NE 1/4) of the Northeast Quarter (NE 1/4) of Section 19, Township 72, Range 13.

Tax Property Identification No. 007411580109000

Parcel 7:

Part of the Northeast Quarter (NE 1/4) of the Northeast Quarter (NE 1/4) of Section Nineteen (19), Township Seventy-two (72) North, Range Thirteen (13) West of the 5th P.M. in Wapello County, Iowa, described as follows, to-wit:

Commencing at the Northeast corner of said Section Nineteen (19); thence South along the Section line 325 feet; thence West parallel to and 325 feet from the North line of said Section 19, a distance of 453.42 feet; thence North parallel to the East line of said Section 19, a distance of 325 feet to the North line of said Section 19; thence East along the North line of said Section 19, a distance of 453.42 feet to the point of beginning, excepting that part sold to Walter 0. Bowden and Patricia E. Bowden, found in Deed Record 243, Page 538, of the Recorder's Office of Wapello County, Iowa.

Tax Property Identification No. 007411580109000

Parcel 8:

Part of the Northeast Quarter (NE 1/4) of the Northeast Quarter (NE 1/4) of Section Nineteen (19) Township Seventy-two (72) North, Range Thirteen (13) West of the 5th P.M. in Wapello County, Iowa, more particularly described as follows: Beginning at a point 325 feet South of the Northeast corner of the NE 1/4 NE 1/4 of said Section 19; thence South along said East Section line a distance of approximately 585 feet to a point 380 feet North of the North line of Pennsylvania Avenue; thence North 89 degrees 47 minutes West a distance of 453.42 feet; thence North to a point 325 feet South of the North Section line of NE 1/4 NE 1/4 said Section 19; thence East to the point of beginning, containing six (6) acres more or less, also legally described as the North 293.56 feet of Auditor's Lot Four; thence East 23.42 feet of the South 291.44 feet of Auditor's Lot Two and the South 291.44 feet of Auditor's Lot One, all in the Northeast Quarter of the Northeast Quarter of 19-72-13.

Together with the benefits of the roadway easement contained in Grant of Roadway Easement filed in Book 490, Page 640.

Tax Property Identification No. 007411580113000
Tax Property Identification No. 007411580108010
Tax Property Identification No. 007411580113000

Tract 4 (Alta Vista Campus): INTENTIONALLY DELETED

Tract 5: (Eddyville Parcel)

Lots 5 and 6 and the North 44 feet of Lot 7, Block 16 of the Original Town of Eddyville, Iowa, Wapello County, Iowa.

Tax Property Identification No. 003350010403000

Palestine Owned Land

TRACT 1:

Parcel ONE -A1:
For informational purposes only:
Tax ID No. R0015807

BEING ALL THAT CERTAIN TRACT OR PARCEL OF LAND CONTAINING 19.9946 ACRES (870,965.5 SQUARE FEET) SITUATED IN PALESTINE, ANDERSON COUNTY, TEXAS LOCATED IN THE WM. S. MCDONALD SURVEY, A-43, BEING ALL THAT CERTAIN PARCEL OF LAND CONVEYED TO S. C. CAL, INC. IN DEED DATED JANUARY 23, 1989 OF RECORD IN VOLUME 1221 AT PAGE 491, LAND RECORDS OF ANDERSON COUNTY, TEXAS AND BEING MORE PARTICULARLY DESCRIBED BY METES AND BOUNDS AS FOLLOWS:

BEGINNING AT A POINT FOR CORNER IN SOUTH RIGHT-OF-WAY LINE OF STATE HIGHWAY #256, SAME BEING IN THE NORTHWEST LINE OF A CALLED 26 ACRE TRACT OF LAND CONVEYED IN DEED TO P. D. WOLFF, ET UX OF RECORD IN VOLUME 151 AT PAGE 259, DEED RECORDS OF ANDERSON COUNTY, TEXAS, SAID POINT ALSO BEING AT THE WESTERNMOST CORNER OF THAT CERTAIN TRACT OF LAND DESCRIBED IN A RIGHT-OF-WAY DEED FROM PHILIP D. WOLFF, JR., ET AL TO THE STATE OF TEXAS DATED OCTOBER 30, 1962 OF RECORD IN VOLUME 654 AT PAGE 403, DEED RECORDS OF ANDERSON COUNTY;

THENCE ALONG THE SOUTH MARGIN OF STATE HIGHWAY LOOP #256 AND WITH THE SOUTH LINE OF THAT TRACT DESCRIBED IN THE DEED FROM WOLFF TO THE STATE OF TEXAS AS FOLLOWS:

SOUTH 64 DEGREES 46 MINUTES 52 SECONDS EAST, A DISTANCE OF 151.70 FEET TO A RIGHT-OF-WAY MARKER FOR CORNER;

SOUTH 66 DEGREES 23 MINUTES 52 SECONDS EAST, A DISTANCE OF 474.81 FEET TO THE RIGHT-OF-WAY MARKER FOR CORNER;

SOUTH 73 DEGREES 31 MINUTES 29 SECONDS EAST, A DISTANCE OF 107.36 FEET TO A RIGHT-OF-WAY MARKER FOR CORNER;

SOUTH 38 DEGREES 46 MINUTES 44 SECONDS EAST, A DISTANCE OF 169.04 FEET TO A RIGHT-OF-WAY MARKER FOR CORNER, SAME BEING IN THE WEST RIGHT-OF-WAY LINE OF FM HIGHWAY 9322 (CALLED POOR FARM ROAD);

THENCE ALONG THE WEST MARGIN OF SAID FM HIGHWAY #332, SOUTH 06 DEGREES 10 MINUTES 04 SECONDS WEST, A DISTANCE OF 156.96 FEET TO A 1/2 IRON PIN FOUND FOR CORNER IN THE WEST RIGHT-OF-WAY OF SAID FM HIGHWAY #322, SAME BEING AT THE NORTHWEST CORNER OF A CALLED TWO ACRE TRACT OWNED BY E.M. DICKEY;

THENCE WITH DICKEY'S NORTH LINE, SOUTH 88 DEGREES 47 MINUTES 29 SECONDS WEST, A DISTANCE OR 409.54 FEET TO AN IRON PIN SET FOR CORNER AT A FENCE CORNER SAME BEING AT THE DICKEY'S NORTHWEST CORNER;

THENCE WITH DICKEY'S WEST LINE, SOUTH 06 DEGREES 59 MINUTES 67 SECONDS WEST, A DISTANCE OF 207.19 FEET TO AN IRON PIN FOR CORNER AT DICKEY'S SOUTHWEST CORNER SAME BEING IN THE SOUTH LINE OF THE AFOREMENTIONED CALLED 26 ACRES DESCRIBED IN DEED TO WOLFF, AND IN THE NORTH LINE OF BLOCK 1 OF TRINITY VALLEY MEDICAL PARK RECORDED IN MAP ENVELOPE RECORD NO. 217-A OF THE MAP ENVELOPE RECORDS OF ANDERSON COUNTY, TEXAS;

THENCE WITH SOUTH LINE OF SAID CALLED 26 ACRE TRACT AND THE NORTH LINE OF SAID TRINITY VALLEY MEDICAL PARK, AND THE NORTH LINE OF BLOCK 1 OF

TRINITY VALLEY MEDICAL PARK UNIT II, RECORDED IN MAP ENVELOPE RECORD NO. 224-B, SOUTH 89 DEGREES 16 MINUTES 20 SECONDS WEST, A DISTANCE OF 1071.91 FEET TO A POINT FOR CORNER AT THE OCCUPIED SOUTHWEST CORNER OF SAID CALLED 26 ACRES;

THENCE ALONG THE OCCUPIED WEST LINE OF SAID CALLED 26 ACRE TRACT NORTH 00 DEGREES 03 MINUTES 51 SECONDS WEST, A DISTANCE OF 624.86 FEET TO A 5/8 INCH IRON ROD SET FOR CORNER AT THE NORTHWEST CORNER OF SAID CALLED 26 ACRE TRACT;

THENCE ALONG THE NORTH OR NORTHWEST LINE OF SAID CALLED 26 ACRE TRACT NORTH 75 DEGREES 43 MINUTES 00 SECONDS EAST, A DISTANCE OF 710.85 TO THE PLACE OF BEGINNING AND CONTAINING 19.9946 ACRES (870,965.5 SQUARE FEET) OF LAND.

SAVE & EXCEPT Parcel ONE - A2:

BEING A PART OF THAT CERTAIN TRACT OR PARCEL OF LAND LOCATED IN PALESTINE, ANDERSON COUNTY, TEXAS LOCATED ON THE WM. S. MCDONALD SURVEY, A-43, BEING ALL THAT CERTAIN PARCEL OF LAND CONVEYED TO S.C. CAL, INC. IN DEED DATED JANUARY 23, 1989 IF RECORD IN VOLUME 1221, PAGE 491, LAND RECORDS OF ANDERSON COUNTY, TEXAS AND BEING MORE PARTICULARLY DESCRIBED BY METES AND BOUNDS AS FOLLOWS;

COMMENCING AT A POINT SITUATED AT THE INTERSECTION OF THE WEST LINE OF F.M 322 AND THE SOUTH LINE OF LOOP #256;

THENCE NORTH 38 DEGREES 46 MINUTES 44 SECONDS WEST, ALONG THE SOUTHERLY LINE OF LOOP 256 A DISTANCE OF 169.04 FEET TO A POINT;
THENCE CONTINUING ALONG THE SOUTHERLY LINE OF LOOP 256 THE FOLLOWING COURSES:

NORTH 73 DEGREES 31 MINUTES 29 SECONDS WEST, A DISTANCE OF 107.36 FEET TO A POINT;

NORTH 66 DEGREES 23 MINUTES 52 SECONDS WEST, A DISTANCE OF 474.81 FEET TO A POINT;

NORTH 64 DEGREES 46 MINUTES 52 SECONDS WEST, A DISTANCE OF 15.62 FEET TO A BENT 5/8 INCH IRON ROD FOUND FOR CORNER AND BEING THE POINT OF BEGINNING OF THE HEREIN DESCRIBED TRACT;

THENCE SOUTH 23 DEGREES 39 MINUTES 15 SECONDS WEST, DEPARTING THE SOUTHERLY LINE OF LOOP #256, A DISTANCE OF 177.65 FEET TO A POINT FOR CORNER;

THENCE SOUTH 66 DEGREES 20 MINUTES 45 SECONDS EAST, A DISTANCE OF 70.00 FEET TO A POINT FOR CORNER;

THENCE SOUTH 23 DEGREES 39 MINUTES 15 SECONDS WEST, A DISTANCE OF 274.50 FEET TO A POINT FOR CORNER;

THENCE NORTH 66 DEGREES 20 MINUTES 45 SECONDS WEST, A DISTANCE OF 30.00 FEET TO A POINT FOR CORNER;

THENCE SOUTH 23 DEGREES 33 MINUTES 15 SECONDS WEST, A DISTANCE OF 214.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 66 DEGREES 20 MINUTES 45 SECONDS WEST, A DISTANCE OF 205.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 23 DEGREES 39 MINUTES 15 SECONDS EAST, A DISTANCE OF 488.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 66 DEGREES 20 MINUTES 45 SECONDS WEST, A DISTANCE OF 20.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 23 DEGREES 39 MINUTES 15 SECONDS EAST, A DISTANCE OF 107.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 68 DEGREES 39 MINUTES 15 SECONDS EAST, A DISTANCE OF 56.57 FEET TO A POINT FOR CORNER;

THENCE SOUTH 66 DEGREES 20 MINUTES 45 SECONDS EAST, A DISTANCE OF 50.00 FEET TO A POINT FOR CORNER;
THENCE NORTH 23 DEGREES 39 MINUTES 15 SECONDS EAST, A DISTANCE OF 33.25 FEET TO A 5/8 INCH IRON ROD FOUND FOR CORNER SITUATED IN THE AFOREMENTIONED SOUTHERLY LINE OF LOOP #256;

THENCE SOUTH 64 DEGREES 46 MINUTES 52 SECONDS EAST, ALONG SAID SOUTHERLY LINE OF LOOP #256, A DISTANCE OF 95.04 FEET TO THE POINT OF BEGINNING AND CONTAINING 3.1963 ACRES (139,231.6 SQUARE FEET) OF LAND.

Parcel ONE - B:
For informational purposes only:
Tax ID No. R0015807

BEING A PART OF THAT CERTAIN LOT, TRACT OR PARCEL OF LAND CONTAINING 3.1963 ACRES (139,231.6 SQUARE FEET) LOCATED IN PALESTINE, ANDERSON COUNTY, TEXAS LOCATED IN THE WM. S. MCDONALD SURVEY, A-43, BEING ALL THAT CERTAIN PARCEL OF LAND CONVEYED TO S.C CAL, INC. IN DEED DATED JANUARY 23, 1989 OF RECORD IN VOLUME 1221 AT PAGE 491, LAND RECORDS OF

ANDERSON COUNTY, TEXAS AND BEING MORE PARTICULARLY DESCRIBED BY METES AND BOUNDS AS FOLLOWS:

COMMENCING AT A POINT SITUATED AT THE INTERSECTION OF THE WEST LINE OF F.M 322 AND THE SOUTH LINE OF LOOP #256;

THENCE NORTH 38 DEGREES 46 MINUTES 44 SECONDS WEST, ALONG THE SOUTHERLY LINE OF LOOP 256 A DISTANCE OF 169.04 FEET TO A POINT;

THENCE CONTINUING ALONG THE SOUTHERLY LINE OF LOOP 256 THE FOLLOWING COURSES:

NORTH 73 DEGREES 31 MINUTES 29 SECONDS WEST, A DISTANCE OF 107.36 FEET TO A POINT;

NORTH 66 DEGREES 23 MINUTES 52 SECONDS WEST, A DISTANCE OF 474.81 FEET TO A POINT;

NORTH 64 DEGREES 46 MINUTES 52 SECONDS WEST, A DISTANCE OF 15.62 FEET TO A BENT 5/8 INCH IRON ROD FOUND FOR CORNER AND BEING THE POINT OF BEGINNING OF THE HEREIN DESCRIBED TRACT;

THENCE SOUTH 23 DEGREES 39 MINUTES 15 SECONDS WEST, DEPARTING THE SOUTHERLY LINE OF LOOP #256, A DISTANCE OF 177.65 FEET TO A POINT FOR CORNER;

THENCE SOUTH 66 DEGREES 20 MINUTES 45 SECONDS EAST, A DISTANCE OF 70.00 FEET TO A POINT FOR CORNER;

THENCE SOUTH 23 DEGREES 39 MINUTES 15 SECONDS WEST, A DISTANCE OF 274.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 66 DEGREES 20 MINUTES 45 SECONDS WEST, A DISTANCE OF 30.00 FEET TO A POINT FOR CORNER;

THENCE SOUTH 23 DEGREES 39 MINUTES 15 SECONDS WEST, A DISTANCE OF 214.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 66 DEGREES 20 MINUTES 45 SECONDS WEST, A DISTANCE OF 205.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 23 DEGREES 39 MINUTES 15 SECONDS EAST, A DISTANCE OF 488.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 66 DEGREES 20 MINUTES 45 SECONDS WEST, A DISTANCE OF 20.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 23 DEGREES 39 MINUTES 15 SECONDS EAST, A DISTANCE OF 107.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 68 DEGREES 39 MINUTES 15 SECONDS EAST, A DISTANCE OF 56.57 FEET TO A POINT FOR CORNER;

THENCE SOUTH 66 DEGREES 20 MINUTES 45 SECONDS EAST, A DISTANCE OF 50.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 23 DEGREES 39 MINUTES 15 SECONDS EAST, A DISTANCE OF 33.25 FEET TO A 5/8 INCH IRON ROD FOUND FOR CORNER SITUATED IN THE AFOREMENTIONED SOUTHERLY LINE OF LOOP #256;

THENCE SOUTH 64 DEGREES 46 MINUTES 52 SECONDS EAST, ALONG SAID SOUTHERLY LINE OF LOOP #256, A DISTANCE OF 95.04 FEET TO THE POINT OF BEGINNING AND CONTAINING 3.1963 ACRES (139,231.6 SQUARE FEET) OF LAND.

NOTE: THIS COMPANY DOES NOT REPRESENT THAT THE ABOVE ACREAGE OR SQUARE FOOTAGE CALCULATIONS ARE CORRECT.

Parcel TWO: SKIP - IS A TAX ACCOUNT ONLY. NO DEED TO THE 3 ACRE TRACT.

Parcel THREE:
For informational purposes only:
Tax ID No. R0825442

BEING ALL THAT CERTAIN LOT, TRACT OR PARCEL OF LAND LOCATED IN PALESTINE, ANDERSON COUNTY, TEXAS, BEING DESCRIBED AS LOT 1, BLOCK 2, TRINITY VALLEY MEDICAL PARK, ACCORDING TO THE MAP OR PLAT OF SAID SUBDIVISION AS SET FORTH IN MAP ENVELOPE 217-A OF THE MAP ENVELOPE RECORDS IN THE OFFICE OF THE COUNTY CLERK OF ANDERSON COUNTY, TEXAS, REFERENCE TO WHICH RECORD IS HEREBY MADE FOR ALL PERTINENT PURPOSES AND BEING MORE PARTICULARLY DESCRIBED BY METES AND BOUNDS AS FOLLOWS:

BEGINNING AT A POINT MARKING THE NORTHEAST CORNER OF SAID LOT 1, IN THE SOUTH LINE OF MEDICAL DRIVE (50 FEET WIDE);

THENCE SOUTH 00 DEGREES 54 MINUTES 45 SECONDS EAST A DISTANCE OF 203.90 FEET TO A 1/2 INCH IRON ROD FOUND FOR THE SOUTHEAST CORNER OF SAID LOT 1;

THENCE SOUTH 89 DEGREES 05 MINUTES 15 SECONDS WEST A DISTANCE OF 166.86 FEET TO A 1/2 INCH IRON ROD FOUND FOR THE SOUTHWEST CORNER OF SAID LOT 1;

THENCE NORTH 00 DEGREES 54 MINUTES 45 SECONDS WEST A DISTANCE OF 104.22 FEET TO A POINT FOR CORNER;

THENCE NORTH 89 DEGREES 05 MINUTES 15 SECONDS EAST A DISTANCE OF 50.00 FEET TO A POINT FOR CORNER;

THENCE NORTH 00 DEGREES 54 MINUTES 45 SECONDS WEST A DISTANCE OF 99.68 FEET TO A 1/2 INCH IRON ROD FOUND FOR THE NORTHWEST CORNER OF SAID LOT 1, IN THE SOUTH LINE OF SAID MEDICAL DRIVE;

THENCE NORTH 89 DEGREES 05 MINUTES 15 SECONDS EAST A DISTANCE OF 116.86 FEET TO THE POINT OF BEGINNING.

Parcel FOUR:
Intentionally deleted.

Parcel FIVE:
Intentionally deleted.

Parcel SIX-A:
Intentionally deleted

Parcel SEVEN:
Intentionally deleted.

Parcel EIGHT:
For informational purposes only:
Tax ID No. R0046579 and R0843418

All that certain 43.359 acre tract or parcel of land being that tract called 43.36 acres described in deed to McDonald Hospital Foundation of Palestine, Inc. from Cartmell Home for the Aged, recorded in Volume 1358, Page 866 of the Anderson County Deed records, Palestine, Texas, situated in the JOHN ARTHUR SURVEY, A-4, within the City of Palestine and described by metes and bounds as follows:

BEGINNING at a 5/8 inch iron rod found in the South right-of-way- (ROW) line of Loop 256 at to NEC of said 43.36 acre tract and being the NWC of a called 5.377 acre tract described in deed to Anderson County Memorial Post #8924, Veterans of Parting West from Cartmell home for the Aged and Orphans recorded in Volume 672, Page 244 of said Deed Records;

THENCE with the EDL of said 43.36 acre tract and the WDL of said 5.377 acre tract as follows:

S 31° 32' 21" W 264.60 feet to a 1 inch iron rod (found);

S 79° 28' 17" W 315.64 feet to a 1 inch iron rod (found); and

S 03° 29' 56" E 313.70 feet to a 5/8 inch iron rod found at the SEC of said 43.36 acre tract being the SWC of said 5.377 acre tract in the North line of Gillisple (ste) Road (Anderson County road number 2101);

THENCE with the SDL of said 43.36 acre tract and the North line of said Gillisple (ste) Road as follows;

Around a curve to the left with a delta angle of 14° 30' 48", a radius of 1350.00 feet and a chord distance being S 74° 42' 17" W 348.84 feet to a 5/8 inch iron rod (found);

S 67° 17' 22" W 375.76 feet to a 5/8 inch iron rod (found);

Around a curve to the left with a delta angle of 07° 20' 13", a radius of 3092.47 feet and a chord distance being S 63° 36' 37" W 395.73 feet to a 5/8 inch iron rod found at point of reverse curve;

Around a curve to the right with a delta angle of 3° 36' 20", a radius of 1493.18 feet and the chord distance being S 61° 19' 09" W 67.89 feet to a 5/8 inch iron rod (found); and,

Around a curve to the right with a delta angle of 01° 10' 26", a radius of 1493.18 feet and the chord distance being S 61° 19' 09" W 67.89 feet to a 5/8 inch iron rod (found): and,

Around a curve to the right with a delta angle of 01° 10' 26", a radius of 1493.18 feet and the chord distance being S 63° 10' 16" W 30.39 feed to a steel spike set in the East edge of Variah Road (Anderson County road number 2101), from which a 1/2 inch iron rod (found) bears S 01° 11' 55" E 47.54 feet at the SEC of a called 62.024 acre tract described in deed to Management Systems Associates Defined benefits Plat tract the Board of Records of the University of Texas System, recorded in Volume 1423, Page 549 of sale Anderson County Deed Records;

THENCE N 15° 09' 03" W along said Variah Road as 1145.03 feet a railroad spike found 0.14 feet left, in the centerline of cache as the NEC of said 62.024 acre tract from which a 10 inch Elm (found marked) basis S 69° 57' 47" W 35.86 feet a 1/2 inch iron rod (found) bears S 72° 36' 22" W 39.96 feet a power pole (found) bears S 37° 30' 06" W 54.62 feet and, containing to all 1731.40 feet to a steel spike (set);

THENCE N 74° 50' 13" E acres tract to a concrete ROW marker (found);

THENCE with the South ROW line of said loop 256 as follows:

N 25° 25' 25" E 220.72 feet to a 1/2 inch iron rod (set);

S 64° 38' 43" E 798.07 feet to a concrete ROW marker (found);

S 61° 31' 44" E 602.12 feet to a concrete ROW marker (found);

S 70° 10' 22" E 300.54 feet to a concrete ROW marker (found); and

S 87° 12' 09" E 299.88 feet to the place of beginning containing 43.359 acres of land of which 1.19 acres with the marketland arcs of Variah Road being described by metes and bounds description on Plat of Survey proposed by Chot M. Glasscock R.P.L.S. No. 4525, in the State of Texas, dated June 10th, 1996.

TRACT 2:

For informational purposes only:
TAX ID No. 704379

All that certain lot, tract at parcel of land situated in the County of Leon Texas and being 3.186 acres out of and a part of the L.R. MOODY SURVEY, A-628 in Leon County. Texas and being the same land described in a deed to Ben Fitzgerald Real Estate Services, L.L.C., dated December 1, 1997, recorded in Vol. 982, Page 359 of the Official Records of Leon County, Texas, which 3.166 acres more particularly described by metes and bounds as follows:

BEGINNING on a 1/2 inch iron rod found for the North, North West corner of this tract and being the East, North East corner of Luak, Inc., called 1.501 acres tract described in Vol. 1021, Page 93 of the Official Records of Leon County, Texas and being in the South West R.O.W. line of Interstate Highway No. 45, Feeder Road;

THENCE S 77° 23' 53" E 103.22 feet to a concrete R.O.W. marker found for corner, same being in the said South West R.O.W. line of said Interstate Hwy. No. 45;

THENCE S 59° 12' 47" E 211.69 feet to a 1/2 inch iron rod found for corner at the intersection of the said South West R.O.W. line of said Interstate Hwy. No. 45 and the North West corner of an unimproved street;

THENCE S 32° 05' 07" W 506.18 feet to a 1/2 inch iron rod found for corner, same being in the North East line of Earnest L. Ferguson Jr. called 1.812 acres tract and also being a West corner of the said unimproved street;

THENCE N 58° 24' 35" W 258.57 feet to a 1/2 inch iron rod found for corner, same being in the North East line of the said Earnest L. Ferguson Jr. tract and being the South, South East corner of the Dairy Queen Corp. tract;

THENCE N 31° 39' 52" E 150.0 feet to 1/2 inch iron rod found for corner, same being the East corner of the said Dairy Queen Corp. tract, and being the South corner of the Luak Inc. called 1.501 acres tract;

THENCE N 23° 18' 30" E 322.98 feet to the place of beginning and containing 3.186 acres of land more or less,

LESS HOWEVER, SAVE AND EXCEPT 1.989 acres

These notes describe that certain 1.989 acres in the L. R. MOODY SURVEY, Abstract 628, located in the City of Buffalo in Leon County, Texas; being part of that "3.188 acres" contained in a Special Warranty Deed dated August 4, 1999 from Ben Fitzgerald Real Estate Services, LLC to Mother Francis Hospital Regional Healthcare Center and recorded in Volume 1027 Page 41 Leon County Official Records; this 1.989 acre tract is described more particularly as follows;

COMMENCING at the most Eastern corner of the "3.188 acres", same being for the North corner of that easement (recorded in Volume 1044 Page 408 LCOR) in the Southwesterly right-of-way of Interstate Highway 45; found a 1/2" steel rod at same; thence with the Southeast line of the "3.188 acre", South 32°-05'-07" West a distance of 185.14 feet to the most Eastern corner of this tract, same being the BEGINNING of this description; set a 1/2" steel rod at same;
THENCE continuing with the Southeast line of the "3.188 acres", South 32°-05'-07" West a distance of 321.00 feet to the Southerly corner of the "3.188 acres", same being for a corner of that "1.812 acres" (recorded in Volume 1043 Page 428 LCOR); found a 1/2" steel rod at same;

THENCE with the Southwest line of the "3.188 acres", same being for the Northeast line of the "1.812 acres", North 58°-22'-06" West a distance of 258.48 feet to the Western corner of the "3.188 acres", same being for the South corner of that "1.50' x 250' lot" (recorded in Volume 836 Page 756 LCOR); found a 1/2" steel rod at same;

THENCE with the Southeast line of the "150' x 250' lot", same being for a line of the "3.188 acres", North 31°-37'-29" East a distance of 149.75 feet to the East corner of the "150' x 250' lot", same being for the South corner of that "1.021 and also being for the South corner of that "0.480 acres" (both recorded in Volume 1021 Page 93 LCOR); found a 1/2" steel rod at same;

THEHCE with the Southeast line of the "0.480 acre", same being for a line of the "3.188 acres", North 23°-17'-51" East a distance of 181.00 feet to the North corner of this tract; set a 1/2" steel rod at same; found a 1/2" steel rod bearing North 23°-17'-51" East 142.05 feet, same being for the North corner of the "3.188 acres"

THENCE South 56°-48'-14" East a distance of 287.38 feet to the PLACE OF BEGINNING.

Containing, according to the dimensions herein stated, an area of 1.989 acres of land.

For informational purposes only all TAX IDs follow: Tax IDs: R0015807; R0843418; R0825442; R0046579; 704379; R0015812

Riverton Owned Land

Parcel 1:

All of Health Care Tract, a replat of Lots 1 and 2, Health Services Park and a portion of Lot 1, Block 1, Hospital Development in the City of Riverton, Fremont County, Wyoming.

Purported Address: 1005 College View Drive, Riverton, Wyoming, 82501
Tax Account No. 19036

Parcel 2:
A tract of land located in Lot 1, Block 1, of the Hospital Development to the City of Riverton, Fremont County, Wyoming, EXCEPT a tract of land deeded to the Board of County Commissioners in Book 263 at Page 976, Fremont County, Wyoming records, AND EXCEPT Lot 3 and 4 in Health Services Park, a replat of a portion of Lot 1, Block 1, Hospital Development in the City of Riverton, Fremont County, Wyoming, FURTHER EXCEPTING all of Health Care Tract as shown on the record plat recorded on March 4, 1996, in Plat Cabinet 5 at Page 71.

Purported Address: 2100 West Sunset Drive, Riverton, Wyoming, 82501
Tax Account No. 19032

Parcel 3:
Lot 4, Health Services Park, a replat of a portion of Lot 1, Block 1, Hospital Development in the City of Riverton, Fremont County, Wyoming.

Address: 1035 Rose Lane
Tax Account No. 19034

Roaring Springs Owned Land

Nason Drive & George Street	Roaring Spring	PA
113 Nason Drive (land surrounding)	Roaring Spring	PA
108 Nason Drive	Roaring Spring	PA
105 June Drive	Roaring Spring	PA
113 June Drive (land surrounding)	Roaring Spring	PA
121 June Drive (land surrounding)	Roaring Spring	PA
102 Hillcrest Drive (land surrounding)	Roaring Spring	PA

104 Hillcrest Drive	Roaring Spring	PA
105 Hillcrest Drive	Roaring Spring	PA
208 June Drive (land surrounding)	Taylor Township	PA
(Cemetery Plot)		
105 Nason Drive	Roaring Spring	PA

Exhibit A-2

Legal Descriptions of Leased Land

An unplatted tract of land in portions of Sections 19 and 20, Township 33 North, Range 99 West of the 6th Principal Meridian, in the City of Lander, Wyoming, more particularly described as follows:

Beginning at point no. 1, which point bears North 50 degrees 21 minutes East, a distance of 866.16 feet from the East one-sixteenth section corner of said Section 19; thence proceed along a boundary common with the City of Lander: North 10 degrees 27 minutes 12 seconds West, a distance of 250.44 feet to point no. 2; South 79 degrees 32 minutes 48 seconds West, a distance of 333.55 feet to point no. 3; South 03 degrees 01 minute 00 seconds East, a distance of 222.92 feet to point no. 4; South 79 degrees 33 minutes 18 seconds West, a distance of 135.04 feet to point no. 5; thence along the eastern boundary of Buena Vista Drive: North 11 degrees 25 minutes 00 seconds West, a distance of 556.76 feet to point no. 6; thence along the boundary common with the Lander Golf and Country Club: North 60 degrees 05 minutes 12 seconds East, a distance of 170.65 feet to point no. 7; North 24 degrees 17 minutes 42 seconds East, a distance of 499.25 feet to point no. 8; North 41 degrees 37 minutes 18 seconds East, a distance of 486.75 feet to point no. 9; South 47 degrees 40 minutes 17 seconds East, a distance of 914.29 feet to point no. 10; South 20 degrees 45 minutes 00 seconds West, a distance of 807.69 feet to point no. 11; thence along the boundary common with Lee Ranches, Inc.: North 39 degrees 23 minutes 28 seconds West, a distance of 4.49 feet to point no. 12; South 66 degrees 41 minutes 41 seconds West, a distance of 33.71 feet to point no. 13; South 54 degrees 00 minutes 41 seconds West, a distance of 9.11 feet to point no. 14; thence along the boundary common with the Hunt Field Airport: North 39 degrees 39 minutes 00 seconds West, a distance of 266.56 feet to point no. 15; South 50 degrees 21 minutes 00 seconds West, a distance of 325.24 feet to point no. 1, the point of beginning.

Tax Parcel No. R0008021

Exhibit B

List of Facilities

See attached.

Exhibit B

List of Facilities

LIMA SUBSIDIARY	MPT PARTY	FACILITY / PROPERTY NAME	ADDRESS	USE OF PROPERTY (per Hospital 2018)
		CONEMAUGH MEMORIAL		
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Hospital campus: CP, M, P, South Garage & E	1086 Franklin Johnstown, PA	Hospital
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Vacant tract	Franklin Street-Rear Johnstown, PA	part of Hospital campus
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Good Sam / Medical Arts Bldg / Central Energy Plant / Parking Lot by Radiation Onc)	1020 Franklin Street Johnstown, PA	Hospital
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Facility House	130 W. Osborne Street Johnstown, PA	Office
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Tumor Registry and Student Laundry	127 Flinn Street Johnstown, PA	Office/Laundry
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Wessel Building& North Parking Garage	1015 Franklin Street Johnstown, PA	MOB and Parking Garage
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Office Building	1017 Franklin Street Johnstown, PA	Office (old nursing care center now used by IT Dept)
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	F & G Building	1097-1098 Franklin Street Johnstown, PA	Office/School of Nursing
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Medical Office Building	1111 Franklin Street Johnstown, PA	MOB
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Warehouse and parking	Southmont Blvd Johnstown, PA	Warehouse/Parking Lot

DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Warehouse and parking	Southmont Blvd - Rear Johnstown, PA	Warehouse/Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	GME Housing and Hospital Parking	1105 Otto Court Johnstown, PA	Vacant/ Student Housing/Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Hospital parking	Milford Street (West side) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Hospital parking	Milford Street (East side) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Hospital parking	113 Mayer Avenue Johnstonw, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Hospital parking	150 Skelly Street (East of Esty St) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Hospital parking	Mulberry Street Parking (North side) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Hospital parking	Mulberry Street Parking (South side) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Hospital parking	Mulberry Street Parking (South side) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Hospital parking	Esty Street (East side) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Hospital parking	Esty Street (East and West sides) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Unimproved - future hospital parking	147 Skelly Street Johnstown, PA	N/A
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Unimproved - future hospital parking	145 Skelly Street Johnstown, PA	N/A

DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Unimproved - future hospital parking	1063 Sunny Court Johnstown, PA	N/A
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking Lot	Franklin Street - Rear (Actually Flynn St) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking Lot	Franklin Street / Otto Court (between F & MOB 1111 Franklin St) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking Lot	1141 Franklin Street Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking Lot	1135-1137 Franklin Street Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking Lot	Franklin Street (Between Moyer and Anstead Pl) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking Lot	Franklin Street (between Baker's Loaf & Ameriserv) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking Lot	Otto Court (Westside) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking Lot	17 Rose Street -corner of Otto Court Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking Lot	46 Valley Pike Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking Lot	50 Valley Pike Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Vacant tract, Chiller Area and Parking lot	Barnett Street (chiller area) Johnstown, PA	Parking Lot

DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Vacant tract	968 Fritz Street Johnstown, PA	N/A
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Buffer zone (beside Johnstown Cariovascular, 1123 Franklin St)	Franklin Street Johnstown, PA	Buffer zone required by city
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Med Park Office Building (formerly Tech Park)	One Tech Park Drive Johnstown, PA	MOB and Office Building
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Medical Office Building	415 Napoleon Place Johnstown, PA	MOB
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Medical Office Building	425 Napoleon Place (On Tax Map as 433 Benton St) Johnstown, PA	MOB
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Lee Campus	320 Main St. Johnstown, PA	MOB
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking lot	Market St Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking lot	112 Walnut St. (Corner Walnut St & Washington St) Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking lot	SE corner of Morrell St & Locust St Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Parking lot	Corner of Seigh Pl and Marion Pl Johnstown, PA	Parking Lot
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Building or shed	231 Locust Street Z231 Johnstown, PA	Facilities Operations
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Conemaugh East Hills Outpatient Center and Land surrounding Holiday Inn Express	1440 Scalp Ave (HI Expess) 1450 Scalp Ave (CEH Outpatient) Johnstown, PA	MOB

DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Land only (Part of 1450 Scalp Ave)	1450 Scalp Avenue Johnstown, PA	land
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Ebensburg MOB	Rt 22, 139 Cook Road Ebensburg, PA	MOB
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Ebandjieff MOB	1060 Lloyd St Nanty Glo, PA	MOB
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Ebandjieff Vacant land	1068 Lloyd St Nanty Glo, PA	land
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	MOB - St. Benedict Rural Health Center	564 Theatre Road St. Benedict, PA	MOB
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Somerset MOB	105 Pine Haven Dr Somerset, PA	MOB
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Somerset MOB	105 Pine Haven Dr Somerset, PA	MOB
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Medical Office Building	2 Celeste Dr (aka 927 Menoher Blvd) Johnstown, PA	MOB
DLP Conemaugh Memorial Medical Center, LLC	MPT of Johnstown-Lima, LLC	Anesthesia Student Housing	123 Mayer Avenue Johnstown, PA	Student Housing
		CONEMAUGH - MEYERSDALE		
DLP Conemaugh Meyersdale Medical Center, LLC	MPT of Meyersdale-Lima, LLC	Meyersdale MOB - land	7160 Mason Dixon Hwy Meyersdale, PA	Part of MOB grounds
DLP Conemaugh Meyersdale Medical Center, LLC	MPT of Meyersdale-Lima, LLC	Meyersdale MOB - land	7160 Mason Dixon Hwy Meyersdale, PA	Part of MOB grounds
DLP Conemaugh Meyersdale Medical Center, LLC	MPT of Meyersdale-Lima, LLC	Meyersdale MOB	7160 Mason Dixon Hwy Meyersdale, PA	MOB and grounds

DLP Conemaugh Meyersdale Medical Center, LLC	MPT of Meyersdale-Lima, LLC	Hospital	Second Ave Meyersdale, PA	Hospital grounds
DLP Conemaugh Meyersdale Medical Center, LLC	MPT of Meyersdale-Lima, LLC	Hospital	Second Ave Meyersdale, PA	Hospital grounds
DLP Conemaugh Meyersdale Medical Center, LLC	MPT of Meyersdale-Lima, LLC	Hospital	Fourth Ave Meyersdale, PA	Hospital grounds
DLP Conemaugh Meyersdale Medical Center, LLC	MPT of Meyersdale-Lima, LLC	Hospital	Sherman St Meyersdale, PA	Hospital grounds
DLP Conemaugh Meyersdale Medical Center, LLC	MPT of Meyersdale-Lima, LLC	Hospital	Second Ave Meyersdale, PA	Hospital grounds
DLP Conemaugh Meyersdale Medical Center, LLC	MPT of Meyersdale-Lima, LLC	Hospital / Nursing Home	200 Hospital Drive Meyersdale, PA	Hospital and ground lease to Nursing Home
DLP Conemaugh Meyersdale Medical Center, LLC	MPT of Meyersdale-Lima, LLC	Hospital	602 Fourth Ave Meyersdale, PA	Hospital grounds
		CONEMAUGH - MINERS		
DLP Conemaugh Miners Medical Center, LLC	MPT of Hastings-Lima, LLC	Hospital campus	290 Haida Ave Hastings, PA	Hospital
		CONEMAUGH - NASON		
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Unused lot behind rear parking lot	Nason Drive & George Street Roaring Spring, PA	Vacant land and gravel lot
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Land lease to AMED - AMED constructed building located on property per lease	113 Nason Drive (land surrounding) Roaring Spring, PA	Land
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Nason Hospital Home Health Office	108 Nason Drive Roaring Spring, PA	Medical Office Building
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Wound Care Office and surrounding land	105 June Drive Roaring Spring, PA	Medical Office Building
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Land surrounding Southern Cove Medical Associates Office	113 June Drive (land surrounding)	Land

			Roaring Spring, PA	
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Land surrounding Blair Orthopedics Office Commercial Nason Hospital owns underlying real estate and Agreement contains a "put" option at FMV	121 June Drive (land surrounding) Roaring Spring, PA	Land
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Land surrounding Cove Surgical Associates Office Commercial	102 Hillcrest Drive (land surrounding) Roaring Spring, PA	Land
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Nason OBGYN Office - .24 acres Office of Nason OBGYN	104 Hillcrest Drive Roaring Spring, PA	Medical Office Building
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Office of Nason Pediatrics and surrounding undeveloped land, currently leased for farming 13.80 ac. Commercial	105 Hillcrest Drive Roaring Spring, PA	Medical Office Building
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Land surrounding Graystone Court Building	208 June Drive (land surrounding) Taylor Township, PA	Land
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Cemetery Plot		Cemetery Plot owned by Hospital per Cemetery Document on file
Nason Medical Center, LLC	MPT of Roaring Springs-Lima, LLC	Hospital	105 Nason Drive Roaring Spring, PA	Hospital
		OTTUMWA		
RCHP-Ottumwa, LLC (D/B/A Ottumwa Regional Health Center)	MPT of Ottumwa-Lima, LLC	Hospital	1001 E. Pennsylvania Ave Ottumwa, IA	Hospital & cancer center
RCHP-Ottumwa, LLC (D/B/A Ottumwa Regional Health Center)	MPT of Ottumwa-Lima, LLC	Ottumwa Pediatrics Building	931 E Pennsylvania Ave Ottumwa, IA	MOB
RCHP-Ottumwa, LLC (D/B/A Ottumwa Regional Health Center)	MPT of Ottumwa-Lima, LLC	Ottumwa Regional Health Foundation	935 E. Pennsylvania Ave Ottumwa, IA	MOB
RCHP-Ottumwa, LLC (D/B/A Ottumwa Regional Health Center)	MPT of Ottumwa-Lima, LLC	Eddyville Clinic	107 N 3rd St Eddyville, IA	MOB

RCHP-Ottumwa, LLC (D/B/A Ottumwa Regional Health Center)	MPT of Ottumwa-Lima, LLC	Vacant land	11565 Bladensburg Rd Ottumwa, IA	Vacant Land
RCHP-Ottumwa, LLC (D/B/A Ottumwa Regional Health Center)	MPT of Ottumwa-Lima, LLC	Own land; ground lease to MOB Owner; master lease back	1011-1013 Pennsylvania Ave Ottumwa, IA	MOB Master Lease
		PALESTINE		
Palestine Principal Healthcare Limited Partnership (D/B/A Palestine Regional Medical Center)	MPT of Palestine-Lima, LLC	Palestine Regional Medical Center	2900 S. Loop 256 Palestine, TX	Hospital
Palestine Principal Healthcare Limited Partnership (D/B/A Palestine Regional Medical Center)	MPT of Palestine-Lima, LLC	MOB	4002 S. Loop 256 Palestine, TX	Clinic - MOB on campus
Palestine-Principal G.P., Inc.	MPT of Palestine-Lima, LLC	Buffalo Medical Clinic	249 S. Craig St. Buffalo, TX	Off campus Clinic
Palestine Principal Healthcare Limited Partnership (D/B/A Palestine Regional Medical Center)	MPT of Palestine-Lima, LLC	Trinity Valley Prof. Bldg	126 Medical Dr. Palestine, TX	Clinic - 3 physician office close to campus
Palestine Principal Healthcare Limited Partnership (D/B/A Palestine Regional Medical Center)	MPT of Palestine-Lima, LLC	Rehab Campus (West Campus BH Beds)	4000 S. Loop 256 Palestine, TX	Rehab/psych hospital - 2nd campus of facility
		SAGEWEST-LANDER		
Riverton Memorial Hospital (D/B/A SageWest Health Care-Lander)	MPT of Lander-Lima, LLC	Lander Regional Hospital	1320 Bishop Randall Drive Lander, WY	Hospital
		SAGEWEST - RIVERTON		
Riverton Memorial Hospital (D/B/A SageWest Health Care-Riverton)	MPT of Riverton-Lima, LLC	Riverton Memorial Hospital	2100 W. Sunset Drive Riverton, WY	Hospital

Riverton Memorial Hospital (D/B/A SageWest Health Care-Riverton)	MPT of Riverton-Lima, LLC	MOB 1	1005 College View Dr Riverton, WY	MOB
Riverton Memorial Hospital (D/B/A SageWest Health Care-Riverton)	MPT of Riverton-Lima, LLC	MOB 2	1035 Rose Lane Riverton, WY	Vacant MOB
		SOUTHWESTERN		
Southwestern Medical Center, LLC	MPT of Lawton-Lima, LLC	MOB II (hospital master leases)	5606 SW Lee Blvd Lawton, OK	MOB Master Lease
Southwestern Medical Center, LLC	MPT of Lawton-Lima, LLC	MOB I (hospital master leases)	5604 SW Lee Blvd Lawton, OK	MOB Master Lease
Southwestern Medical Center, LLC	MPT of Lawton-Lima, LLC	Hospital	5602 SW Lee Blvd Lawton, OK	Hospital
Southwestern Medical Center, LLC	MPT of Lawton-Lima, LLC	Behavioral Health Center (West Campus)	1602 SW 82nd St Lawton, OK	Behavioral hospital
Southwestern Medical Center, LLC	MPT of Lawton-Lima, LLC	Vacant Land	Adjacent to 1602 SW 82nd St	Vacant land
Southwestern Medical Center, LLC	MPT of Lawton-Lima, LLC	Vacant Land	Adjacent to 1602 SW 82nd St	Vacant land
Southwestern Medical Center, LLC	MPT of Lawton-Lima, LLC	Surgery Center at Southwestern	5608 SW Lee Blvd Lawton, OK	
		WESTERN PLAINS		
Dodge City Healthcare Group, LLC	MPT of Dodge City-Lima, LLC	Hospital	3001 Avenue A Dodge City, KS	Hospital
Dodge City Healthcare Group, LLC	MPT of Dodge City-Lima, LLC	Western Plains Butler Bldg	3001 Avenue A Dodge City, KS	Hospital
Dodge City Healthcare Group, LLC	MPT of Dodge City-Lima, LLC	Western Plains Maintenance Shop/Storage	3001 Avenue A Dodge City, KS	Part of Hospital property; maintenance shop and storage facility
Dodge City Healthcare Group, LLC	MPT of Dodge City-Lima, LLC	Western Plains Medical Complex MOB	112 Ross Blvd Dodge City, KS	MOB
Dodge City Healthcare Group, LLC	MPT of Dodge City-Lima, LLC	Surgery Center	100 Ross Blvd (connected by hallway to Pain Clinic) Dodge City, KS	MOB

Dodge City Healthcare Group, LLC	MPT of Dodge City-Lima, LLC	Pain Clinic (prior Women's Center)	100 Ross Blvd (connected by hallway to Surgery Center) Dodge City, KS	MOB
Dodge City Healthcare Group, LLC	MPT of Dodge City-Lima, LLC	Occupational Health and Annex - same building; two doors	108 Ross Blvd Dodge City, KS	MOB

Exhibit C

Form of Master Lease

See attached.

MASTER LEASE AGREEMENT

BY AND AMONG

THE ENTITIES LISTED ON *SCHEDULE 1-A* ATTACHED HERETO,

collectively, jointly and severally, Lessor

AND

THE ENTITIES LISTED ON *SCHEDULE 1-B* ATTACHED HERETO,

collectively, jointly and severally, as Lessee

Table of Contents

Page

4850-8732-8417

4850-8732-8417

****

EXHIBITS AND SCHEDULES:

4850-8732-8417

4850-8732-8417

MASTER LEASE AGREEMENT

This MASTER LEASE AGREEMENT (the "**Lease**") is dated this _____ day of _____, ____ (the "**Effective Date**"), and is by and among the entities listed on ***Schedule 1-A*** attached hereto and made a part hereof by reference and incorporation (collectively, jointly and severally, the "**Lessor**"), having their principal office at 1000 Urban Center Drive, Suite 501, Birmingham, Alabama 35242, and the entities listed on ***Schedule 1-B*** attached hereto and made a part hereof by reference and incorporation (collectively, jointly and severally, the "**Lessee**"), having their principal office at 330 Seven Springs Way, Brentwood Tennessee 37027.

STATEMENT OF INTENT

Subject to Articles V, XIV, XV, XXX and Section 16.1, this Lease constitutes one unitary, indivisible, non-severable true lease of all the Leased Property. This Lease does not constitute separate leases contained in one document each governed by similar terms. The use of the expression "unitary lease" to describe this Lease is not merely for convenient reference. It is the conscious choice of a substantive appellation to express the intent of Lessor and Lessee in regard to an integral part of this transaction, which is to accomplish the creation of an indivisible lease. Lessor and Lessee agree that from an economic point of view the portions of the Leased Property leased pursuant to this Lease constitute one economic unit and that the Rent and all other provisions have been negotiated and agreed to based upon a lease of all the portions of the Leased Property as a single, composite, inseparable transaction. Except as expressly provided in this Lease for specific isolated purposes (and in such cases only to the extent expressly so stated), all provisions of this Lease, including definitions, commencement and expiration dates, rental provisions, use provisions, renewal provisions, breach, default, enforcement, termination and assignment and subletting provisions, shall apply equally and uniformly to all the Leased Property as one unit and are not severable. The economic terms of this Lease would have been substantially different had separate leases or a "divisible" lease been acceptable to Lessor. A default of any of the terms or conditions of this Lease occurring with respect to any particular Property shall constitute a default under this Lease with respect to all the Leased Property. Except as expressly provided in this Lease for specific isolated purposes (and in such cases only to the extent expressly so stated), Lessor and Lessee agree that the provisions of this Lease shall at all times be construed, interpreted and applied such that the intention of Lessor and Lessee to create a unitary lease shall be preserved and maintained. Lessor and Lessee agree that for the purposes of any assumption, rejection or assignment of this Lease under 11 U.S.C. Section 365 or any amendment or successor section thereof, this is one indivisible and non-severable lease dealing with and covering one legal and economic unit which must be assumed, rejected or assigned as a whole with respect to all (and only all) the Leased Property.

W I T N E S S E T H:

WHEREAS, Lessor is the current owner or lessee of that certain real property more particularly described on ***Exhibits A-1*** *et seq.* attached hereto and incorporated herein by reference (together with all hereditaments, easements, mineral rights, rights of way and other appurtenances related thereto, and any other parcel of land acquired or leased and made subject to this Lease, collectively, the "**Land**"), and is also the current owner or lessee of all of the Leased Improvements

(as hereinafter defined) located on the Land (subject, as applicable, to the respective terms of the Pass-Through Leases (as hereinafter defined));

WHEREAS, pursuant to those certain Assignment and Assumption of Lease Agreements, each dated as of even date herewith, by and between certain of the Pass-Through Lessees (as hereinafter defined) (or, as applicable) their Affiliates, on the one hand, and the Pass-Through Lessors (as hereinafter defined), on the other hand, each of the Pass-Through Lessees (or, as applicable, their Affiliates) assigned to the applicable Pass-Through Lessors all of the Pass-Through Lessees' (or, as applicable, their Affiliates') respective rights, title and interest in, to and under each of the applicable Pass-Through Leases (as hereinafter defined), whereby the applicable Pass-Through Lessor, respectively: (i) acquired and now holds a leasehold interest in the Pass-Through Lease Land, and (ii) either owns or leases the improvements located on the Pass-Through Lease Land during the respective terms of the Pass-Through Leases (after which time the owned improvements located on the Pass-Through Lease Land revert to the respective "landlords" or "lessors" under the Pass-Through Leases);

WHEREAS, the parties acknowledge that (a) a portion of the Lawton Property (as herein defined) consists of a certain tract of land on which is situated a freestanding medical office building located at 5604 S.W. Lee Boulevard, Lawton, Oklahoma, and the land on which it is situated is subject to the Lawton MOB Ground Lease I (as herein defined), (b) a portion of the Lawton Property consists of a certain tract of land on which is situated a freestanding medical office building located at 5606 S.W. Lee Boulevard, Lawton, Oklahoma, and the land on which it is situated is subject to the Lawton MOB Ground Lease II (as herein defined), (c) a portion of the Ottumwa Property consists of a certain tract of land on which is situated a freestanding medical office building commonly known as the "Ottumwa Medical Office Building" located at 1013 Pennsylvania Avenue, Ottumwa, Iowa, and the land on which it is situated is subject to the Ottumwa MOB Ground Lease (as herein defined), and (d) a portion of the Roaring Springs Property (as herein defined) consists of a certain tract of land on which is situated an ambulance and equipment storage facility located in Roaring Springs, Pennsylvania, and the land on which it is situated is subject to the Roaring Springs Ambulance Facility Lease;

WHEREAS, pursuant to (a) each of those certain Assignment and Assumption of Ground Leases, each dated contemporaneously herewith, Lawton Lessee assigned to Lawton Lessor all of its right, title, and interest in, to, and under each of the Lawton MOB Ground Leases (as herein defined) and the Lawton Ground Lease Property (as herein defined); (b) that certain Assignment and Assumption of Ground Lease, dated contemporaneously herewith, Ottumwa Lessee assigned to Ottumwa Lessor all of its right, title, and interest in, to, and under each of the Ottumwa MOB Ground Lease (as herein defined) and the Ottumwa Ground Leased Property (as herein defined); and (c) that certain Assignment and Assumption of Ground Lease, dated contemporaneously herewith, Roaring Springs Lessee assigned to Roaring Springs Lessor all of its right, title, and interest in, to, and under the Roaring Springs Ambulance Facility Lease; and

WHEREAS, Lessor desires to lease (or sublease, as applicable) the Land and Leased Improvements to Lessee and to make the Ground Leased MOB Property subject to the terms of this Lease, and Lessee desires to lease (or sublease, as applicable) the same from Lessor, on the terms and conditions hereinafter provided.

NOW, THEREFORE, the parties agree as follows:

ARTICLE I.
DEFINITIONS

1.1. **Certain Defined Terms**. Capitalized terms used herein shall have the respective meanings ascribed to them in this Section 1.1.

Acceptable Replacement Guarantor: One or more Persons that (i) either (a) is Controlled By LifePoint or (b) has been approved in writing by Lessor (such approval not to be unreasonably withheld) to replace the initial Guarantor or to become an additional Guarantor, as applicable; (ii) executes, acknowledges and delivers to Lessor a joinder to the Guaranty; (iii) for whom Lessor shall have received confirmation of financial and credit characteristics reasonably satisfactory to Lessor; and (iv) either Controls any Facility Lessee or owns a direct or indirect ownership interest in such Facility Lessee.

ACH: As defined in Section 3.1.

Additional Charges: As defined in Section 3.2.

Adjustment Date: As defined in Section 3.1(b).

Affiliate: With respect to any Person (i) any Person that, directly or indirectly, Controls or is Controlled By or is Under Common Control With such Person, (ii) any other Person that owns, beneficially, directly or indirectly, 10% or more of the outstanding capital stock, shares or equity interests of such Person, or (iii) any officer, director, employee, partner, member, manager or trustee of such Person or any Person controlling, Controlled By or Under Common Control With such Person (excluding trustees and persons serving in similar capacities who are not otherwise an Affiliate of such Person).

AIREA: The American Institute of Real Estate Appraisers, or any successor organization.

Allocated Base Rent: As defined in Section 3.1(a).

Allocated Reserve: As defined in Section 9.2(a).

Anti-Terrorism Laws: Any applicable laws, statutes and regulations relating to terrorism or money laundering, including Executive Order No. 13224 (effective September 24, 2001), the Patriot Act, the laws, statutes and regulations comprising or implementing the Bank Secrecy Act, and the laws, statutes and regulations administered by OFAC.

Award: All compensation, sums or anything of value awarded, paid or received on a total or partial Condemnation.

Bankruptcy Code: Chapter 11 U.S.C. § 101, *et seq.*

Base Rent: At any time the total Allocated Base Rent payable with respect to the Properties for any period.

Binding Agreement: As defined in Section 34.2(a).

Blocked Person: Any Person: (a) listed in the annex to, or is otherwise subject to the provisions of, Executive Order No. 13224, (b) a Person owned 50% or more by, or acting for or on behalf of, any Person that is listed in the annex to, or is otherwise subject to the provisions of, Executive Order No. 13224, (c) a Person with which Lessor is prohibited from dealing or otherwise engaging in any transaction by any Anti-Terrorism Law, or (d) a Person that is named a "specially designated national" or "blocked person" on the OFAC List.

Business: With respect to each of the Properties (other than the Ground Leased MOB Property), the operation of a hospital facility thereon and, in each case, the engagement in and pursuit and conduct of any business venture or activity incident or related thereto, including any business that relates to the business currently conducted by the applicable Facility Lessee (such as bariatric centers and/or health plans) at the applicable Property. With respect to each of the Ground Leased MOB Properties, the operation of a professional medical office building thereon and, in each case, the engagement in and pursuit and conduct of any business venture or activity incident or related thereto, including any business that relates to the business currently conducted by the applicable Facility Lessee at the applicable Ground Leased MOB Property.

Business Day: Each Monday, Tuesday, Wednesday, Thursday and Friday that is not a day on which money centers in the City of New York, New York are authorized or obligated by law or executive order to close.

Capital Additions: With respect to each Property, (a) extraordinary renovations or expansions of buildings, structures or other improvements currently located on that Property (or on additional parcels added to such Property), (b) the addition of one or more parcels of land to such Property (whether by purchase or ground lease), or (c) the addition of one or more new buildings or additional structures placed on such Property or any such additional parcels of land, including, without limitation, the construction of a new wing or new story.

Cash Collections: Any and all payments received for patient related services that are posted to Lessee's accounting system for a Facility, including, without limitation, any such payments received from patients, insurance companies, managed care and preferred provider organizations, Medicaid, Medicare, or other payors.

Casualty Impacted Property: As defined in Section 14.2(a).

CERCLA: As defined in the definition of "Hazardous Materials Law."

Change of Control Transaction: Any transaction or series of related transactions in which a Person (the "Acquiring Person") shall, following the Effective Date, acquire or receive ownership of more than Fifty Percent (50%) of the direct or indirect Equity Interests of any Facility Lessee or Guarantor; *provided, however,* any transaction (a) constituting a Permitted Transaction shall not constitute a Change of Control Transaction, and (b) involving a direct transfer of Equity Interests of LifePoint or any Person directly or indirectly holding Equity Interests of LifePoint shall not constitute a Change of Control Transaction except in the case of a transaction or series of related transactions that otherwise would be a Change of Control Transaction in which a Major

Healthcare REIT becomes the holder of the Equity Interests of DSB Parent L.P. or any of its Subsidiaries.

Claim: As defined in Section 8.2(b).

CMS: The Centers for Medicare and Medicaid Services.

Code: The United States Internal Revenue Code of 1986, as amended through the date hereof, and all regulations thereunder. Any reference herein to a specific section or sections of the Code shall be deemed to include a reference to any corresponding provision of future law.

Commencement Date: The Effective Date; *provided, that*, with respect to any New Property, the term "Commencement Date" shall mean the date that such New Property becomes subject to this Lease.

Competing Business: As defined in Section 40.10.

Condemnation: Either (a) the exercise of any governmental power, whether by legal proceedings or otherwise, by a Condemnor or (b) a voluntary sale or transfer by Lessor to any Condemnor, either under threat of Condemnation or while legal proceedings for Condemnation are pending, in all of the foregoing cases with respect to any portion of the Leased Property.

Condemnor: Any public or quasi-public authority, or private corporation or individual, having the power of Condemnation.

Conemaugh Capital Commitment Obligation: As defined in Section 8.8.

Conemaugh Capital Project: As defined in Section 8.8.

Conemaugh Purchase Agreement: That certain Asset Purchase Agreement, dated as of August 20, 2014, among Conemaugh Health System Inc., Conemaugh Valley Memorial Hospital, Meyersdale Community Hospital, Miners Hospital, Conemaugh Health Initiatives, Inc., Conemaugh Enterprises, Inc., 1086 Real Estate, LLC, DLP Conemaugh Memorial Medical Center, LLC, DLP Conemaugh Meyersdale Medical Center, LLC, DLP Conemaugh Miners Medical Center, LLC, DLP Conemaugh Physician Practices, LLC, and DLP Conemaugh JV, LLC, as the same has been amended or modified from time to time.

Control; Controlled By; and Under Common Control With: As used with respect to any Person, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, through the ownership of voting securities or otherwise.

Consolidated Fixed Charges: For any period, for Lima Holdco and its Subsidiaries on a consolidated basis (provided that for purposes of calculating Consolidated Fixed Charges for testing compliance with the covenants set forth in Section 16.1(l) prior to the completion of the LifePoint Upper Tier Restructuring Transaction, the LifePoint Upper Tier Restructuring Transaction shall be deemed to have been completed on or before the first day of the trailing twelve (12) month period which ends on the applicable quarter end date), an amount equal to the sum for

such period of (a) rent payments, plus, (b) consolidated interest charges, plus (c) consolidated maintenance capital expenditures, plus (d) consolidated funded debt payments.

Consolidated Net Income: The aggregate Net Income of Lima Holdco and its Subsidiaries (provided that for purposes of calculating Consolidated Net Income for testing compliance with the covenants set forth in Section 16.1(l) prior to the completion of the LifePoint Upper Tier Restructuring Transaction, the LifePoint Upper Tier Restructuring Transaction shall be deemed to have been completed on or before the first day of the trailing twelve (12) month period which ends on the applicable quarter end date) for such period, on a consolidated basis, determined in accordance with GAAP; provided, however, that, without duplication,

(i) any net after-tax extraordinary, exceptional, nonrecurring or unusual gains or losses or income or expense or charge (less all fees and expenses relating thereto), any severance, relocation or other restructuring expenses, curtailments or modifications to pension and post-retirement employee benefit plans, excess pension charges (including, in each case, any cost or expense related to employment of terminated employees), any expenses related to any New Project or any reconstruction, decommissioning, recommissioning or reconfiguration of fixed assets for alternative uses, fees, expenses or charges relating to closing costs, rebranding costs, acquisition integration costs, opening costs, recruiting costs, signing, retention or completion bonuses, litigation and arbitration costs, charges, fees and expenses (including settlements), and expenses or charges related to any offering of equity interests or debt securities of Lima Holdco, any investment, acquisition, disposition, recapitalization or incurrence, issuance, repayment, repurchase, refinancing, amendment or modification of indebtedness (in each case, whether or not successful), and any fees, expenses, charges or change in control payments related to the Transactions (including any costs relating to auditing prior periods, any transition-related expenses, and expenses related to the Transactions incurred before, on or after the Effective Date), in each case, shall be excluded,

(ii) effects of purchase accounting adjustments (including the effects of such adjustments pushed down to such Person and its subsidiaries and including the effects of adjustments to (A) deferred rent, (B) capitalized lease obligations or other obligations or deferrals attributable to capital spending funds with suppliers or (C) any deferrals of revenue) in component amounts required or permitted by GAAP, resulting from the application of purchase accounting or the amortization or write-off of any amounts thereof, net of taxes, shall be excluded,

(iii) the cumulative effect of a change in accounting principles during such period shall be excluded,

(iv) any net after-tax income or loss from disposed of, abandoned, closed or discontinued operations or fixed assets and any net after-tax gain or loss on the dispositions of disposed of, abandoned, closed or discontinued operations or fixed assets shall be excluded,

(v) any net after-tax gain or loss (less all fees and expenses or charges relating thereto) attributable to business dispositions or asset dispositions other than in the ordinary course of business (as determined in good faith by the management of Lima Holdco) shall be excluded,

(vi) any net after-tax income or loss (less all fees and expenses or charges relating thereto) attributable to the early extinguishment or buy-back of indebtedness, hedging agreements or other derivative instruments shall be excluded,

(vii) (A) the Net Income for such period of any Person that is not a Subsidiary of such Person shall be included to the extent of the amount of such Net Income multiplied by Lima Holdco's and its Subsidiaries' percentage ownership of the economic interests in such Person and (B) the Net Income for such period shall include any dividend, distribution or other payment in cash (or to the extent converted into cash) received by the referent Person or a Subsidiary thereof from any Person that is not a Subsidiary of such Person in excess of, but without duplication of, any amounts included in subclause (A) with respect to such Person that is not a Subsidiary,

(viii) an amount equal to the amount of distributions actually made to any parent or equity holder of such Person in respect of such period for income taxes shall be included as though such amounts had been paid as income taxes directly by such Person for such period,

(ix) any impairment charges or asset write-offs, in each case pursuant to GAAP, and the amortization of intangibles and other fair value adjustments arising pursuant to GAAP, shall be excluded,

(x) any (a) non-cash compensation charge or (b) costs or expenses realized or resulting from stock option plans, employee benefit plans or post-employment benefit plans, or grants or sales of stock, stock appreciation or similar rights, stock options, restricted stock, preferred stock or other rights shall be excluded,

(xi) accruals and reserves that are established or adjusted in connection with the Transactions or within twelve months after the Effective Date or the closing of any acquisition or investment and that are so required to be established or adjusted in accordance with GAAP or as a result of adoption or modification of accounting policies shall be excluded,

(xii) (A) the non-cash portion of "straight-line" rent expense shall be excluded, (B) the cash portion of "straight-line" rent expense which exceeds the amount expensed in respect of such rent expense shall be included, (C) the non-cash amortization of tenant allowances shall be excluded, (D) cash received from landlords for tenant allowances shall be included and (E) to the extent not already included in Net Income, the cash portion of sublease rentals received shall be included (for the avoidance of doubt, the net effect of the adjustments in this clause (xii) as well as any related adjustments pursuant to clause (ii) above shall be to compute rent expense and rental income on a cash basis for purposes of determining Consolidated Net Income),

(xiii) non-cash gains, losses, income and expenses resulting from fair value accounting required by the applicable standard under GAAP and related interpretation shall be excluded,

(xiv) any currency translation gains and losses related to currency remeasurements of indebtedness, and any net loss or gain resulting from hedging agreements for currency exchange risk, shall be excluded,

(xv) (A) to the extent covered by insurance and actually reimbursed, or, so long as such Person has made a determination that there exists reasonable evidence that such amount will in fact be reimbursed by the insurer and only to the extent that such amount is (x) not denied by the

applicable carrier in writing within 180 days and (y) in fact reimbursed within 365 days following the date of such evidence (with a deduction for any amount so added back to the extent not so reimbursed within such 365 days), expenses with respect to liability or casualty events or business interruption shall be excluded; and (B) amounts estimated in good faith to be received from insurance in respect of lost revenues or earnings in respect of liability or casualty events or business interruption shall be included (with a deduction for amounts actually received up to such estimated amount to the extent included in Net Income in a future period),

(xvi) capitalized software expenditures and software development costs shall be excluded,

(xvii) any non-cash charges for deferred tax asset valuation allowances shall be excluded,

(xviii) any other costs, expenses or charges resulting from facility closures or sales, including income (or losses) from such facility closures or sales, shall be excluded,

(xix) any deductions attributable to minority interests shall be excluded,

(xx) without duplication, an amount equal to the amount of distributions actually made to any parent or equity holder of such Person in respect of such period for income taxes shall be included as though such amounts had been paid as income taxes directly by such Person for such period, and

(xxi) (A) a deemed management fee of 2% of the consolidated net revenue of Lima Holdco and its Subsidiaries for such period shall be included and (B) any allocated overhead, corporate or management costs, other than as described in clause (A), shall be excluded.

CPI: The Consumer Price Index, all urban consumers, all items, U.S. City Average, published by the United States Department of Labor, Bureau of Labor Statistics, in which 1982-1984 equals one hundred (100). If the Consumer Price Index is discontinued or revised during the term of this Lease, such other governmental index or computation with which it is replaced shall be used in order to obtain substantially the same result as would be obtained if the Index had not been discontinued or revised.

Credit Enhancements: With respect to each Property, all security deposits, security interests, letters of credit, pledges, guaranties, prepaid rent or other sums, deposits or interests held by Lessee, if any, with respect to such Property, the Tenant Leases relating to such Property or the Tenants or subtenants thereunder.

Date of Taking: The date the Condemnor has the right to possession of the property being condemned.

Decision Period: As defined in Section 34.2(a).

Declarations: As defined in Section 40.7.

Defaulted Property: As defined in Section 16.1B.

DHS: For each particular Facility, the governmental or quasi-governmental entities and other third parties, which may be necessary for the operation of the Facility operated by such Facility Lessee for the Primary Intended Use, or required for certification and participation under Medicare and Medicaid legislation and regulations or the provider programs of the State Regulatory Authorities.

DHHS: The United States Department of Health and Human Services.

Dodge City Facility: The healthcare facilities or operations listed on ***Exhibit C-1*** attached hereto.

Dodge City Lessee: Dodge City Healthcare Group, LLC, a Kansas limited liability company, together with its successors and permitted assigns.

Dodge City Lessor: MPT of Dodge City-Lima, LLC, a Delaware limited liability company, together with its successors and assigns.

Dodge City Medical Center: That certain general acute care hospital facility operated at the Dodge City Owned Land, commonly known as Western Plains Medical Complex, containing ninety-nine (99) licensed beds available for use.

Dodge City Owned Land: That certain real property located in Dodge City, Ford County, Kansas, as more particularly described on ***Exhibit A-1*** attached hereto and made a part hereof by reference and incorporation, together with all hereditaments, easements, mineral rights, rights of way and other appurtenances related thereto.

Dodge City Property: The Dodge City Owned Land and related Leased Improvements located thereon relating to the Dodge City Facility.

Dollar Amount: As defined in Section 9.2(a).

DTPA: As defined in ***Schedule 39.25***.

EBITDAR: With respect to Lima Holdco and its Subsidiaries on a consolidated basis for any period, the Consolidated Net Income of Lima Holdco and its Subsidiaries (provided that for purposes of calculating EBITDAR for testing compliance with the covenants set forth in Section 16.1(l) prior to the completion of the LifePoint Upper Tier Restructuring Transaction, the LifePoint Upper Tier Restructuring Transaction shall be deemed to have been completed on or before the first day of the trailing twelve (12) month period which ends on the applicable quarter end date) for such period plus (a) the sum of (in each case without duplication and to the extent the respective amounts described in subclauses (i) through (xiii) of this clause (a) reduced such Consolidated Net Income (and were not excluded therefrom) for the respective period for which EBITDAR is being determined):

(i) provision for taxes based on income, profits or capital of Lima Holdco and its Subsidiaries for such period, including, without limitation, state, franchise and similar taxes and foreign withholding taxes (including penalties and interest related to taxes or arising from tax examinations),

(ii) Interest Expense (and to the extent not included in Interest Expense, (x) all cash dividend payments (excluding items eliminated in consolidation) on any series of preferred stock and (y) costs of surety bonds in connection with financing activities) of Lima Holdco and its Subsidiaries for such period,

(iii) depreciation and amortization expenses of Lima Holdco and its Subsidiaries for such period including the amortization of intangible assets, deferred financing fees, original issue discount and capitalized software expenditures, amortization of unrecognized prior service costs and actuarial gains and losses related to pensions and other post-employment benefits,

(iv) any other non-cash charges; provided, that for purposes of this subclause (iv) of this clause (a), any non-cash charges or losses shall be treated as cash charges or losses in any subsequent period during which cash disbursements attributable thereto are made (but excluding, for the avoidance of doubt, amortization of a prepaid cash item that was paid in a prior period),

(v) any expenses or charges (other than depreciation or amortization expense as described in the preceding subclause (iii)) related to any issuance of equity interests, investment, acquisition, New Project, disposition, recapitalization or the incurrence, modification or repayment of indebtedness (including a refinancing thereof) (whether or not successful),

(vi) business optimization expenses and other restructuring charges, reserves or expenses (which, for the avoidance of doubt, shall include the effect of inventory optimization programs, facility, branch, office or business unit closures, facility, branch, office or business unit consolidations, retention, severance, systems establishment costs, contract termination costs, future lease commitments and excess pension charges) and Pre-Opening Expenses,

(vii) the amount of loss or discount in connection with a securitization financing, including amortization of loan origination costs and amortization of portfolio discounts,

(viii) any costs or expense incurred pursuant to any management equity plan or stock option plan or any other management or employee benefit plan or agreement or any stock subscription or shareholder agreement, to the extent that such costs or expenses are funded with cash proceeds contributed to the capital of Lima Holdco or its Subsidiaries (other than contributions received from Lima Holdco or its Subsidiaries) or net cash proceeds of an issuance of equity interests of Lima Holdco,

(ix) [reserved],

(x) the amount of any loss attributable to a New Project, until the date that is twelve (12) months after the date of completing the construction, acquisition, assembling or creation of such New Project, as the case may be; provided, that (A) such losses are reasonably identifiable and factually supportable and certified by an officer of Lima Holdco and (B) losses attributable to such New Project after twelve (12) months from the date of completing such construction, acquisition, assembling or creation, as the case may be, shall not be included in this subclause (x),

(xi) [reserved],

(xii) with respect to any joint venture that is not a Subsidiary, (A) an amount equal to the proportion of those items described in clause (a) of this definition (other than this subclause (xii)) relating to such joint venture corresponding to Lima Holdco's and its Subsidiaries' proportionate share of such joint venture's Consolidated Net Income (determined as if such joint venture were a Subsidiary) and (B) solely to the extent relating to any Consolidated Net Income referred to in clause (vii)(B) of the definition of "Consolidated Net Income", an amount equal to the proportion of those items described in subclauses (i) and (ii) above relating to such joint venture corresponding to the proportion of such joint venture's Consolidated Net Income represented by the amount included in Consolidated Net Income of Lima Holdco and its Subsidiaries under clause (vii)(B) of the definition of "Consolidated Net Income" (determined as if such joint venture were a Subsidiary),

(xiii) one-time costs associated with commencing Public Company Compliance, and

(xiv) the amount of any rent or other similar charges with respect to the lease of real property;

minus (b) the sum of (without duplication and to the extent the amounts described in this clause (b) increased such Consolidated Net Income for the respective period for which EBITDAR is being determined) non-cash items increasing Consolidated Net Income of Lima Holdco and its Subsidiaries for such period (but excluding any such items (A) in respect of which cash was received in a prior period or will be received in a future period or (B) which represent the reversal of any accrual of, or cash reserve for, anticipated cash charges that reduced EBITDAR in any prior period).

Effective Date: As defined in the preamble of this Lease.

Eliminated Property: As defined in Section 35.1.

Entered Property: As defined in Section 16.1A.

Environmental Indemnification Agreement: That certain Environmental Indemnification Agreement, dated as of the date hereof, executed and delivered by Lima Holdco and Lessee to and in favor of Lessor, as the same may be amended, modified and/or restated from time to time.

Equity Constituents: With respect to any Person, as applicable, the members, general or limited partners, shareholders, stockholders or other Persons, however designated, who are the owners of the issued and outstanding equity or ownership interests of such Person.

Equity Cure Expiration Date: As defined in Section 16.1(l)(iii).

Equity Cure Right: As defined in Section 16.1(l)(iii).

Equity Interests: With respect to any Person, the voting power, ownership, or other equitable interests of such Person, including any interest represented by any capital stock, convertible or participating debt instruments, membership interest, partnership interest, or any similar interest therein.

Escalator: As defined in Section 3.1(b).

Event of Default: As defined in Section 16.1.

Existing Subleases: As defined in Section 23.4.

Extension Notice: As defined in Article II.

Extension Term(s): As defined in Article II.

Facility: Each of the Ottumwa Facility, Dodge City Facility, Lawton Facility, Johnstown Facility, Meyersdale Facility, Hastings Facility, Roaring Springs Facility, Palestine Facility, the Lander Facility, and the Riverton Facility, sometimes collectively referred to as the "Facilities."

Facility Instrument: A note (whether secured or unsecured), loan agreement, credit agreement, guaranty, security agreement, mortgage, deed of trust or other agreement pursuant to which a Facility Lender has provided financing to Lessor in connection with any portion of the Leased Property or any part thereof, or funding provided to Lessee, if such funding is provided by Lessor or any Affiliate of Lessor (other than Obligors) or in connection with a Capital Addition, and any and all renewals, replacements, modifications, supplements, consolidations and extensions thereof.

Facility Lender: A holder (which may include any Affiliate of Lessor) of any Facility Instrument.

Facility Lessee: The (i) Ottumwa Lessee, with respect to the Ottumwa Property, (ii) Dodge City Lessee, with respect to the Dodge City Property, (iii) Lawton Lessee, with respect to the Lawton Property, (iv) Johnstown Lessee, with respect to the Johnstown Property, (v) Meyersdale Lessee, with respect to the Meyersdale Property, (vi) Hastings Lessee, with respect to the Hastings Property, (vii) Roaring Springs Lessee, with respect to the Roaring Springs Property, (viii) Palestine Lessee, with respect to the Palestine Property (other than the Palestine GP Property), (ix) Palestine GP Lessee, with respect to the Palestine GP Property, (x) Lander Lessee, with respect to the Lander Property, (ix) Riverton Lessee, with respect to the Riverton Property, and (xii) the Lessee party thereto, with respect to any New Property.

Facility Lessor: The (i) Ottumwa Lessor, with respect to the Ottumwa Property, (ii) Dodge City Lessor, with respect to the Dodge City Property, (iii) Lawton Lessor, with respect to the Lawton Property, (iv) Johnstown Lessor, with respect to the Johnstown Property, (v) Meyersdale Lessor, with respect to the Meyersdale Property, (vi) Hastings Lessor, with respect to the Hastings Property, (vii) Roaring Springs Lessor, with respect to the Roaring Springs Property, (viii) Palestine Lessor, with respect to the Palestine Property, (ix) Lander Lessor, with respect to the Lander Property, (x) Riverton Lessor, with respect to the Riverton Property, and (xi) the Lessor party thereto, with respect to any New Property.

Facility Loan: A loan made by a Facility Lender.

Fair Market Added Value: With respect to each Property, the Fair Market Value of the Property, including all Capital Additions, less the Fair Market Value of the Property determined as if no Capital Additions paid for by Lessee had been constructed.

Fair Market Value: With respect to each Property, the Fair Market Value of such Property, including all Capital Additions with respect thereto, (a) as shall be determined in accordance with the appraisal procedures set forth in Article XXXIII or in such other manner as shall be mutually acceptable to Lessor and Lessee, and (b) which shall not take into account any reduction in value resulting from any damage, destruction or condemnation of any part of such Property or any indebtedness to which such Property is subject and which encumbrance Lessee or Lessor is otherwise required to remove pursuant to any provision of this Lease or agrees to remove at or prior to the closing of the transaction as to which such Fair Market Value determination is being made. With respect to each Property, and notwithstanding anything contained in this Lease to the contrary, any appraisal of such Property shall assume the Lease is in place for a term of twenty (20) years, and shall not take into account any purchase options.

Fair Market Value Purchase Price: The Fair Market Value of the Leased Property, less the Fair Market Added Value.

Fair Market Value Rent: With respect to each Property (and each Extension Term), the fair market annual rental value of such Property as of the first day of the applicable Extension Term with the following characteristics: an absolute net lease for a five (5) year term with no more than one (1) five-year extension option of comparable healthcare facility space, with the Leased Property considered as vacant and in its then "as is" condition but with all of Lessee's Personal Property removed, with Lessor providing no services to Lessee, and an annual increase in base rent after the first year of the term equal to the Escalator. The calculation of Fair Market Value Rent shall also take into account all other reasonable relevant factors. Lessor shall advise Lessee (the "Rent Notice") of Lessor's determination of Fair Market Value Rent for the Properties that will be subject to this Lease during the applicable Extension Term within sixty (60) days following Lessee's exercise of the extension option for such applicable Extension Term. If Lessee disputes Lessor's determination of Fair Market Value Rent, the dispute shall be resolved by arbitration as provided in Section 39.26. If the Allocated Base Rent payable during a particular Extension Term for the Properties that will be subject to this Lease during such Extension Term has not been determined prior to the first (1st) day of such Extension Term, then, commencing on the first (1st) Business Day of such applicable Extension Term, Lessee shall pay Allocated Base Rent for such Properties that will be subject to this Lease during such applicable Extension Term in an amount equal to (i) in connection with the calculation of the Allocated Base Rent that will be payable during the first (1st) Extension Term, in an amount equal to the Allocated Base Rent that was paid by Lessee during the last year of the Fixed Term, and (ii) in connection with the calculation of the Allocated Base Rent that will be payable during the second (2nd) Extension Term, in an amount equal to the Allocated Base Rent that was paid by Lessee during the last year of the immediately preceding Extension Term, as the case may be, in each case, as increased by the Escalator (the "**Interim Rent**"). Upon final determination of the Allocated Base Rent for the applicable Extension Term (if this occurs after the commencement of such Extension Term), Lessee shall commence paying such Allocated Base Rent as so determined, and, within thirty (30) days after such determination, Lessee shall pay any deficiency in prior payments of Allocated Base Rent.

Financial Statements: For any fiscal year or other accounting period for the applicable Person, balance sheets, statements of operations and capital accounts, and statements of cash flows setting forth in comparative form the corresponding figures for the year-earlier fiscal period.

Fixed Term: As defined in Article II.

Fixtures: All equipment, machinery, fixtures, and other items of real property, including all components thereof, now and hereafter located in, on, or used in connection with, and that are, in each case, permanently affixed to the Land, or affixed or incorporated into the buildings and structures on the Land, including, without limitation, all affixed furnaces, boilers, heaters, electrical equipment, heating, plumbing, lighting, ventilating, refrigerating, incineration, air and water pollution control, waste disposal, air-cooling and air-conditioning systems and apparatus, sprinkler systems and fire and theft protection equipment, and built-in oxygen and vacuum systems, all of which, to the greatest extent permitted by law, are hereby deemed by the parties to constitute real estate, together with all replacements, modifications, alterations and additions thereto.

Force Majeure: As defined in Section 40.8.

GAAP: Generally accepted accounting principles in the United States as in effect from time to time and applied consistently throughout the periods involved.

Governmental Body: Any United States federal, state or local, or any supra national or non U.S., government, political subdivision, governmental, regulatory or administrative authority, instrumentality, agency body or commission, court, tribunal or judicial or arbitral body, in each case of competent jurisdiction, including the Securities and Exchange Commission.

Ground Leased MOB Improvements: All buildings, improvements, structures, and fixtures now or hereafter located on the Ground Leased MOB Property.

Ground Leased MOB Property: Collectively, the Lawton Ground Leased Property, Ottumwa Ground Leased Property, and the Roaring Springs Ground Leased Property.

Guarantor: Collectively, Lima Holdco and LifePoint; *provided, however*, that upon the termination of the LifePoint Guaranty, all references to the Guarantor shall no longer apply to LifePoint and shall only refer to Lima Holdco.

Guaranty: Collectively, (i) the Lima Guaranty and (ii) the LifePoint Guaranty; *provided, however*, that upon the termination of the LifePoint Guaranty, all references to the Guaranty shall no longer apply to the LifePoint Guaranty and shall only refer to the Lima Guaranty.

Hastings Facility: The healthcare facilities or operations listed on ***Exhibit C-2*** attached hereto.

Hastings Lessee: DLP Conemaugh Miners Medical Center, LLC, a Delaware limited liability company, together with its successors and permitted assigns.

Hastings Lessor: MPT of Hastings-Lima, LLC, a Delaware limited liability company, together with its successors and assigns.

Hastings Medical Center: That certain [general acute care hospital facility][1] operated at the Hastings Owned Land, commonly known as Conemaugh Miners Medical Center, containing thirty (30) licensed beds available for use.

Hastings Owned Land: That certain real property located in Hastings, Cambria County, Pennsylvania, as more particularly described on ***Exhibit A-2*** attached hereto and made a part hereof by reference and incorporation, together with all hereditaments, easements, mineral rights, rights of way and other appurtenances related thereto.

Hastings Property: The Hastings Owned Land and related Leased Improvements located thereon relating to the Hastings Facility.

Hazardous Materials: Any asbestos or any substance containing asbestos and deemed hazardous under any Hazardous Materials Law, the group of organic compounds known as polychlorinated biphenyls, flammable explosives, radioactive materials, infectious wastes, biomedical and medical wastes, chemicals known to cause cancer or reproductive toxicity, radon gas, and any items included in the definition of hazardous or toxic wastes, materials or substances under any Hazardous Materials Laws.

Hazardous Materials Laws: Each federal, state and local law and regulation relating to pollution or protection of the environment, including ambient air, surface water, ground water, land surface or subsurface strata, and natural resources, and including each law and regulation relating to emissions, discharges, releases or threatened releases of Hazardous Materials, or otherwise relating to the manufacturing, processing, distribution, use, treatment, generation, storage, containment (whether above ground or underground), disposal, transport or handling of Hazardous Materials, and each law and regulation with regard to record keeping, notification, disclosure and reporting requirements respecting Hazardous Materials, including, without limitation, the Resource Conservation and Recovery Act of 1976 ("**RCRA**"), the Comprehensive Environmental Response, Compensation and Liability Act of 1980 ("**CERCLA**"), as amended by the Superfund Amendments and Reauthorization Act of 1986 ("**SARA**"), the Hazardous Materials Transportation Act, the Federal Water Pollution Control Act, the Clean Air Act, the Clean Water Act, the Toxic Substances Control Act, the Safe Drinking Water Act, and all similar federal, state and local environmental statutes and ordinances, and the regulations, orders, and decrees now or hereafter promulgated thereunder, in each case as amended from time to time.

Health Benefit Laws: Laws relating to the licensure, certification, qualification or authority to transact business relating to the provision of, or payment for, or both the provision of and payment for, health benefits, health care or insurance coverage, including ERISA, COBRA, HIPAA, SCHIP, Medicare, Medicaid, CHAMPUS/TriCare, and laws relating to the regulation of workers compensation and coordination of benefits.

[1] To be updated, as applicable, depending on when this lease is executed.

Health Compliance Laws: All applicable laws pertaining to billing, kickbacks, false claims, self-referral, claims processing, marketing, HIPAA security standards for the storage, maintenance, transmission, utilization and access to and privacy of patient information, and HIPAA and state standards for electronic transactions and data code sets, including, without limitation, the False Claims Act (31 U.S.C. Section 3729 *et seq.*), the Anti-Kickback Act of 1986 (41 U.S.C. Section 51 *et seq.*), the Federal Health Care Programs Anti-Kickback Statute (42 U.S.C. Section 1320a-7a(b)), the Stark Law, the Civil Monetary Penalties Law (42 U.S.C. Section 1320a-7a), or the Truth in Negotiations (10 U.S.C. Section 2304 *et seq.*), Health Care Fraud (18 U.S.C. Section 1347), Mail Fraud (18 U.S.C. Section 1341), Wire Fraud (18 U.S.C. Section 1343), Theft or Embezzlement (18 U.S.C. Section 669), Fraud and False Statements (18 U.S.C. Section 1001), False Statements Relating to Health Care Matters (18 U.S.C. Section 1035), and any other applicable federal health care law or equivalent state statutes or any rule or regulation promulgated by a Governmental Body with respect to any of the foregoing, as any of the same may be amended, modified and/or restated from time to time.

Healthcare Laws: Health Benefit Laws, Health Compliance Laws and Information Privacy and Security Laws.

Healthcare Real Estate: Any real estate and the improvements located thereon that is operated as hospitals, medical centers, surgical centers, ambulatory centers, diagnostic centers, emergency departments, assisted living facilities and skilled nursing facilities.

Healthcare REIT: As of the date of determination, a real estate investment trust (a) engaged primarily in the business of directly owning Healthcare Real Estate and (b) with not less than fifty percent (50%) of its total assets by then current book value, comprised of investments in Healthcare Real Estate. For the avoidance of doubt, no investment bank, private equity or hedge fund or other investment vehicle (e.g. Blackstone) whose primary business is providing investment management or investment banking services but who owns or Controls a Healthcare REIT, will itself be deemed a Healthcare REIT for purposes of this Lease.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, as the same may be amended, modified or supplemented from time to time, and any successor statute thereto, and any and all rules or regulations promulgated from time to time thereunder.

Impartial Appraiser: As defined in Section 13.1.

Impositions: Collectively, with respect to each Property, all civil monetary penalties, fines and overpayments imposed by state and federal regulatory authorities (excluding all penalties or fines caused by the action or inaction of any Lessor), all Real Estate Taxes, all state and local sales and use taxes, single business, gross receipts, transaction privilege, rent or similar taxes, all assessments, charges and costs imposed under the Permitted Exceptions (including, without limitation, all penalties, fines, damages, costs and expenses for any violation of or a default under any of the Permitted Exceptions), franchise taxes (including but not limited to taxes based on capital, net worth or assets and specifically including the Texas margin tax), license, business entity, annual report, registration and statutory representation fees and other taxes imposed on any business entities, including limited partnerships, limited liability companies and other "pass through" entities, and any such items imposed on Lessor or Lessor's Affiliates (including Lessor's

parent organizations), all assessments for utilities, public improvements or benefits, ground rents, water, wastewater, sewer, sanitary sewer or other rents and charges, excises, tax levies, fees (including, without limitation, impact, development, license, permit, inspection, authorization and similar fees), and all other governmental charges, in each case whether general or special, ordinary or extraordinary, or foreseen or unforeseen, of every character in respect of such Property, the Rent relating thereto (including all interest and penalties thereon due to any failure in payment by Lessee), and all other fees, costs and expenses which at any time, during or in respect of the Term may be charged, assessed or imposed on or in respect of or be a lien upon (a) Lessor or Lessor's interest in all or any portion of such Property, (b) such Property or any part thereof or any rent therefrom or any estate, right, title or interest therein, or (c) any occupancy, operation, use or possession of, sales from, or activity conducted on, or in connection with, such Property or the leasing or use of such Property or any part thereof. Notwithstanding any provision hereof to the contrary, nothing contained in this Lease shall be construed to require Lessee to pay (1) any tax based on net income (whether denominated as a financial institutions or other tax) imposed on Lessor, or (2) any transfer tax of Lessor, or (3) any tax imposed with respect to the sale, exchange or other disposition by Lessor of any Property or the proceeds thereof or (4) except as expressly provided elsewhere in this Lease, any principal or interest on any Lien on any Property, except to the extent that any tax, assessment, tax levy, or charge which Lessee is obligated to pay pursuant to the first sentence of this definition and which is in effect at any time during the Term is totally or partially repealed, and a tax, assessment, tax levy, or charge set forth in clause (1) or (2) is levied, assessed, or imposed expressly in lieu thereof, in which case the substitute tax, assessment, tax levy, or charge shall be deemed to be an Imposition.

Information Privacy or Security Laws: The provisions of HIPAA and any other laws concerning the privacy and/or security of personal information, including but not limited to the Gramm-Leach-Bliley Act, state data breach notification laws, state health information privacy laws, the Federal Trade Commission Act and state consumer protection laws.

Insurance Premiums: As defined in Section 4.4.

Insurance Requirements: All terms of any insurance policy required by this Lease and all requirements of the issuer of any such policy.

Intercreditor Agreement: That certain Intercreditor Agreement, dated as of April 29, 2016, among certain affiliates of Lessor, representatives of certain creditors of LifePoint and certain of its subsidiaries, and RegionalCare Hospital Partners Holdings, Inc., as modified, amended or restated or joined (or replaced by a Replacement Intercreditor) from time to time.

Interest Expense: With respect to Lima Holdco for any period, the gross interest expense of Lima Holdco for such period on a consolidated basis, including the portion of any payments or accruals with respect to capitalized lease obligations allocable to interest expense. For purposes of the foregoing, gross interest expense shall be determined after giving effect to any net payments made or received and costs incurred by Lima Holdco and its Subsidiaries with respect to hedging agreements, and interest on a capitalized lease obligation shall be deemed to accrue at an interest rate reasonably determined by Lima Holdco to be the rate of interest implicit in such capitalized lease obligation in accordance with GAAP.

Interim Capital Addition Rent: As defined in Section 3.1(b).

Johnstown Facility: The healthcare facilities or operations listed on ***Exhibit C-3*** attached hereto.

Johnstown Lessee: DLP Conemaugh Memorial Medical Center, LLC, a Delaware limited liability company, together with its successors and permitted assigns.

Johnstown Lessor: MPT of Johnstown-Lima, LLC, a Delaware limited liability company, together with its successors and assigns.

Johnstown Medical Center: That certain general acute care hospital facility operated at the Johnstown Owned Land, commonly known as Conemaugh Memorial Medical Center, containing five hundred thirty-seven (537) licensed beds available for use.

Johnstown Owned Land: That certain real property located in (i) Johnstown, Cambria County, Pennsylvania, (ii) Ebensburg, Cambria County, Pennsylvania, (iii) Nanty Glo, Cambria County, Pennsylvania, (iv) Bedford, Bedford County, Pennsylvania, (v) Somerset, Somerset County, Pennsylvania, and (vi) Richmond, Cambria County, Pennsylvania, each as more particularly described on ***Exhibit A-3*** attached hereto and made a part hereof by reference and incorporation, together with all hereditaments, easements, mineral rights, rights of way and other appurtenances related thereto.

Johnstown Property: The Johnstown Owned Land and related Leased Improvements located thereon relating to the Johnstown Facility.

Joint Commission: As defined in Article XXIV.

Land: As defined in the recitals.

Lander Facility: The healthcare facilities or operations listed on ***Exhibit C-4*** attached hereto.

Lander Lease: That certain Lease Agreement, dated July 10, 1982, between the City of Lander, Wyoming, as lessor, and the Lander Lessor, as successor lessee by assumption from Lander Lessee, as successor lessee by merger from Lander Valley Regional Medical Center, LLC, relating to the Lander Leased Land, as modified, amended or restated from time to time.

Lander Lease Rent: All rent and all other charges and amounts due and payable under the Lander Lease during the Term.

Lander Leased Land: That certain real property located in Lander, Fremont County, Wyoming, as more particularly described on ***Exhibit A-4*** attached hereto and made a part hereof by reference and incorporation, together with all hereditaments, easements, mineral rights, rights of way and other appurtenances related thereto.

Lander Leased Property: The Lander Leased Land and related Leased Improvements located thereon relating to the Lander Medical Center.

Lander Lessee: Riverton Memorial Hospital, LLC, a Delaware limited liability company, together with its successors and permitted assigns.

Lander Lessor: MPT of Lander-Lima, LLC, a Delaware limited liability company, together with its successors and assigns.

Lander Medical Center: That certain general acute care hospital facility operated at the Lander Leased Land, commonly known as SageWest Health Care - Lander Campus, containing seventy-six (76) licensed beds available for use.

Lander Property: The Lander Leased Land and related Leased Improvements located thereon relating to the Lander Facility.

Late Payment Penalty: Shall mean an amount equal to the product of Four Percent (4%) and the amount of any overdue and unpaid amount under this Lease.

Lawton Facility: The healthcare facilities or operations listed on ***Exhibit C-6*** attached hereto.

Lawton Ground Leased Property: That certain real property ground leased under the Lawton Ground Leases.

Lawton Lessee: Southwestern Medical Center, LLC, a Delaware limited liability company, together with its successors and permitted assigns.

Lawton Lessor: MPT of Lawton-Lima, LLC, a Delaware limited liability company, together with its successors and assigns.

Lawton Medical Center: That certain general acute care hospital facility operated at the Lawton Owned Land, commonly known as Southwestern Medical Center, containing one hundred ninety-nine (199) licensed beds available for use.

Lawton MOB Ground Leases: Collectively, (a) that certain Amended and Restated Ground Lease, dated as of January 7, 2008, between Lawton Lessor (as successor by assignment to Lawton Lessee), as lessor, and G&E HC REIT II Lawton MOB Portfolio LLC, a Delaware limited liability company (as successor by assignment to Southwestern MOB I, LLC, a Delaware limited liability company, as lessee), and (b) that certain Ground Lease, dated as of January 7, 2008, between Lawton Lessor (as successor by assignment to Lawton Lessee), as lessor, and G&E HC REIT II Lawton MOB Portfolio LLC, a Delaware limited liability company (as successor by assignment to Southwestern MOB I, LLC, a Delaware limited liability company), as lessee, as the same has been or may be amended, modified, or restated from time to time, as each of the foregoing has been or may be modified, amended, or restated from time to time.

Lawton Owned Land: That certain real property located in Lawton, Comanche County, Oklahoma, as more particularly described on ***Exhibit A-6*** attached hereto and made a part hereof by reference and incorporation, together with all hereditaments, easements, mineral rights, rights of way and other appurtenances related thereto.

Lawton Property: The Lawton Owned Land and related Leased Improvements located thereon relating to the Lawton Facility.

Lease: As defined in the Preamble.

Lease Assignments: Those certain Assignments of Rents and Leases, executed and delivered by each Facility Lessee to and in favor of Lessor and certain of its Affiliates, as each may be amended, modified and/or restated from time to time.

Lease Base: As to each Property, as defined on ***Schedule 3.1(a)*** attached hereto and made a part hereof by reference and incorporation.

Lease Payments: For any period, the sum of the payment obligations of Lessee under this Lease.

Lease Rate: As defined on ***Schedule 3.1(a)*** attached hereto and made part hereof by reference and incorporation.

Leased Improvements: As defined in Article II(b).

Leased Property: Collectively, those items described in Article II, as well as all Capital Additions thereto.

Legal Requirements: With respect to each Property and the conduct of the Business thereon, all federal, state, county, municipal and other governmental statutes, laws, rules, orders, regulations, ordinances, judgments, decrees and injunctions affecting such Property, Lessee's operation of the Business on such Property, or the construction, use or alteration of such Property (including, without limitation, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973), whether now or hereafter enacted and in force, including any which may (a) require repairs, modifications, or alterations in or to such Property, or (b) in any way adversely affect the use and enjoyment thereof, and all permits, licenses, authorizations and regulations relating thereto, and all covenants, agreements, restrictions and encumbrances contained in any instruments, either of record or known to Lessee, at any time in force affecting such Property.

Lessee: Collectively and jointly and severally, the: (i) Ottumwa Lessee, (ii) Dodge City Lessee, (iii) Lawton Lessee, (iv) Johnstown Lessee, (v) Meyersdale Lessee, (vi) Hastings Lessee, (vii) Roaring Springs Lessee, (viii) Palestine Lessee, (ix) Palestine GP Lessee, (x) Lander Lessee, and (xi) Riverton Lessee, together with their respective successors and permitted assigns.

Lessee Parties: As defined in Section 40.6.

Lessor: Collectively and jointly and severally, the: (i) Ottumwa Lessor, (ii) Dodge City Lessor, (iii) Lawton Lessor, (iv) Johnstown Lessor, (v) Meyersdale Lessor, (vi) Hastings Lessor, (vii) Roaring Springs Lessor, (viii) Palestine Lessor, (ix) Lander Lessor, and (x) Riverton Lessor, together with their respective successors and permitted assigns.

Lessor's Notice Address: As defined in Section 13.2(c).

Lessor Parties: As defined in Section 39.6.

Letter of Credit: As defined in Section 39.15.

Licenses: As defined in Article XXXVIII.

Liens: As defined in Article XXXVI.

LifePoint: LifePoint Health, [Inc.][2] or its successor in interest.

LifePoint Guaranty: That certain Guaranty, dated as of the date hereof, executed and delivered by LifePoint in favor of Lessor, as may be modified, amended, restated and/or supplemented from time to time.

LifePoint Non-Competition Agreement: Means that certain Non-Competition Agreement, dated as of the date hereof, executed by LifePoint in favor of Lessor and its Affiliates, as the same is amended, modified, and/or restated from time to time.

LifePoint Upper Tier Distribution: As defined in the Purchase Agreement.

LifePoint Upper Tier Restructuring Transaction: As defined in the Purchase Agreement.

Lima Guaranty: That certain Guaranty, dated as of the date hereof, executed and delivered by Lima HoldCo in favor of Lessor, as may be modified, amended, restated and/or supplemented from time to time.

Lima Holdco: Lima HoldCo, LLC, a Delaware limited liability company.

Lima Non-Competition Agreement: Means that certain Non-Competition Agreement, dated as of the date hereof, executed by Lima Holdco in favor of Lessor and its Affiliates, as the same is amended, modified, and/or restated from time to time.

Major Event of Default: The occurrence of (i) an Event of Default under clause (a), (e), (j), (k), or (l) of Section 16.1; (ii) an Event of Default by the Guarantor under clause (c) or (g) of Section 16.1 (subject to the cure right described herein), or (iii) an Event of Default under any of clauses (b), (c), (d), (f), (g), (h), or (i) of Section 16.1 with respect to three (3) or more Facility Lessees.

Major Healthcare REIT: Any publicly listed Healthcare REIT with total assets of more than $2,500,000,000, or (b) any Person in which a publicly listed Healthcare REIT with total assets of more than $2,500,000,000 owns, directly or indirectly, a beneficial or record interest of twenty-five percent (25%) or more at the time of the applicable transfer.

Major Healthcare REIT Transaction: With respect to any Facility Lessee or Guarantor, any transaction pursuant to which any Major Healthcare REIT other than the Permitted Holders (or any holding company parent of such Facility Lessee or Guarantor owned directly or indirectly by

[2] To be updated to LifePoint Health, LLC if LifePoint has been converted to an LLC before closing.

the Permitted Holders) shall have acquired (i) direct or indirect beneficial ownership (as defined in Rules 13(d)-3 and 13(d)-5 under the Securities Exchange Act of 1934 (as amended)) in such Facility Lessee or Guarantor of Fifty Percent (50%) or more, or (ii) direct or indirect beneficial ownership (as defined in Rules 13(d)-3 and 13(d)-5 under the Securities Exchange Act of 1934 (as amended)) of voting power of the Equity Interests of such Facility Lessee or Guarantor having more than fifty percent (50%) of the ordinary voting power for the election of directors or managers of such Facility Lessee or Guarantor.

Major Repairs: All repairs to the Leased Property of every kind and nature, whether interior or exterior, structural or non-structural (including, without limitation, all parking decks and parking lots), which extend the life of the Leased Property (as opposed to being routine maintenance and repair expenditures), as deemed necessary or appropriate by Lessor, in its reasonable discretion, from time to time during the Term.

Make-Up Payment: As defined in Section 15.6.

Management Agreement: Any contract or agreement for the provision of whole-hospital management services to any of the Facility Lessees with respect to the operation of any hospital on any of the Property, whether now existing or hereafter entered into (but shall not be construed to cover management agreements or similar agreements relating to only a small portion of a Facility, such as an inpatient psychiatric unit or a wound care facility (as opposed to the management and operation of the hospital).

Management Company: Any person, firm, corporation or other entity or individual who or which will provide management services under a Management Agreement to a Facility Lessee with respect to the operation of a hospital on a Property.

Material Obligation: Any obligation of the Guarantor or any Facility Lessee (other than any obligations owing to Lessor or any of its Affiliates) which (i) is in excess of Twenty Million Dollars ($20,000,000) (including, without limitation the Conemaugh Capital Commitment Obligation) and (ii) is not an obligation owed to a lender or creditor that is a party the an Intercreditor Agreement.

Medicaid: The medical assistance program established by Title XIX of the Social Security Act (42 U.S.C. Sections 1396 *et seq.*) and any statute succeeding thereto.

Medicare: The health insurance program for the aged and disabled established by Title XVIII of the Social Security Act (42 U.S.C. Sections 1395 *et seq.*) and any statute succeeding thereto.

Meyersdale Facility: The healthcare facilities or operations listed on ***Exhibit C-7*** attached hereto.

Meyersdale Lessee: DLP Conemaugh Meyersdale Medical Center, LLC, a Delaware limited liability company, together with its successors and permitted assigns.

Meyersdale Lessor: MPT of Meyersdale-Lima, LLC, a Delaware limited liability company, together with its successors and assigns.

Meyersdale Medical Center: That certain critical access hospital facility operated at the Meyersdale Owned Land, commonly known as Conemaugh Meyersdale Medical Center, containing twenty (20) licensed beds available for use.

Meyersdale Owned Land: That certain real property located in Meyersdale, Somerset County, Pennsylvania, as more particularly described on ***Exhibit A-7*** attached hereto and made a part hereof by reference and incorporation, together with all hereditaments, easements, mineral rights, rights of way and other appurtenances related thereto.

Meyersdale Property: The Meyersdale Owned Land and related Leased Improvements located thereon relating to the Meyersdale Facility.

MOB Ground Leases: Individually, and collectively, each of the Lawton MOB Ground Leases, the Ottumwa Ground Lease, and the Roaring Springs Ambulance Facility Lease.

MPT: MPT Operating Partnership, L.P., an Affiliate of Lessor.

MPT Damages: As defined in Section 8.2(b).

MPT Indemnified Parties: As defined in Section 8.2(b).

New Construction Project: (x) each facility, branch, business unit, hospital or related healthcare facility which is either a new facility, branch, business unit, hospital or related healthcare facility or an expansion, relocation, remodeling, refurbishment or substantial modernization of an existing facility, branch, business unit, hospital or related healthcare facility owned by Lima Holdco or its Subsidiaries which is then under construction (or, in the case of a new business unit, hospital or related healthcare facility, otherwise in process but not yet completed) and (y) each creation (in one or a series of related transactions) of a business unit (including, without limitation, individual hospitals) and each expansion (in one or a series of related transactions) of business into a new market to the extent that such creation (in one or a series of related transactions) of a business unit (including, without limitation, individual hospitals) or is in process but not yet completed or offered, as applicable.

New Project: (x) each plant, facility, branch, business unit, hospital or related healthcare facility which is either a new plant, facility, branch, business unit, hospital or related healthcare facility or an expansion, relocation, remodeling, refurbishment or substantial modernization of an existing plant, facility, branch, business unit, hospital or related healthcare facility owned by Lima Holdco or its Subsidiaries which in fact commences operations, (y) each creation (in one or a series of related transactions) of a business unit (including, without limitation, individual hospitals) to the extent such business unit commences operations or each expansion (in one or a series of related transactions) of business into a new market and (z) each New Construction Project.

New Property: Any real property (other than real property constituting a Capital Addition to a Property that is already subject to this Lease) that becomes subject to this Lease after the Effective Date; it being understood that except as set forth in the Purchase Agreement and in this Lease, neither Lessee nor any Affiliate of Lessee shall have any obligation to cause any real property to become subject to this Lease.

Net Income: The net income (or loss) of a Person determined in accordance with GAAP.

Noncompete Period: As defined in Section 39.10.

Obligation Documents: Individually and collectively, this Lease, the Guaranty, the Lease Assignments, the Environmental Indemnification Agreement, any Subordination of Management Agreement, the LifePoint Non-Competition Agreement, the Lima Non-Competition Agreement, and all other documents or instruments entered into by Lessee or its Affiliates in connection with this Lease, or as may be necessary to give effect to the provisions hereof and thereof, or to evidence or secure the payment and performance of the Lessee or its Affiliates' respective obligations and liabilities under this Lease, and any other documents or instruments entered into in connection therewith, as each of the same may be modified, amended or restated from time to time.

Obligors: Collectively, Lessee, Guarantor, and their respective successors and permitted assigns.

OFAC: The U.S. Department of Treasury Office of Foreign Assets Control.

OFAC List: The list of specially designated nationals and blocked persons subject to financial sanctions that is maintained and published by the U.S. Treasury Department, Office of Foreign Assets Control and any other similar list maintained and published by the U.S. Treasury Department, Office of Foreign Assets Control pursuant to any law, including, without limitation, trade embargo, economic sanctions, or other prohibitions imposed by Executive Order of the President of the United States. The OFAC List currently is accessible through the internet website https://www.treasury.gov/ofac/downloads/sdnlist.pdf.

Officer's Certificate: With respect to each Facility Lessee, a certificate of such Facility Lessee signed by the representative(s) authorized to so sign by the governing body of such Facility Lessee, or any other Person whose power and authority to act has been properly authorized.

Operating Agreements: With respect to each Facility Lessee, all written agreements to which such Facility Lessee is a party with respect to the ownership, operation or management of the Business at a Property, including, without limitation, any and all service and maintenance contracts, management agreements, equipment leases, consulting agreements, laboratory servicing agreements, pharmaceutical contracts and physician, other clinician or other professional services provider contracts, but excluding employment contracts and any Participation Agreements, as the same may from time to time be amended, restated, supplemented, renewed or modified.

Organizational Documents: With respect to any Person, the articles of incorporation or organization, certificate of incorporation or formation or other formation document, together with all other documents creating and governing such Person, including stockholder agreements, limited liability company or operating agreements, partnership agreements and bylaws.

Other Credit Enhancements: As defined in Section 30.2.

Ottumwa Facility: The healthcare facilities or operations listed on ***Exhibit C-8*** attached hereto.

Ottumwa Ground Leased Property: That certain real property ground leased under the Ottumwa Ground Lease.

Ottumwa Lessee: RCHP-Ottumwa, LLC, a Delaware limited liability company, together with its successors and permitted assigns.

Ottumwa Lessor: MPT of Ottumwa-Lima, LLC, a Delaware limited liability company, together with its successors and assigns.

Ottumwa Medical Center: That certain general acute care hospital facility operated at the Ottumwa Owned Land, commonly known as Ottumwa Regional Health Center, containing two hundred seventeen (217) licensed beds available for use.

Ottumwa MOB Ground Lease: That certain Ground Lease, dated as of November 22, 2010, between Ottumwa Lessor (as successor by assignment to Ottumwa Lessee), as lessor, and Ottumwa Medical Properties, LLC, an Iowa limited liability company (as successor by assignment to Ottumwa MOB, LLC, a Georgia limited liability company), as lessee, as the same has been or may be amended, modified, or restated from time to time.

Ottumwa Owned Land: That certain real property located in (i) Ottumwa, Wapello County, Iowa, and (ii) Eddyville, Wapello County, Iowa, as more particularly described on ***Exhibit A-8*** attached hereto and made a part hereof by reference and incorporation, together with all hereditaments, easements, mineral rights, rights of way and other appurtenances related thereto.

Ottumwa Property: The Ottumwa Owned Land and related Leased Improvements located thereon relating to the Ottumwa Facility.

Overdue Rate: On any date, the Lease Rate plus Five Percent (5%).

Owned Land: Collectively, Dodge City Owned Land, Hastings Owned Land, Johnstown Owned Land, Lawton Owned Land, Meyersdale Owned Land, Ottumwa Owned Land, Palestine Owned Land, Riverton Owned Land and Roaring Springs Owned Land.

Palestine Facility: The healthcare facilities or operations listed on ***Exhibit C-9*** attached hereto.

Palestine GP Lessee: Palestine-Principal G.P., Inc., a Texas corporation, together with its successors and permitted assigns.

Palestine GP Property: A portion of the Palestine Property consisting of a certain tract of land on which is situated a freestanding medical office building commonly known as the "Buffalo Medical Clinic" located at 249 South Craig Street, Buffalo, Texas.

Palestine Lessee: Palestine Principal Healthcare Limited Partnership, a Texas limited partnership, together with its successors and permitted assigns.

Palestine Lessor: MPT of Palestine-Lima, LLC, a Delaware limited liability company, together with its successors and assigns.

Palestine Medical Center: That certain general acute care hospital facility operated at the Palestine Owned Land, commonly known as Palestine Regional Medical Center, containing one hundred fifty-six (156) licensed beds available for use.

Palestine Owned Land: That certain real property located in (i) Palestine, Anderson County, Texas, and (ii) Buffalo, Leon County, Texas, each as more particularly described on ***Exhibit A-9*** attached hereto and made a part hereof by reference and incorporation, together with all hereditaments, easements, mineral rights, rights of way and other appurtenances related thereto.

Palestine Property: The Palestine Owned Land and related Leased Improvements located thereon relating to the Palestine Facility.

Partial Taking: As defined in Section 15.3.

Partial Taking Property: As defined in Section 15.6.

Participation Agreements: With respect to each Facility Lessee, all third-party payor participation or reimbursement agreements, and provider numbers and provider agreements, to which such Facility Lessee is a party relating to rights to payment or reimbursement from, and claims against, private insurers, managed care plans, employee assistance programs, Blue Cross and/or Blue Shield, governmental authorities, Medicare, Medicaid and TRICARE, and other third-party payors, as the same may from time to time be amended, restated, extended, supplemented or modified, together with all rights, privileges and entitlements thereunder.

Pass-Through Lease Land: The Lander Leased Land.

Pass-Through Lease Rent: The Lander Lease Rent.

Pass-Through Leases: The Lander Lease, as the same may be modified, amended, restated or supplemented from time to time, and each of which has been assumed by the applicable Facility Lessor from the applicable Facility Lessee (or an Affiliate thereof) and shall be subject to Article XL of this Lease.

Pass-Through Lessees: The Lander Lessee, together with its successors and permitted assigns.

Pass-Through Lessors: The Lander Lessor, together with its successors and permitted assigns.

Patriot Act: The Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001, Pub. L. 107-56, as the same may be amended, modified or restated from time to time.

Pennsylvania Property: Collectively, the Hastings Property, the Johnstown Property, the Meyersdale Property, the Roaring Springs Property, and any New Property located in the Commonwealth of Pennsylvania.

Permitted Exceptions: As defined in Article II.

Permitted Holders: (a) (i) Apollo Global Management, Inc. and investment funds, alternative investment vehicles and managed accounts, managed by (x) Apollo Global Management, Inc. or (y) any of its Subsidiaries and (ii) Affiliates of any of the Persons referred to in the immediately preceding clause (i), (b) AP VIII DSB Co-Invest, L.P., (c) LifePoint, (d) any Qualified Transferee or other Person that becomes a transferee in connection with a Permitted Transaction, (e) DSB Parent L.P., (f) DSB Holdings, Inc., (g) each of the current or future wholly-owned Subsidiaries of the Persons in the foregoing clauses (a) through (f), and (h) any current or future direct or indirect holder of Equity Interests of any of the Persons referred to in the foregoing clauses (a) through (g). Notwithstanding the foregoing, in no event shall any (x) Major Healthcare REIT or (y) portfolio company (other than LifePoint, or any Person that becomes a Qualified Transferee or other Person that becomes a transferee in connection with a Permitted Transaction or their respective current Subsidiaries or future wholly-owned Subsidiaries) of any of the Persons referred to in (x) clauses (a), (b), (e), and (f) of this definition ("Covered Persons") and (y) solely as they relate to any Covered Persons clauses (g) and (h) of this definition shall be deemed to be a Permitted Holder.

Permitted Reorganization: The transfer of the direct or indirect Equity Interests in any Facility Lessee to Lima Holdco or a Subsidiary thereof.

Permitted Transaction: With respect to any Facility Lessee or the Guarantor, the transfer of direct or indirect Equity Interests in such Facility Lessee or such Guarantor if:

(a) such transfer is to a Qualified Transferee;

(b) (i) (A) after giving effect to such transfer such Facility Lessee or Guarantor is directly or indirectly Controlled by LifePoint (or any Qualified Transferee or other Person that becomes a transferee in connection with a Permitted Transaction) or (B) such transfer is to a Person that has been approved in writing by Lessor (such approval not to be unreasonably withheld, conditioned or delayed);

(i) Lessor has received confirmation in writing that (A) after giving effect to the transfer such Facility Lessee or Guarantor will continue to have financial and credit characteristics reasonably satisfactory to Lessor and (B) such transferee (together with the Facility Lessees and other entities acquired by such transferee) has operating characteristics and experience operating acute care hospital facilities reasonably satisfactory to Lessor;

(ii) With respect to such Guarantor, after giving effect to such transfer the Guarantor (or the applicable Acceptable Replacement Guarantor) continues to own a direct or indirect ownership interest in each Facility Lessee; and

(iii) such transferee, in the case of clause (b)(i)(B) has complied with Section 8.7 and Section 39.15 (i.e., has delivered a Substitute Letter of Credit; provided, however, that such Substitute Letter of Credit shall be in an amount equal to six (6) months Base Rent (as the amount of such Base Rent is adjusted from time to time pursuant to this Lease).

(c) such transfer occurs in connection with a Qualified Public Offering; or

(d) such transfer is to a Permitted Holder.

provided, that, (1) in no event shall a transaction constituting a Major Healthcare REIT Transaction constitute a Permitted Transaction without Lessor's prior written consent (which consent may be withheld in Lessor's sole and absolute discretion); and (2) Guarantor and Lessee shall provide Lessor with fifteen (15) days prior written notice of the consummation of any Permitted Transaction (together with a description of such proposed Permitted Transaction in reasonable detail to verify such transaction constitutes a Permitted Transaction) in which (x) LifePoint (or any Qualified Transferee or other Person that becomes a transferee in connection with a Permitted Transaction) ceases to directly or indirectly own more than 50% of the Equity Interests of Lima Holdco or any Facility Lessee or (y) Lima HoldCo (or any Acceptable Replacement Guarantor) ceases to directly or indirectly own more than 50% of the Equity Interests of any Facility Lessee.

Person: An individual, a corporation, a limited liability company, a general or limited partnership, an unincorporated association, a joint venture, a Governmental Body or another entity or group.

Personal Property: With respect to a Facility Lessee, all of such Facility Lessee's consumable inventory and supplies, machinery, equipment, furniture, furnishings, trailers, movable walls or partitions, computers, trade fixtures and other tangible or intangible personal property (including all such items not permanently affixed to the applicable Property), currently owned and acquired after the execution of this Lease, and necessary, used, or useful in the operation of the applicable Facility, but excluding any items within the definition of Fixtures.

Portfolio Sale: Any (i) sale, transfer, assignment or conveyance by Medical Properties Trust, Inc., MPT, any Facility Lessor or any of their respective Affiliates of two (2) or more healthcare facilities that includes at least one (1) Facility subject to this Master Lease and at least one (1) other healthcare facility that is not a Facility subject to this Master Lease, where the value of such other healthcare facilities comprises at least twenty percent (20%) of the aggregate value of such sale, transfer, assignment or conveyance; or (ii) as applicable, sale of equity, merger, combination, sale of all or substantially all of the assets of or similar transaction involving Medical Properties Trust, Inc., MPT, or their respective Affiliates and any other Person.

Pre-Opening Expenses: With respect to any fiscal period, the amount of expenses (other than interest expense) incurred with respect to facilities which are classified as "pre-opening expenses" or "facility-opening costs" (or any similar or equivalent caption) in the applicable financial statements of Lima Holdco and its Subsidiaries for such period, prepared in accordance with GAAP.

Primary Intended Use: As defined in Article VII.

Pro Forma Basis: As to Lima Holdco, for any events as described below that occur subsequent to the commencement of a period for which the financial effect of such events is being calculated, and giving effect to the events for which such calculation is being made, such calculation as will give pro forma effect to such events as if such events occurred on the first day of the four consecutive fiscal quarter period ended on or before the occurrence of such event (the "**Reference Period**"): (i) pro forma effect shall be given to any disposition, acquisition, investment, capital expenditure, construction, repair, replacement, improvement, development,

merger, amalgamation, consolidation (including the Transactions), any dividend, distribution or other similar payment, any New Project, and any restructurings of the business of Lima Holdco and its Subsidiaries that Lima Holdco or any of its Subsidiaries has determined to make and/or made and in the good faith determination of an officer of Lima Holdco are expected to have a continuing impact and are factually supportable, which would include cost savings resulting from head count reduction, closure of facilities and similar operational and other cost savings, which adjustments Lima Holdco determines are reasonable as set forth in a certificate of an officer of Lima Holdco (the foregoing, together with any transactions related thereto or in connection therewith, the "relevant transactions"), in each case that occurred during the Reference Period and (ii) in making any determination on a Pro Forma Basis, (x) all indebtedness (including indebtedness issued, incurred or assumed as a result of, or to finance, any relevant transactions and for which the financial effect is being calculated, but excluding normal fluctuations in revolving indebtedness incurred for working capital purposes) issued, incurred, assumed or permanently repaid during the Reference Period shall be deemed to have been issued, incurred, assumed or permanently repaid at the beginning of such period, (y) Interest Expense of such person attributable to interest on any indebtedness, for which pro forma effect is being given as provided in the preceding clause (x), bearing floating interest rates shall be computed on a pro forma basis as if the rates that would have been in effect during the period for which pro forma effect is being given had been actually in effect during such periods, and (z) in giving effect to clause (i) above with respect to each New Project (other than New Construction Projects) which commences operations and records not less than one full fiscal quarter's operations during the Reference Period, the operating results of such New Project (other than New Construction Projects) shall be annualized on a straight line basis during such period, taking into account any seasonality adjustments determined by Lima Holdco in good faith.

Pro forma calculations made pursuant to the definition of the term "Pro Forma Basis" shall be determined in good faith by an officer of Lima Holdco and may include adjustments to reflect (i) operating expense reductions and other operating improvements, synergies or cost savings reasonably expected to result from any relevant pro forma event (including, to the extent applicable, the Transactions) and (ii) anticipated run-rate operating results expected to be achieved from New Construction Projects (and the achievement of related operational efficiencies associated therewith) to be scheduled for completion or operational within eighteen (18) months after the date any such calculation is performed.

Properties; Property: Individually and collectively, all of the: (i) Ottumwa Property, (ii) Dodge City Property, (iii) Lawton Property, (iv) Johnstown Property, (v) Meyersdale Property, (vi) Hastings Property, (vii) Roaring Springs Property, (viii) Palestine Property, (ix) Lander Property, (x) Riverton Property, and (xi) following the Effective Date, any New Property, each sometimes individually referred to as a "Property."

Property Substitution: As defined in Section 35.1.

Property Substitution Date: With respect to any applicable Property, the effective date of a Property Substitution.

Proprietary Information: As defined in Section 24(j).

Public Company Compliance: Compliance with the requirements of the Sarbanes-Oxley Act of 2002 and the rules and regulations promulgated in connection therewith, the provisions of the Securities Act of 1933 and the Securities Exchange Act of 1934, and the rules of national securities exchange listed companies (in each case, as applicable to companies with equity or debt securities held by the public), including procuring directors' and officers' insurance, legal and other professional fees, and listing fees.

Public Corporation: As defined in the definition of "Qualified Public Offering."

Purchase Agreement: That certain Real Property Asset Purchase Agreement, dated as of November 4, 2019, by and among Lima Holdco, Lessees, and Lessors, and certain of their respective Affiliates, as the same has been or may be modified, amended, restated and/or supplemented from time to time.

Qualified Manager: Means (i) DLP Partner, LLC, (ii) DLP Conemaugh Memorial Medical Center, LLC, (iii) LifePoint Corporate Services, General Partnership, each of which management companies are hereby approved by Lessor, and (iv) any other management company with experience managing assets of the size, use and value of the applicable Property, reasonably approved by Lessor.

Qualified Public Offering: A public offering by LifePoint, DSB Holdings, Inc. or any entity into which LifePoint, DSB Parent L.P. or DSB Holdings, Inc. is merged, converted, or consolidated into or to which the Equity Interests of LifePoint, DSB Parent L.P., or DSB Holdings, Inc. are contributed, as determined by LifePoint's board of directors as being advisable or convenient to create a suitable vehicle for a public offering (the resulting entity, the "**Public Corporation**"), of the Equity Interests in LifePoint, DSB Parent L.P., DSB Holdings Inc. or such Public Corporation, which public offering is registered with the United States Securities and Exchange Commission.

Quarterly Statements: As defined in Article XXIV(b)(ii).

Qualified Transferee: A Person that, at the date of determination:

(a) is a Person, or an Affiliate of a Person, that owns or operates, has owned and/or operated, or procures the services of a Person that has owned or operated, (i) at least ten (10) hospitals or (ii) one (1) or more hospitals having an aggregated annual net revenue of $500,000,000 or more;

(b) has not, and neither have any of such Person's senior officers or directors: (i) had any license or certification to operate any healthcare facility or any other similar business irrevocably revoked by any Governmental Authority, or caused any such revocation, due to any actual fault involving quality of care, overpayments, or fraud and abuse compliance matters, (ii) been found to have been grossly negligent or to have committed willful or intentional misconduct pursuant to a non-appealable judgement in any lawsuit alleging any wrongdoing by such Person or any of such senior officers, directors, shareholders or members relating to patient care, (iii) been permanently excluded from providing services in connection with the operation of any healthcare facility or any other similar business by any applicable state healthcare licensing authority, (iv) been permanently excluded or restricted from participation in Medicare, Medicaid

or any other governmental payor program; and (v) been the subject of a pending investigation or proceeding within the past 5 years that is reasonably likely to result in any of the foregoing;

(c) has not: (i) made an assignment of all or substantially all of its property for the benefit of creditors, (ii) had a receiver, trustee or liquidator appointed for any of its property (unless such appointment was discharged within 60 days after the date of such appointment), (iii) filed a voluntary petition under any federal bankruptcy law or state Legal Requirements to be adjudicated as bankrupt or for any arrangement or other debtor's relief, or (iv) had an involuntary filing of such a petition against any such Person by any other Person (unless such petition was dismissed within 90 days after filing);

(d) has provided Lessor with written confirmation that such Person is in pro forma compliance with Section 16.1(l) of this Lease; and

(e) has complied with Section 8.7 and Section 39.15 (i.e., has delivered a Substitute Letter of Credit; *provided, however*, that such Substitute Letter of Credit shall be in an amount equal to six (6) months Base Rent (as the amount of such Base Rent is adjusted from time to time pursuant to this Lease)).

RCRA: As defined in the definition of "Hazardous Materials Law."

Real Estate Taxes: All taxes, assessments and special assessments, and dues which are levied or imposed during the Term upon the Leased Property.

Rent: Collectively, the Base Rent (as increased in accordance with the provisions of Section 3.1(b)), and the Additional Charges.

Rent Schedule: As defined in Section 3.1(e).

Replacement Intercreditor: With respect to any Change of Control Transaction, any Permitted Transaction (other than a Permitted Reorganization or other transaction if, after giving effect to such transaction, the Intercreditor Agreement continues to be applicable), or any substitution of an Acceptable Replacement Guarantor pursuant to Section 16.1(c), an intercreditor agreement in form substantially identical (other than in respect of details specific to any such transaction) to the Intercreditor Agreement or in a form otherwise acceptable to the Lessor.

Replacement Property: As defined in the definition of Substitute Property.

Request: As defined in Section 10.3.

Requesting Party: As defined in Section 39.5.

Required Ongoing Capital Project: As defined in Section 10.5.

Reserve: As defined in Section 9.2(a).

Revised Sale Terms: As defined in Section 34.2(b).

Riverton Facility: The healthcare facilities or operations listed on ***Exhibit C-10*** attached hereto.

Riverton Lessee: Riverton Memorial Hospital LLC, a Delaware limited liability company, together with its successors and permitted assigns.

Riverton Lessor: MPT of Riverton-Lima, LLC, a Delaware limited liability company, together with its successors and assigns.

Riverton Medical Center: That certain general acute care hospital facility operated at the Riverton Owned Land, commonly known as SageWest Health Care - Riverton Campus, containing seventy (70) licensed beds available for use.

Riverton Owned Land: That certain real property located in Riverton, Fremont County, Wyoming, as more particularly described on ***Exhibit A-10*** attached hereto and made a part hereof by reference and incorporation, together with all hereditaments, easements, mineral rights, rights of way and other appurtenances related thereto.

Riverton Property: The Riverton Owned Land and related Leased Improvements located thereon relating to the Riverton Facility.

Roaring Springs Ambulance Facility Lease: That certain Lease Agreement dated June 1, 1992, by and between Nason Hospital, as landlord, and Altoona-Logan Township Mobile Medical Emergency Department Authority f/k/a Roaring Spring Ambulance Service, Inc., as tenant, as the same has been or may be amended, modified, or restated from time to time.

Roaring Springs Facility: The healthcare facilities or operations listed on ***Exhibit C-11*** attached hereto.

Roaring Springs Ground Leased Property: That certain real property ground leased under the Roaring Springs Ambulance Facility Lease.

Roaring Springs Lessee: Nason Medical Center, LLC, a Delaware limited liability company, together with its successors and permitted assigns.

Roaring Springs Lessor: MPT of Roaring Springs-Lima, LLC, a Delaware limited liability company, together with its successors and assigns.

Roaring Springs Medical Center: That certain general acute care hospital facility operated at the Roaring Springs Owned Land, commonly known as Nason Medical Center, containing forty-five (45) licensed beds available for use.

Roaring Springs Owned Land: That certain real property located in (i) Roaring Springs, Blair County, Pennsylvania and (ii) Taylor Township, Blair County, Pennsylvania, as more particularly described on ***Exhibit A-11*** attached hereto and made a part hereof by reference and incorporation, together with all hereditaments, easements, mineral rights, rights of way and other appurtenances related thereto.

Roaring Springs Property: The Roaring Springs Owned Land and related Leased Improvements located thereon relating to the Roaring Springs Facility.

ROFO Exercise Notice: As defined in Section 10.3.

SARA: As defined in the definition of "Hazardous Materials Law."

Severance Date: As defined in Section 30.2.

Severance Notice: As defined in Section 30.2.

Severed Lease: As defined in Section 30.2.

Severed Property: As defined in Section 30.2.

Single Purpose Entity: With respect to each Facility Lessee, an entity which (i) exists solely for the purpose of owning and/or leasing the Property operated by such Facility Lessee and conducting the operation of the Business thereon, including any business that relates to the business currently conducted by Lima Holdco, (ii) does not engage in any business other than the ownership and/or leasing of such Property and the Personal Property and the operation of the Business thereon, (iii) does not hold, directly or indirectly, any ownership interest (legal or equitable) in any entity or any real or personal property other than the interest in such Property, the Personal Property and the other assets (including ownership interests in entities) incident to the operation of the Business, (iv) has its own separate books, records, accounts, financial statements and tax returns, except that financial statements and/or tax returns of the individual Facility Lessees may be consolidated, (v) holds itself out as being a company separate and apart from any other entity, and (vi) maintains all entity formalities independent of any other entity.

Specified Equity Contribution: As defined in Section 16.1(l)(iii).

State Regulatory Authorities: As applicable to each Facility, the state licensing and certification agencies, together with all applicable statutes and regulations, related to healthcare facilities in each respective state.

Subordination of Management Agreement: A Subordination of Management Agreement, in the form attached to this Lease as ***Exhibit G***.

Subsidiary or Subsidiaries: With respect to any Person (herein referred to as the "parent"), any corporation, partnership, association or other business entity (a) that is, at the time any determination is made, Controlled By the parent or one or more subsidiaries of the parent or by the parent and one or more subsidiaries of the parent, (b) of which securities or other ownership interests representing at least 50% of the economic interests or at least 50% of the ordinary voting power (or board representation, including through block voting arrangements) or at least 50% of the general partnership interests are, at the time any determination is being made, directly or indirectly, owned, Controlled By or held by the parent or one or more subsidiaries of the parent or by the parent and one or more subsidiaries of the parent or (c) the financial results of which are (or are expected to be) consolidated with those of LifePoint and its Subsidiaries in the financial statements of LifePoint and its Subsidiaries delivered hereunder; *provided* that, for purposes of

determining compliance with Section 16.1(l) hereof, any such Person described under clauses (b) and (c) above may be determined to be or not be a "Subsidiary" at the option of Lima Holdco upon delivery of a notice of such election to the Lessor.

Substitute Letter of Credit: As defined in Section 39.15.

Substitute Property: With respect to any Property, a fee interest in land and improvements thereon which may be included in the Property Substitution, with respect to which: (i) such improvements consist solely of a hospital location (the "**Replacement Property**"), and which may also include medical office buildings, clinics and other improvements either necessary for or commonly associated with the operation of a Replacement Property or consented to by Lessor in its sole and absolute discretion; (ii) financial records pertaining to such operations (which records will include audited financial statements if available) shall have been made available to Lessor; (iii) all certificates of need, permits, approvals and authorizations pertaining to ownership and operation of such land and improvements as Replacement Property shall be in full force and effect, free of material defaults or notices of material default; (iv) neither the Property Substitution nor the utilization of such land and improvements in a Property Substitution will result in the realization of taxable income or gain to MPT or its Equity Constituents under the Code, as determined by MPT in its sole discretion; and (v) neither the Property Substitution nor the utilization of such land and improvements in a Property Substitution will jeopardize MPT's status as a qualified real estate investment trust under the Code, as determined by MPT in its sole discretion.

Taking: A taking or voluntary conveyance during the Term of all or part of any Property, or any interest therein or right accruing thereto or use thereof, as the result of, or in settlement of, any Condemnation or other eminent domain proceeding affecting such portion of the Leased Property whether or not the same shall have actually been commenced.

Tenant(s): The lessees, tenants, sublessees or subtenants under the Tenant Leases, if any.

Tenant Leases: All leases, subleases, and other rental agreements (written or verbal, now or hereafter in effect), if any, including any Existing Subleases as described in Section 23.1, pursuant to which any Facility Lessee has granted or will grant a possessory interest in and to any space in or any part of the Leased Property, or that otherwise provide rights with respect to the Leased Property, and all Credit Enhancements, if any, held in connection therewith.

Term: With respect to a particular Property, the actual duration of this Lease, including the Fixed Term and the Extension Terms (if extended by Lessee).

Terminated Property: As defined in Section 16.1D.

Texas Property: Collectively, the Palestine Property and any New Property located in the State of Texas.

Third Party Offer: As defined in Section 34.2(a).

Third Party Offer Notice: As defined in Section 34.2(a).

Transactions: The transactions contemplated by the Purchase Agreement.

Unsuitable for Its Use or Unsuitable for Its Primary Intended Use: As used anywhere in this Lease, the terms "Unsuitable for Its Use" or "Unsuitable for Its Primary Intended Use" shall mean that, with respect to any Property or part thereof, by reason of damage or destruction or a partial Taking by Condemnation, such Property cannot be operated on a commercially practicable basis for its Primary Intended Use, taking into account, all relevant factors (including, without limitation, anticipated repairs and/or restorations), and the effect of such damage or destruction or partial Taking, and which shall be as determined by Lessor, in its reasonable discretion.

USPAP: The Uniform Standards of Professional Appraisal Practice, as amended from time to time.

Vacated Property: As defined in Section 16.1A.

1.2. **Interpretation; Terms Generally**. The definitions set forth in Section 1.1 and elsewhere in this Lease shall apply equally to both the singular and plural forms of the terms defined. Whenever the context may require, any pronoun shall include the corresponding masculine, feminine and neuter forms. Unless otherwise indicated, the words "include", "includes" and "including" shall be deemed to be followed by the phrase "without limitation." The words "herein", "hereof" and "hereunder" and words of similar import shall be deemed to refer to this Lease (including the Schedules and Exhibits) in its entirety and not to any part hereof, unless the context shall otherwise require. All references herein to Articles, Sections, Schedules and Exhibits shall be deemed to refer to Articles, Sections and Schedules of, and Exhibits to, this Lease, unless the context shall otherwise require. Unless the context shall otherwise require, any references to any agreement or other instrument or statute or regulation are to it as amended and supplemented from time to time (and, in the case of a statute or regulation, to any corresponding provisions of successor statutes or regulations). Any reference in this Lease to a "day" or number of "days" that does not refer explicitly to a "Business Day" or "Business Days" shall be interpreted as a reference to a calendar day or number of calendar days. If any action or notice is to be taken or given on or by a particular calendar day, and such calendar day is not a Business Day, then such action or notice shall be deferred until, or may be taken or given on, the next Business Day. For all purposes hereunder, whenever reference is made to "continuance" or "continuation" of an Event of Default (or words of similar import), such reference shall mean that the relevant Event of Default has not been waived in writing by the Lessor (or Affiliate of Lessor) or (as to any Event of Default that is subject to cure) cured within the applicable cure period.

1.3. **Accounting Terms**. All accounting terms not specifically defined herein shall be construed in accordance with GAAP. Defined terms and calculations in connection with the covenants and other provisions of this Lease, including Section 16.1(l), shall be based upon and utilize GAAP applied in a manner consistent with that used in preparing the financial statements referred to in Article XXIV(b)(i)-(iii). If at any time any change in GAAP would affect the computation of any financial ratio or requirement set forth in this Lease, and Lessee shall so request, Lessor and Lessee shall negotiate in good faith to amend such ratio or requirement to preserve the original intent thereof in light of such change in GAAP; *provided, that*, until so amended, (a) such ratio or requirement shall continue to be computed in accordance with GAAP prior to such change therein and (b) Lessee shall provide to Lessor financial statements and other

documents required under this Lease or as reasonably requested hereunder setting forth a reconciliation between calculations of such ratio or requirement made before and after giving effect to such change in GAAP. Notwithstanding the foregoing, (x) all financial statements delivered hereunder shall be prepared, and all financial covenants contained herein shall be calculated, without giving effect to an election under Statement of Financial Accounting Standards 159 (or any similar accounting principal) permitting a Person to value its financial liabilities at the fair market value thereof, and (y) any obligations of a Person under a lease (whether now existing or entered into in the future) that is not (or would not be) a finance obligation under GAAP as in effect on the Commencement Date, shall not be treated as a finance obligation solely as a result of the adoption of changes in GAAP outlined by Leases, Topic 842, issued as Accounting Standards Update No. 2016-02 in February 2016.

1.4. **Certain Matters Relating to References to Leased Property**. References herein to "a portion" of the Leased Property (or words or phrases of similar import) shall mean, unless the context clearly indicates otherwise, a specific Property.

ARTICLE II.
LEASED PROPERTY; TERM

Upon and subject to the terms and conditions hereinafter set forth, Lessor leases to Lessee and Lessee rents from Lessor all of Lessor's rights and interest in and to the following property (collectively, and as modified from time to time pursuant to the terms of this Lease, the "**Leased Property**"):

(a) the Land; and

(b) the existing improvements on the Land and the buildings and any improvements constructed on the Land, including, but not limited to, all buildings, structures, Fixtures and other improvements of every kind, alleyways and connecting tunnels, sidewalks, utility pipes, conduits and lines (on-site and off-site), parking areas and roadways appurtenant to such buildings and structures presently or hereafter situated upon the Land, Capital Additions and all hereditaments, easements, rights of way and other appurtenances related thereto, but excluding the Ground Leased MOB Improvements (collectively, the "**Leased Improvements**").

SUBJECT, HOWEVER, to all applicable matters of record and any other matters as set forth on ***Exhibits B-1*** *et seq.* (the "**Permitted Exceptions**"), Lessee shall have and hold the Leased Property for a fixed term (the "**Fixed Term**") commencing on the Commencement Date and ending at midnight on the last day of the Two Hundred Fortieth (240th) full month after the Effective Date, unless sooner terminated as herein provided.

So long as no Event of Default then exists and no event has then occurred which with the giving of notice or the passage of time or both would constitute such an Event of Default, Lessee shall have the option to extend the Fixed Term on the same terms and conditions set forth herein for two (2) additional periods of five (5) years each (each, an "**Extension Term**"), which extension option may be exercised solely with respect to all of the Properties. Lessee may exercise each such option by giving written notice to Lessor at least one hundred eighty (180) days prior to the expiration of the Fixed Term or Extension Term, as applicable (the "**Extension Notice**"). If, during

the period following the delivery of the Extension Notice to Lessor and prior to the effective date of such extension, an Event of Default shall occur which is continuing on the commencement date of the Extension Term, at Lessor's option, the Term shall not be so extended and Lessee shall be deemed to have forfeited all subsequent options to extend the Fixed Term of this Lease. If Lessee elects not to exercise its option to extend as herein provided, all subsequent options to extend shall be deemed to have lapsed and be of no further force or effect.

Notwithstanding the foregoing, this Lease is expressly made subject to the terms and conditions of the Pass-Through Leases, copies of which have been provided to Lessee prior to the execution hereof. Notwithstanding anything to the contrary contained in this Lease, if (a) during the Term, any of the Pass-Through Leases expires by its terms, without Lessor or Lessee being able to negotiate an extension of the respective terms thereof acceptable to the parties, or (b) Lessor rejects any of the Pass-Through Leases in a bankruptcy proceeding, the Base Rent shall be reduced in accordance with Section 5.2. To the extent any of the Pass-Through Leases has any renewal options that cover a period during the Term, Lessee and Lessor agree that Lessor shall exercise such renewal options.

ARTICLE III.
RENT

3.1. **Rent**. During the Term, Lessee shall pay to Lessor, in advance and without notice, demand, set off or counterclaim, in lawful money of the United States of America, at Lessor's address set forth herein or at such other place or to such other person, firm or entity as Lessor may designate from time to time in writing in accordance with Article XXXII, the Rent as provided in this Lease. Lessor has the sole discretion to determine the method of payment of Rent, and will require that such payments initially be forwarded to Lessor utilizing the Automated Clearing House ("**ACH**") Network. Lessee shall take all reasonably necessary steps and bear any and all reasonable costs associated with utilizing ACH to timely deliver payments of Rent to Lessor. All payments of Rent made through ACH remain payments of Rent and, as such, are subject to all terms and conditions of this Lease, including, but not limited to, the default provisions. With respect to each Facility, Rent shall be calculated and payable as follows:

(a) **Allocated Base Rent**. With respect to each Property, subject to adjustment as provided herein (including adjustments set forth in Section 3.1(b) below), Lessee shall pay to Lessor in advance on the first (1st) day of each calendar month during the Term base rent allocated thereto (the "**Allocated Base Rent**") in an amount equal to the product of (i) the Lease Base for such Property as of the last day of the immediately preceding month (or as of the Commencement Date with respect to the amount payable for the first month of the Term), multiplied by (ii) the Lease Rate, divided by (iii) twelve (12); *provided, however*, if the Commencement Date with respect to such Property is other than the first day of a calendar month, Allocated Base Rent for the period from the Commencement Date for such Property to the first day of the first (1st) full month shall be prorated on a per diem basis based upon three hundred sixty (360) days and shall be paid on the Commencement Date. Lessor and Lessee acknowledge that the Allocated Base Rent is payable in advance and, accordingly, with respect to additions to the Lease Base and Capital Additions funded by Lessor with respect to any Property on or after the first (1st) day of any month (and, therefore, not included in the calculation of the Allocated Base Rent paid in advance for a particular month with respect to such Property), Allocated Base Rent shall include

a per diem Allocated Base Rent for the prior month (prorated based upon a three hundred sixty (360) day year in the same manner as set forth above) to be calculated by multiplying the amount of any such advance by the Lease Rate for such Property. Lessor shall provide Lessee with an invoice of such amounts prior to the first day of the next calendar month (the "**Interim Capital Addition Rent**"); *provided, however*, Lessor's failure to provide Lessee with an invoice for the Interim Capital Addition Rent relating to any Property prior to the first day of the next calendar month shall not limit or affect the Lessee's obligations hereunder to pay such Interim Capital Addition Rent. Allocated Base Rent and Interim Capital Addition Rent relating to each Property shall be payable in advance in equal, consecutive monthly installments.

(b) **Adjustment of Allocated Base Rent**. With respect to each Property, commencing on January 1, 2021, and continuing on each January 1 thereafter (each an "**Adjustment Date**") during the Term, the Lease Rate applicable to such Property shall be increased (and in no event decreased) and shall be determined as follows:

(i) On the first Adjustment Date, the Lease Rate applicable to such Property shall be increased (and in no event decreased) and shall equal to (A) the Lease Rate for such Property previously in effect, and (B) the product of such previous Lease Rate multiplied by the percentage by which the CPI published for the month of October 2020 shall have increased over the CPI figure published for the month of October 2019; and

(ii) on each Adjustment Date thereafter (except with respect to the first year of an Extension Term if the Allocated Base Rent with respect to such Property is reset pursuant to Section 3.1(c)(i)), the Lease Rate applicable to such Property shall be increased (and in no event decreased) and shall equal to the sum of (A) the Lease Rate for such Property previously in effect, and (B) the product of such previous Lease Rate multiplied by the greater of (1) Two Percent (2.0%); provided, however, that in no event shall the increase under this clause (B) be greater than four percent (4%) on any Adjustment Date; and (2) the percentage by which the CPI published for the month of October prior to the applicable Adjustment Date shall have increased over the CPI figure published for the month of October prior to the previous Adjustment Date.

The foregoing escalators used in calculating the adjusted Lease Rate are herein referred to as the "**Escalator**". For any monetary increases or adjustments that cannot be determined as of the applicable Adjustment Date due to then unknown variables (such as CPI), such amounts shall become due (and calculated retroactively to the Adjustment Date) and payable as of the time of determination.

(c) **Adjustment of Allocated Base Rent on the First Day of Each Extension Term**. On the first (1st) day of each Extension Term, the Allocated Base Rent for each Property shall be reset to the greater of:

(i) the Fair Market Value Rent for such applicable Property; and

(ii) the Allocated Base Rent paid by Lessee for such Property during (A) the last year of the Fixed Term (if determining the Base Rent for the first (1st) Extension Term) or (B) the last year of the first (1st) Extension Term (if determining the Base Rent for second (2nd) Extension Term), as applicable, as increased pursuant to Section 3.1(b)(ii) as of such first (1st) day of such Extension Term;

in either case, subject to increase on the next succeeding Adjustment Date and each Adjustment Date thereafter as set forth in Section 3.1(b)(ii).

(d) For any monetary increases or adjustments that cannot be determined as of the applicable Adjustment Date due to then unknown variables (such as CPI), such amounts shall become due (and calculated retroactively to the Adjustment Date) and payable as of the time of determination.

(e) **Rent Schedule**. From time to time during the Term, Lessor may, in its reasonable discretion, calculate the Base Rent and Interim Capital Addition Rent payable hereunder (the "**Rent Schedule**"), and provide a copy of such Rent Schedule to Lessee. Base Rent, as calculated in accordance with Sections 3.1(a), 3.1(b) and 3.1(c) above, shall include Interim Capital Addition Rent and Allocated Base Rent payable with respect to the entire Leased Property. The Rent Schedule shall be adjusted and substituted on a periodic basis by Lessor, in its reasonable discretion, as the Interim Capital Addition Rent and Base Rent are adjusted and calculated during the Term as provided herein and a copy thereof shall be provided to Lessee. Lessor's failure to provide a copy of the Rent Schedule or substitute or adjusted Rent Schedule shall not limit or affect the Lessee's obligations hereunder.

3.2. **Additional Charges**. In addition to the Base Rent that Lessee assumes or agrees to pay under this Lease, (a) Lessee will pay and discharge as and when due and payable other amounts, liabilities, obligations and Impositions related to the ownership, use, possession and operation of the Leased Property, including, without limitation, all costs of owning and operating each Facility, all Real Estate Taxes, Insurance Premiums, maintenance and capital improvements, all violations of and defaults under any of the Permitted Exceptions, and all licensure violations, civil monetary penalties and fines, and (b) in the event of any failure on the part of Lessee to pay any of those items referred to in clause (a) above, Lessee will also promptly pay and reimburse Lessor, and/or its Affiliates for all such amounts paid by Lessor, and/or its Affiliates and promptly pay and discharge every fine, penalty, interest and cost which may be added for non-payment or late payment of such items (the items referred to in clauses (a) and (b) above being referred to herein collectively as the "**Additional Charges**"), and Lessor shall have all legal, equitable and contractual rights, powers and remedies provided in this Lease, by statute, or otherwise, in the case of non-payment of the Additional Charges, as in the case of the Base Rent. If any installment of Base Rent or Additional Charges shall not be paid within five (5) Business Days after the applicable due date, Lessee, in addition to all other obligations hereunder, will pay to Lessor on demand as Additional Charges, a late charge computed at the Overdue Rate on the amount of such installment from the due date of such installment to the date of payment thereof, and a Late Payment Penalty with respect to such installment. To the extent that Lessee pays any Additional Charges to Lessor pursuant to clause (b) above or pursuant to any other requirement of this Lease,

Lessee shall be relieved of its obligation to pay such Additional Charges to the entity to which they would otherwise be due. Nothing in this Section 3.2 limits the provisions of Article XXII.

3.3. **Rent and Payments under the Pass-Through Leases**. Lessee shall pay all of the Pass-Through Lease Rent during the Term directly to the respective "landlord" or "lessor" under the applicable Pass-Through Lease as and when the same becomes due and payable as required thereunder, and Lessee shall provide Lessor with reasonable evidence of payment each month confirming that the Pass-Through Lease Rent has been timely paid.

ARTICLE IV.
IMPOSITIONS

4.1. **Payment of Impositions**. Subject to and without limiting Article XII relating to permitted contests, Lessee will pay, or cause to be paid, all Impositions before any fine, penalty, interest or cost may be added for non-payment, with such payments to be made directly to the taxing or assessing authorities, and Lessee will promptly furnish to Lessor copies of official receipts or other satisfactory proof evidencing such payments. Lessee's obligation to pay such Impositions shall be deemed absolutely fixed upon the date that any such Imposition becomes a lien upon the Leased Property or any part thereof. Lessor shall promptly notify and provide Lessee any correspondence or documentation received from a taxing or assessing authority that relates to a paid or unpaid Imposition. If any such Imposition may lawfully be paid in installments (whether or not interest shall accrue on the unpaid balance of such Imposition), Lessee may, with Lessor's consent, not to be unreasonably withheld, conditioned, or delayed, exercise the option to pay the same (and any accrued interest on the unpaid balance of such Imposition) in installments and, in such event, shall pay such installments during the Term (subject to and without limiting Lessee's right of contest pursuant to the provisions of Article XII) as the same respectively become due. Lessor, at its expense, shall, to the extent permitted by applicable law, prepare and file all tax returns and reports as may be required by governmental authorities in respect of Lessor's net income (however denominated), gross receipts, franchise taxes and taxes on its capital stock, and Lessee, at its expense, shall, to the extent permitted by applicable laws and regulations, prepare and file all other tax returns and reports in respect of any Imposition as may be required by governmental authorities during the Term. If any refund shall be due from any taxing authority with respect to any Imposition paid by Lessee, the same shall be paid over to, or retained by, Lessee. Lessor and Lessee shall, upon request of the other, provide any data (i) that is maintained by the party to whom the request is made, and (ii) that pertains to the Leased Property, as may be necessary to prepare any required returns and reports. In the event that any Governmental Body classifies any property covered by this Lease as personal property, Lessee shall file all personal property tax returns in such jurisdictions where it may legally so file. Lessor, to the extent it possesses the same, and Lessee, to the extent it possesses the same, will provide the other party, upon request, with cost and depreciation records necessary for filing returns for any property so classified as personal property. In the event that Lessor is legally required to file personal property tax returns, Lessee will be provided with copies of assessment notices indicating a value in excess of the reported value in sufficient time for Lessee to file a protest. After obtaining written approval from Lessor, which approval shall not to be unreasonably withheld, conditioned or delayed, Lessee may, at Lessee's sole cost and expense, protest, appeal, or institute such other proceedings as Lessee may deem appropriate to effect a reduction of real estate or personal property assessments, and Lessor, at Lessee's expense as aforesaid, shall fully cooperate with Lessee in such protest,

appeal, or other action. Billings for reimbursement by Lessee to Lessor of personal property taxes shall be accompanied by copies of a bill therefor and payments thereof which identify the personal property with respect to which such payments are made.

4.2. **Adjustment of Impositions**. Impositions that are levied or assessed with respect to the tax-fiscal period during which the Term terminates, shall be adjusted and prorated between Lessor and Lessee, whether or not such Imposition is imposed before or after such termination, and Lessee's obligation to pay its prorated share thereof shall survive such termination.

4.3. **Utility Charges**. Lessee will contract for, in its own name, and will pay or cause to be paid all charges for electricity, power, gas, oil, sewer, water and other utilities used in connection with the Leased Property during the Term, including, without limitation, all impact and tap fees necessary for the operation of the Facilities, except to the extent that such impact and tap fees were or are to be paid by Lessor as part of the cost of a Capital Addition.

4.4. **Insurance Premiums**. Lessee shall contract for, in its own name, and shall pay or cause to be paid all premiums for the insurance coverage required to be maintained pursuant to Article XIII during the Term (the "**Insurance Premiums**").

ARTICLE V.
ABSOLUTE NET LEASE; NO TERMINATION; TERMINATION WITH RESPECT TO FEWER THAN ALL PROPERTIES

5.1. **Absolute Net Lease; No Termination**. The parties understand, acknowledge and agree that this is an absolute net lease and this Lease shall yield to Lessor the full amount of the installments of Base Rent and the payments of Additional Charges throughout the Term. Lessee further acknowledges and agrees that all charges, assessments or payments of any kind are due and payable without notice, demand, set off or counterclaim (other than notices to Lessee that are expressly required hereunder) and shall be paid by Lessee as they become due and payable. Lessee shall remain bound by this Lease in accordance with its terms and shall neither take any action without the consent of Lessor to modify, surrender or terminate the same, nor seek nor be entitled to any abatement, deduction, deferment or reduction of Rent (except as expressly provided herein), or set-off against the Rent, nor shall the respective obligations of Lessor and Lessee be otherwise affected by reason of (a) any damage to, or destruction of, any Property from whatever cause or any Taking of any Property or any portion thereof (except as expressly provided herein), (b) the lawful or unlawful prohibition of, or restriction upon, Lessee's use of the Leased Property, or any portion thereof, or the interference with such use by any person, corporation, partnership or other entity, or by reason of eviction by paramount title; (c) any claim which Lessee has or might have against Lessor or by reason of any default or breach of any warranty by Lessor under this Lease or any other agreement between Lessor and Lessee, or to which Lessor and Lessee are parties, (d) any bankruptcy, insolvency, reorganization, composition, readjustment, liquidation, dissolution, winding up or other proceedings affecting Lessor or any assignee or transferee of Lessor, or (e) any other cause whether similar or dissimilar to any of the foregoing other than a discharge of Lessee from any such obligations as a matter of law. Lessee hereby specifically waives all rights, arising from any occurrence whatsoever, which may now or hereafter be conferred upon it by law to (i) modify, surrender or terminate this Lease or quit or surrender the Leased Property or any portion

thereof, or (ii) entitle Lessee to any abatement, reduction, suspension or deferment of the Rent or other sums payable by Lessee hereunder, except as otherwise specifically provided in this Lease. The obligations of Lessor and Lessee hereunder shall be separate and independent covenants and agreements and the Rent and all other sums payable by Lessee hereunder shall continue to be payable in all events unless the obligations to pay the same shall be terminated pursuant to the express provisions of this Lease or by termination of this Lease other than by reason of an Event of Default.

5.2. **Termination with Respect to Fewer than All Properties**. Wherever in this Lease the action of terminating this Lease with respect to a particular Property (or action of similar import) is described or permitted, such action shall mean the termination of Lessee's rights in and to such Property. Notwithstanding anything in this Lease to the contrary, if this Lease shall be terminated by Lessor or Lessee pursuant to rights granted hereunder with respect to any particular Property, such termination shall not affect the Term of this Lease with respect to the balance of the Leased Property relating to Properties not so terminated and this Lease shall continue in full force and effect with respect to such portion of the Leased Property, except that (a) the total Base Rent payable hereunder shall be reduced by the amount of Allocated Base Rent with respect to the Property as to which this Lease has been so terminated, (b) all references herein to Leased Property shall thereafter no longer include such terminated Property, (c) the terminated Property shall no longer be leased hereunder, (d) so long as no Event of Default then exists, and no event has then occurred which with the giving of notice or the passage of time or both would constitute such an Event of Default, the unapplied portion of the Allocated Reserve with respect to such Property shall be returned to the applicable Facility Lessee; and (e) *provided that* all of Lessee's obligations hereunder with respect to such portion of the Leased Property (excluding unasserted contingent indemnification obligations) have been paid in full to Lessor, the relevant Facility Lessee shall no longer be a Facility Lessee hereunder or a party hereto with respect to such Property (and for the avoidance of doubt, if all Properties of a Facility Lessee shall have been so terminated, such Facility Lessee shall no longer be a Facility Lessee hereunder or a party hereto); subject, however, to Lessor's right, in the event of any such termination because of an Event of Default, to recover damages with respect to any such terminated Property.

ARTICLE VI.
OWNERSHIP OF LEASED PROPERTY AND PERSONAL PROPERTY

6.1. **Ownership of the Leased Property**. Lessee acknowledges that: (a) the Owned Land and owned Improvements located thereon are the property of Lessor and that Lessee has only the right to possession and use thereof as a lessee of Lessor and upon and subject to the terms, provisions and conditions of this Lease, (b)(i) the Leased Improvements owned by Lessor and that are located on the Pass-Through Lease Land subject to each Pass-Through Lease will revert to the applicable "landlord" or "lessor" thereunder upon the respective expirations of the Pass-Through Leases, and (ii) Lessee has only the right to the possession and use of the Pass-Through Lease Land and any Improvements located thereon as a sublessee of Lessor and upon and subject to the terms, provisions and conditions of this Lease, the Pass-Through Leases, and the Existing Subleases, and (c) the portions of the Owned Land that are subject to the MOB Ground Leases are subject to the rights of the "tenant" or "lessee" thereunder and the Ground Leased MOB Improvements are owned by each such "tenant" or "lessee" until the respective expirations of the MOB Ground Leases.

6.2. **Lessee's Personal Property**. Lessee, at its expense, shall install, affix, assemble and place on the Leased Property the Lessee's Personal Property. Lessee shall provide and maintain during the entire Term all such Lessee's Personal Property as shall be necessary to operate each Property in compliance in all material respects with all licensure and certification requirements, in compliance in all material respects with all applicable Legal Requirements and Insurance Requirements, and otherwise substantially in accordance with customary practice in the industry for the Primary Intended Use. Following the expiration or earlier termination of this Lease with respect to any one or more of the Properties and subject to Lessor's option to purchase such Lessee Personal Property as provided in Section 34.1, Lessee agrees that all of Lessee's Personal Property relating to such one or more Properties not removed by Lessee within fifteen (15) days following the expiration or earlier termination of this Lease with respect thereto shall be considered abandoned by Lessee and may be appropriated, sold, destroyed or otherwise disposed of by Lessor (at Lessee's cost) with prior written notice thereof to Lessee, without any payment to Lessee and without any obligation to Lessee to account therefor. Lessee will, at its expense, restore the Leased Property and repair all damage to the Leased Property caused by the installation or removal of Lessee's Personal Property, ordinary wear and tear excepted, whether affected by Lessee, Lessor, any Lessee lender, or any Facility Lender, unless caused by the gross negligence or willful misconduct of Lessor or any Facility Lender. Lessee shall have the right to create a security interest in the Lessee's Personal Property in favor of any lender of Lessee, and Lessor hereby waives any liens on (all rights to assert any lien on) any of Lessee's Personal Property. Lessor hereby agrees that Lessee's lender may enter onto the Leased Property and take possession of the Lessee's Personal Property in accordance with the Intercreditor Agreement and in such a manner as to not unreasonably disrupt the normal operations of the applicable Property; *provided, that*, Lessee, at its sole cost and expense, shall be liable to repair any damage or destruction caused to the Leased Property by Lessee's lender or its representatives in connection therewith.

ARTICLE VII.
CONDITION AND USE OF LEASED PROPERTY

7.1. **Condition of the Leased Property**. Lessee acknowledges receipt and delivery of possession of the Leased Property and that Lessee has examined and otherwise has acquired knowledge of the condition of the Leased Property prior to the execution and delivery of this Lease and has found the same to be in good order and repair and satisfactory for its purpose hereunder. Lessee is leasing the Leased Property "as is" and "where is" in its present condition. Lessee has not relied on any representation or warranty by Lessor and hereby waives any claim or action against Lessor in respect of the condition of the Leased Property. LESSOR MAKES NO WARRANTY OR REPRESENTATION, EXPRESS OR IMPLIED, IN RESPECT OF THE LEASED PROPERTY OR ANY PART THEREOF, EITHER AS TO ITS FITNESS FOR USE, SUITABILITY, DESIGN OR CONDITION FOR ANY PARTICULAR USE OR PURPOSE OR OTHERWISE, AS TO QUALITY OF THE MATERIAL OR WORKMANSHIP THEREIN, LATENT OR PATENT, IT BEING AGREED THAT ALL SUCH RISKS ARE TO BE BORNE BY LESSEE. LESSEE ACKNOWLEDGES THAT THE LEASED PROPERTY HAS BEEN INSPECTED BY LESSEE AND IS SATISFACTORY TO IT. ACCORDINGLY, LESSEE HEREBY ACKNOWLEDGES THAT LESSOR HAS NOT MADE AND WILL NOT MAKE, NOR SHALL LESSOR BE DEEMED TO HAVE MADE ANY WARRANTY OR

REPRESENTATION, WHETHER EXPRESS OR IMPLIED, INCLUDING WITHOUT LIMITATION, ALL WARRANTIES THAT THE LEASED PROPERTY IS FREE FROM VICES, DEFECTS AND DEFICIENCIES, WHETHER HIDDEN OR APPARENT OR ANY WARRANTY AS TO THE FITNESS, DESIGN OR CONDITION OF THE LEASED PROPERTY FOR ANY PARTICULAR USE OR PURPOSE OF SUCH LEASED PROPERTY. THE PROVISIONS OF THIS SECTION 7.1 HAVE BEEN NEGOTIATED, AND ARE INTENDED TO BE A COMPLETE EXCLUSION AND NEGATION OF ANY WARRANTIES BY LESSOR, EXPRESS, IMPLIED OR CREATED BY APPLICABLE LAW, WITH RESPECT TO THE CONDITION OF THE LEASED PROPERTY.

7.2. **Use of the Leased Property**. Each (a) Property (other than any portions thereof that are Ground Leased MOB Property) that, as of the applicable Commencement Date, is being operated as a licensed hospital facility shall be operated as a licensed hospital facility, (b) other Property (other than any portions thereof that are Ground Leased MOB Property) shall be operated for such ancillary healthcare purposes related thereto in a manner consistent with its use as of the applicable Commencement Date, and (c) Ground Leased MOB Property shall be operated as a professional medical office building, and, in each case, for such other legal ancillary uses as may be necessary in connection with or incidental to such uses and, in each case, subject to all covenants, restrictions, easements and all other matters of record (including those set forth in the Permitted Exceptions) relating to the applicable Property (collectively, the "**Primary Intended Use**"). Lessee shall comply in all material respects with all Legal Requirements and shall maintain all Licenses and Participation Agreements that are necessary for the operation of Business with respect to the applicable Property consistent with the Primary Intended Use; provided, however, Lessee shall not be required to maintain any Participation Agreements unless such agreements are required for participation in Medicare and Medicaid programs.

(a) Except as expressly authorized herein, Lessee shall not use any Property for any use other than as provided herein, nor, with respect to Properties that are being operated as licensed hospital facilities, change the number or type of beds within any Facility, in either case, to the extent such change in use or decrease has a material adverse effect on the Primary Intended Use or the ability of the Lessee to meet its obligations under this Lease without the prior written consent of Lessor, not to be unreasonably withheld, conditioned or delayed.

(b) No use shall be made or permitted to be made of the Leased Property and no acts shall be done which will cause the cancellation of any insurance policy covering the Leased Property or any part thereof, nor shall Lessee sell or otherwise provide to residents or patients therein, or permit to be kept, used or sold in or about the Leased Property any article which is prohibited by law or by the standard form of fire insurance policies, any other insurance policies required to be carried hereunder, or fire underwriters regulations. Lessee shall, at its sole cost, comply in all material respects with all of the requirements, covenants and restrictions pertaining to the Leased Property, including, without limitation, all of the Permitted Exceptions, and other requirements of any insurance board, association, organization or company necessary for the maintenance of the insurance, as herein provided, covering the Leased Property and Lessee's Personal Property.

(c) Lessee shall continuously operate the portions of the Leased Property operated as licensed general acute care hospital facilities or critical access hospitals only in

accordance with the Primary Intended Use and as a provider of goods and services incidental thereto.

(d) Lessee shall not commit or suffer to be committed any waste on the Leased Property, or in any of the Facilities, nor shall Lessee cause or permit any nuisance thereon.

(e) Lessee shall neither suffer nor permit the Leased Property or any portion thereof, including any Capital Addition whether or not funded by Lessor, or Lessee's Personal Property, to be used in such a manner as (i) might reasonably tend to impair Lessor's (or Lessee's, as the case may be) title thereto or to any portion thereof, or (ii) may reasonably make possible a claim or claims of adverse usage or adverse possession by the public, as such, or of implied dedication of the Leased Property or any portion thereof.

(f) With respect to each Property, Lessor shall have the right and option to erect a sign on such Property stating that such Property is owned by Lessor. Such sign shall be in a size, and shall be erected in a location acceptable to Lessor and approved by Lessee, which approval shall not be unreasonably withheld, conditioned or delayed. Lessor shall be responsible for all costs related to such signage and complying with all Legal Requirements with respect to such signage.

7.3. **Lessor to Grant Easements**. From time to time during the Term, upon the request of Lessee, and so long as no Event of Default then exists, and no event has then occurred which with the giving of notice or the passage of time or both would constitute such an Event of Default, Lessor may, in its reasonable discretion, subject to the terms of the Pass-Through Leases (if applicable) and at Lessee's cost and expense, (a) grant easements and other rights in the nature of easements, (b) release existing easements or other rights in the nature of easements which are for the benefit of the Leased Property or any portion thereof; (c) dedicate or transfer unimproved portions of the Leased Property for road, highway or other public purposes; (d) execute petitions to have the Leased Property or any portion thereof annexed to any municipal corporation or utility district; (e) execute amendments to any covenants and restrictions affecting the Leased Property or any portion thereof; and (f) execute and deliver to any person any instrument appropriate to confirm or effect such grants, releases, dedications and transfers (to the extent of its interest in the Leased Property), but only upon delivery to Lessor of such information as Lessor may reasonably require confirming that such grant, release, dedication, transfer, petition or amendment is required for, and not materially detrimental to, the proper conduct of the Primary Intended Use on the Leased Property and does not reduce the value of the Leased Property or any portion thereof.

ARTICLE VIII.
LEGAL AND INSURANCE REQUIREMENTS

8.1. **Compliance with Legal and Insurance Requirements**. Subject to Article XII relating to permitted contests, Lessee, at its expense, (a) shall comply in all material respects with all Legal Requirements and Insurance Requirements applicable to Lessee and the use, operation, maintenance, repair and restoration of the Facilities and the Leased Property, whether or not compliance therewith shall require structural change in any of the Leased Improvements or interfere with the use and enjoyment of the Leased Property; (b) shall not use the Leased Property and Lessee's Personal Property for any unlawful purpose; (c) shall procure, maintain and comply

in all material respects with all Licenses and other governmental approvals and authorizations required for any use of the Leased Property and Lessee's Personal Property then being made, and for the proper erection, installation, operation and maintenance of the Leased Property or any part thereof, including, without limitation, any Capital Additions; and (d) shall use its commercially reasonable efforts consistent with its rights under the Tenant Leases to cause all Tenants to acquire and maintain all licenses, certificates, permits, provider agreements and other authorizations and approvals necessary to operate in its customary manner any portion of the Leased Property subleased to them for the Primary Intended Uses and any other uses conducted on the Leased Property as may be permitted from time to time hereunder, it being acknowledged by Lessor that any failure by any Tenant under this clause (d) shall not cause (or be deemed to cause) a breach by Lessee of this Section 8.1 unless Lessee has so failed to use commercially reasonable efforts. Lessee's use of the Leased Property, the use of all Lessee's Personal Property used in connection with the Leased Property, and the maintenance, alteration, and operation of the same, and all parts thereof, shall at all times conform in all material respects to all Legal Requirements. Upon Lessor's request, Lessee shall deliver to Lessor copies of all such Licenses and other approvals and authorizations. Lessee shall indemnify and defend, at Lessee's sole cost and expense, and hold Lessor, its Affiliates and their respective successors and assigns harmless from and against and agrees to reimburse Lessor, its Affiliates and their respective successors and assigns with respect to any and all claims, demands, actions, causes of action, losses, damages, liabilities, costs and expenses (including, without limitation, reasonable attorneys' fees and court costs) of any and every kind or character, known or unknown, fixed or contingent, asserted against or incurred by Lessor, its Affiliates and their respective successors and assigns, at any time and from time to time by reason or arising out of any breach by Lessee or any Person other than MPT Indemnified Parties of any of the provisions of this Article VIII or any breach or violation by Lessee or any Person other than MPT Indemnified Parties of any Legal Requirements, including any and all such claims, demands, liabilities, damages, costs and expenses relating to immaterial violations or breaches of this Section 8.1, except to the extent arising solely as a result of the gross negligence or willful misconduct of Lessor or its Affiliates.

8.2. **Hazardous Materials**.

(a) Lessee shall ensure that the Leased Property and the operation of the Business thereon complies in all material respects with all Hazardous Materials Laws. Except for Hazardous Materials generated, used, installed, manufactured, treated, handled, refined, produced, processed, stored or disposed of in the normal course of business regarding the Primary Intended Use or the conduct of the Business (which Hazardous Materials shall be handled and disposed of in compliance in all material respects with all Hazardous Materials Laws), Lessee shall not cause any Hazardous Materials to be installed, used, generated, manufactured, treated, handled, refined, produced, processed, stored or disposed of, or otherwise present in, on or under any Property or in connection with the conduct of the Business thereon in a manner that could result in a material violation of any Hazardous Materials Laws. Lessee shall take commercially reasonable precautions to ensure that no activity shall be undertaken on any Property or in connection with the operation of the Business thereon which would cause (a) any Property to become a treatment, storage or disposal facility of hazardous waste, infectious waste, biomedical or medical waste, within the meaning of, or otherwise bring such Property within the ambit of RCRA as a treatment, storage or disposal facility, (b) a release of Hazardous Materials from any Property within the meaning of, or otherwise bring such Property within the ambit of, and as would give rise to material

liability under CERCLA or SARA or any similar Hazardous Materials Laws, (c) the discharge of Hazardous Materials into any watercourse, surface or subsurface of body of water or wetland, or the discharge into the atmosphere of any Hazardous Materials, except as authorized under a permit under any Hazardous Materials Laws, in a manner that would give rise to a material liability under Hazardous Materials Laws, or (d) a material violation or a material claim under RCRA, CERCLA, SARA or any Hazardous Materials Laws. Lessee shall, at its sole cost, expense, risk and liability, remove or cause to be removed from any Property all Hazardous Materials generated in connection with the Primary Intended Use and as found in hospital and healthcare facilities, including, without limitation, all infectious waste materials, syringes, needles and any materials contaminated with bodily fluids of any type, character or description of whatsoever nature to the extent required to comply in all material respects with all Hazardous Materials Laws. Lessee shall not dispose of any such infectious waste and Hazardous Materials in any receptacles used for the disposal of normal refuse to the extent such disposal is not in compliance in all material respects with any Hazardous Materials Laws.

(b) Lessee shall indemnify and defend, at its sole cost and expense, and hold harmless and reimburse the Lessor, its Affiliates and their respective officers, directors, members, (general and limited) partners, shareholders, employees, agents, representatives, successors and assigns (collectively, the "**MPT Indemnified Parties**") from and against any and all claims, demands, actions, causes of action, losses, damages, liabilities, penalties, taxes, costs and expenses (including, without limitation, attorneys' and accountants' fees, settlement costs, arbitration costs and any reasonable other expenses for investigating or defending any action or threatened action) (each, a "**Claim**") of any and every kind or character, known or unknown, fixed or contingent, asserted against or incurred by any of the MPT Indemnified Parties at any time and from time to time by reason of, arising out of or resulting from (i) events, conditions or circumstances which occurred or existed on, under, in, about, to or from the Property prior to execution of this Agreement and that give rise to a liability under Hazardous Materials Laws, (ii) any liability under Hazardous Materials Laws arising out of the ownership or operation of the Property, or (iii) any Claim arising out of or, in connection with or resulting from any breach by Lessee of this Section 8.2 or any other violation of this Section 8.2 by any Person other than the MPT Indemnified Parties, including any and all such claims, demands, liabilities, damages, costs and expenses relating to immaterial violations or breaches of this Section 8.2 (collectively, "**MPT Damages**"), except to the extent any such Claim or MPT Damages is found to have resulted from the bad faith, gross negligence or willful misconduct of any MPT Indemnified Party. All such MPT Damages shall be due and payable by Lessee, jointly and severally, within fifteen (15) days after any MPT Indemnified Party's demand therefor.

(c) In the event any of the MPT Indemnified Parties has a claim for MPT Damages resulting from the assertion of liability by a third party, the applicable Facility Lessor will give Lessee notice of any such third-party claim, and Lessee shall be jointly and severally obligated to undertake the defense thereof by counsel of its own choosing. No Indemnitor shall settle any such third-party claim without the consent of the MPT Indemnified Parties, which consent shall not be unreasonably conditioned or delayed. Any of the MPT Indemnified Parties may, by counsel, participate in such proceedings, negotiations or defense, at their own expense. The MPT Indemnified Parties shall furnish to Lessee in reasonable detail such information as the MPT Parties may have with respect to such claim, including all records and materials that are reasonably required in the defense of such third-party claim. In the event that Lessee does not

collectively defend the third-party claim in a diligent manner, any MPT Indemnified Party will have the right (at Lessee's sole expense) to undertake the defense, compromise or settlement of such claim and any Indemnitor may elect to participate in such proceedings, negotiations or defense at any time at their own expense. No MPT Indemnified Party shall settle any such third-party claim without the consent of Lessee, which consent shall not be unreasonably withheld, conditioned or delayed.

(d) Lessor and Lessee acknowledge that, based upon recent environmental reports relating to the Leased Property, the potential for environmental liability for conditions occurring prior to (or existing as of) the Effective Date for all Facilities is remote; *provided, that* such acknowledgment shall not limit or preclude any Claim by the MPT Indemnified Parties.

8.3. **Healthcare Laws**.

(a) Lessor and Lessee acknowledge and agree that all Rent and other amounts paid hereunder between the parties has been determined by the parties through good-faith and arm's-length bargaining and is believed to represent fair market value for the Leased Property. No payment made under this Lease is contingent on the referral of any patient or any other business. Neither Lessor nor Lessee intends any portion of the payments made under this Lease to influence or reward the referral of any patients or other business that will be paid for from any state or federal health care insurance programs, including Medicare or any state medical assistance program.

(b) Lessee hereby covenants, warrants and represents to Lessor that throughout the Term, each Facility Lessee shall: (i) be validly licensed, Medicare and/or Medicaid certified, and, if required, accredited to operate the Facilities in accordance with the applicable rules and regulations of the State in which the applicable Facility is located, federal governmental authorities, and accrediting bodies, including, but not limited to, DHHS and CMS; (ii) be certified by and the holder of valid provider agreements with Medicare/Medicaid issued by DHHS, DHS and/or CMS and shall remain so certified and shall remain such a holder of such licenses and Medicare and/or Medicaid certifications for it to operate in accordance with the Primary Intended Use; (iii) be in substantial compliance with all state and federal laws, rules, regulations and procedures with regard to the operation of the Facility operated by such Facility Lessee, including, without limitation, substantial compliance under HIPAA; (iv) operate the Facility operated by such Facility Lessee in a manner substantially consistent with quality acute care or critical access services and sound reimbursement principles under the Medicare and/or Medicaid programs and as required under state and federal law; and (v) not abandon, terminate, vacate or fail to renew any license, certification, accreditation, certificate, approval, permit, waiver, provider agreement or any other authorization which is required or material for the lawful and proper operation of the Facility operated by such Facility Lessee for its Primary Intended Use or in any way commit any act which will or could reasonably be expected to cause any such license, certification, accreditation, certificate, approval, permit, waiver, provider agreement or other authorization required to operate a Facility to be revoked by any federal, state or local governmental authority or accrediting body having jurisdiction thereof.

(c) Lessee represents, warrants and covenants that Lessee, this Lease, and all Tenant Leases, are, and at all times during the Term will be, in compliance in all material respects with all applicable Healthcare Laws. In the event it is determined that any provision of this Lease

is in violation of the Healthcare Laws, the parties in good faith shall renegotiate such provision so that same is in compliance with all applicable Healthcare Laws. Lessee shall add to all of its third party agreements relating to any portion of the Leased Property, including, without limitation, all Tenant Leases, that in the event it is determined that such agreement and/or Tenant Lease is in violation of the Healthcare Laws, as applicable, such agreement and/or Tenant Lease shall be renegotiated so that same are in compliance with all applicable Healthcare Laws. Lessee shall indemnify and defend, at Lessee's sole cost and expense, and hold Lessor, its Affiliates and their respective successors and assigns, harmless from and against, and shall reimburse Lessor, its Affiliates and their successors and assigns with respect to, any and all claims, demands, actions, causes of action, losses, damages, liabilities, costs and expenses (including, without limitation, reasonable attorneys' fees and court costs) of any and every kind or character, known or unknown, fixed or contingent, asserted against or incurred by Lessor, its Affiliates and their respective successors and assigns, at any time and from time to time by reason, or arising out, of any breach by Lessee or any Person other than MPT Indemnified Parties of any of the provisions set forth in this Section 8.3 or any violation of any Healthcare Laws by Lessee or any Person other than MPT Indemnified Parties, including any and all such claims, demands, liabilities, damages, costs and expenses relating to immaterial violations or breaches of this Section 8.3.

8.4. **Single Purpose Entity**. Each Facility Lessee shall remain at all times during the Term a Single Purpose Entity in accordance with the terms of this Lease. Promptly following any written request by Lessor during the Term, each Facility Lessee shall provide Lessor with evidence that such Facility Lessee is a Single Purpose Entity and is in good standing in the state of its organization or incorporation and in the state in which the portion of the Leased Property relating to such Facility Lessee is located.

8.5. **Organizational Covenants**. Lessee shall not permit or suffer, without the prior written consent of Lessor, which consent shall not be unreasonably withheld, conditioned or delayed, (a) any material amendment or modification of any Facility Lessee's Organizational Documents or any material amendment or modification of any Organizational Documents of any constituent entity within such Facility Lessee, including, without limitation, any such amendment that changes such Facility Lessee's status as a Single Purpose Entity or any amendment changing or modifying the governance or structure of, or changing the manager or managing member of, such Facility Lessee; (b) any dissolution or termination of any Facility Lessee's existence or sale of substantially all of any Facility Lessee's assets, whether by sale, transfer, merger, consolidation or otherwise; (c) any division, split-up, split-off, spin-off, or similar transaction of or with respect to any Facility Lessee (including, without limitation, a division or similar transaction pursuant to Section 18-217 of the Delaware Limited Liability Company Act), or the approval of a plan of division with respect to any Facility Lessee; or (d) a change in any Facility Lessee's state of formation or any Facility Lessee's name. Lessee has, simultaneously with the execution of this Lease, delivered to Lessor a true and complete copy of each Facility Lessee's Organizational Documents. Lessee represents and warrants that the Organizational Documents (i) were duly executed and delivered; and (ii) are in full force and effect, binding upon the applicable Facility Lessee, and enforceable in accordance with their terms.

8.6. **Representations and Warranties of Lessee**. Each Facility Lessee is making, on the applicable Commencement Date, the representations and warranties set forth in ***Exhibit D*** attached hereto.

8.7. **Covenant to Deliver Replacement Intercreditor**. Lessee hereby covenants and agrees that prior to or contemporaneously with any Change of Control Transaction, Permitted Transaction (other than a Permitted Reorganization or other transaction if, after giving effect to such transaction, the Intercreditor Agreement continues to be applicable), or substitution of an Acceptable Replacement Guarantor pursuant to Section 16.1(c), with respect to any Facility Lessee or any Guarantor, as applicable, Lessee shall deliver or cause to be delivered to Lessor a fully executed Replacement Intercreditor executed by such Facility Lessee or Guarantor, as applicable, and any lender (excluding any purchase money lender) or agent or trustee acting on behalf of such lender that has any Lien on a material portion of the assets or properties of any Facility Lessee.

8.8. **Covenants under Conemaugh Purchase Agreement**. With respect to the Pennsylvania Properties (excluding the Roaring Springs Property), Lessee, at its sole cost and expense, shall ensure that the Pennsylvania Properties (excluding the Roaring Springs Property), and the operation of the Business thereon, comply with the post-closing covenants, agreements, and obligations set forth and described in Section 9.9 (Indigent Care), Section 9.10 (Capital Commitment; Medical Staff Development Plan) (the capital commitment set forth in such Section 9.10 of the Conemaugh Purchase Agreement is referred to herein as the "**Conemaugh Capital Commitment Obligation**"), and Section 9.12 (Continuation of Services) of the Conemaugh Purchase Agreement, in each case, for or within the required time periods described therein. Lessee shall keep Lessor apprised of its compliance and progress under this Section 8.8, and, upon Lessor's request, Lessee shall submit to Lessor a compliance report in reasonable detail describing Lessee's progress and compliance with the foregoing. Lessor hereby covenants and agrees that it will do nothing to impede or interfere with the implementation and/or satisfaction of those post-closing covenants, agreements, or obligations of Lessee described in this Section 8.8; provided, that, for the avoidance of doubt, nothing in this Section 8.8 is intended or shall be deemed to limit or modify in any respect any of Lessor's or its Affiliates' respective rights and remedies (including consent or approval rights) under this Lease or any of the other Obligation Documents. With respect to any construction project, Capital Addition, or other project undertaken to comply with or to satisfy the Conemaugh Capital Commitment Obligation (collectively, a "**Conemaugh Capital Project**"), without limiting the generality of Section 9.1, Lessee shall use commercially reasonably efforts to pursue and exercise for Lessor's benefit any warranty claims or rights Lessee shall have under any construction, engineering, and architecture contracts or agreements with respect to any such Conemaugh Capital Project.

ARTICLE IX.
REPAIRS; RESERVES; RESTRICTIONS

9.1. **Maintenance; Repair and Remodel**.

(a) Lessee, at its expense, will keep the Leased Property and all private roadways, sidewalks and curbs appurtenant thereto (and Lessee's Personal Property) in good first class order and repair (whether or not the need for such repairs occurs as a result of Lessee's use, any prior use, the elements, the age of the Leased Property or any portion thereof) and, except as otherwise provided in Article XIV and Article XV, with reasonable promptness, will make all necessary and appropriate repairs thereto of every kind and nature whether interior or exterior, structural or non-structural, ordinary or extraordinary, foreseen or unforeseen, or arising by reason of a condition existing prior to the commencement of the Term (concealed or otherwise), ordinary

wear and tear excepted. All repairs shall, to the extent reasonably achievable, be at least equivalent in quality to the original work. Lessee will not take or omit to take any action the taking or omission of which is reasonably likely to materially impair the value or the usefulness of the Leased Property or any part thereof for the Primary Intended Use.

(b) Notwithstanding anything contained in this Lease to the contrary, from time to time Lessee may remodel, modify and make additions to the Leased Property, or any portion thereof, which remodeling, modifications and additions are not Capital Additions (it being understood that Capital Additions are subject to the requirements of Article X hereof) but which are necessary or advisable for the Primary Intended Use and which permit Lessee to fully comply with its obligations as set forth in this Lease. Lessee shall undertake any such actions expeditiously and in a workmanlike manner and will not significantly alter the character or purpose, or detract from the value or operating efficiency of, the Leased Property nor significantly impair the revenue producing capability of the Leased Property nor adversely affect the ability of Lessee to comply with the provisions of this Lease.

(c) Lessee shall notify Lessor of any and all repairs, improvements, additions, modifications and remodeling made to any portion of a particular Property in excess of Three Million and No/100 Dollars ($3,000,000) during any consecutive twelve (12) month period for the applicable Property and obtain consent from Lessor (which consent shall not be unreasonably withheld, conditioned or delayed) prior to making such repairs, improvements, additions, modifications or remodeling.

(d) Except as otherwise expressly provided in this Lease, Lessor shall not under any circumstances be required to build or rebuild any improvements on the Leased Property, or to make any repairs, replacements, alterations, restorations, or renewals of any nature or description to the Leased Property, whether ordinary or extraordinary or capital in nature, structural or non-structural, foreseen or unforeseen, or to make any expenditure whatsoever with respect thereto in connection with this Lease, or to maintain the Leased Property in any way.

(e) Nothing contained in this Lease and no action or inaction by Lessor shall be construed as (i) constituting the consent or request of Lessor, expressed or implied, to any contractor, subcontractor, laborer, materialman or vendor for the provision or performance of any labor or services or the furnishing of any materials or other property for the construction, alteration, addition, repair or demolition of or to the Leased Property or any part thereof, or (ii) giving Lessee any right, power or permission to contract for, or permit the performance of, any labor or services or the furnishing of any materials or other property in such fashion as would permit the making of any claim against Lessor in respect thereof or to make any agreement that may create, or in any way be the basis for, any right, title, interest, lien, claim or other encumbrance upon the estate of Lessor in the Leased Property or any portion thereof.

(f) Unless Lessor conveys any of the Leased Property to Lessee pursuant to Section 34.2 of this Lease, Lessee will, upon the expiration or prior termination of the Term, vacate and surrender the Leased Property to Lessor in the condition in which the Leased Property was originally received from Lessor, except as improved, constructed, repaired, rebuilt, restored, altered or added to as permitted or required by the provisions of this Lease and except for (i) ordinary wear and tear (subject to the obligation of Lessee to maintain the Leased Property in

good order and repair during the entire Term), (ii) damage caused by the gross negligence or willful misconduct of Lessor, and (iii) damage or destruction as described in Article XIV or resulting from a Taking as described in Article XV, which Lessee is not required by the terms of this Lease to repair or restore.

9.2. **Reserves for Major Repairs**.

(a) Beginning on January 1, 2021 and on each January 1 thereafter during the Term, Lessee shall deliver to Lessor, to be held by Lessor, deposits in an amount (subject to escalation as provided below) equal to the sum of Two Thousand and No/100 Dollars ($2,000.00) (the "**Dollar Amount**") multiplied by collective the "number of beds" at each Facility (the "**Reserve**"). The Reserve with respect to each Facility (the "**Allocated Reserve**") shall be held by Lessor for the purpose of making Major Repairs at such Facility. The "number of beds" shall be determined based upon the number of beds available for active use in such Facility, which shall not be reduced without the prior written consent of Lessor. The total "number of beds" available for active use at each Facility as of the date hereof is set forth on the attached ***Schedule 9.2***. Lessor shall advance to or reimburse Lessee for Major Repairs upon Lessor's receipt from Lessee of documentation of such costs that is sufficient in Lessor's reasonable judgment; *provided, however*, that Lessor has no obligation to advance or reimburse Lessee any amount in excess of the amount of the Reserve held by Lessor.

(b) Beginning January 1, 2022, and on each January 1 thereafter during the entire Term, the Dollar Amount to be multiplied by the number of beds as provided above shall be increased (and in no event decreased) by the amount by which the CPI published for the month which is two months prior to the applicable Adjustment Date shall have increased over the CPI figure published for the month which is two months prior to the previous Adjustment Date. The amounts in the Reserve shall, with the joint approval of Lessor and Lessee, be used to pay for Major Repairs on the Facility, or, in the event Lessee fails to make any required non-Major Repairs hereunder, Lessor may use funds in the Reserve for that purpose without obtaining the prior approval of Lessee.

(c) The Reserve shall be held by Lessor in an interest bearing account for the purpose of making Major Repairs to the Leased Property, and Lessee shall not be entitled to any interest earned on the Reserve unless required by applicable law. Lessor shall advance to or reimburse Lessee for Major Repairs, limited to the amount of the Reserve, upon Lessor's receipt from Lessee of documentation of such costs that is sufficient in Lessor's reasonable judgment. Lessor shall not be required to segregate the Reserve in a separate account and may commingle the Reserve with other assets of Lessor or its Affiliates. The Reserve is not an advance payment of Rent or a measure of damages.

(d) In the event that Lessor uses or applies all or any portion of the Reserve during the continuation of an Event of Default for any Leased Property pursuant to the last sentence of Section 9.2(e), Lessee shall deposit with Lessor an amount sufficient to replenish the Reserve to its original amount within thirty (30) days following receipt of written demand from Lessor.

(e) Lessee hereby grants to Lessor a first priority security interest in all monies deposited into the Reserve. At Lessor's request, Lessee shall, as soon as practicable, execute all

documents necessary to effect such security interest in all monies deposited into the Reserve. Lessee consents to Lessor's pledge of the Reserve to any Facility Lender. So long as no Event of Default has occurred and is continuing, and no event then exists which with the giving of notice or the passage of time or both would constitute an Event of Default, any amounts remaining in the Reserve, after the payment of and the reimbursement for the Major Repairs on the Facility, shall be returned to Lessee following the expiration of this Lease. Notwithstanding the foregoing, upon the occurrence and during the continuation of an Event of Default, or if an event then exists which with the giving of notice or the passage of time or both would constitute an Event of Default, Lessee shall not be entitled to any funds in the Reserve, and Lessor may from time to time and without prejudice to any other remedy provided in this Lease or by applicable law, (i) use all or a portion of the Reserve to satisfy past due Rent, (ii) use all or a portion of the Reserve to satisfy any other loss or damage resulting from Lessee's breach of this Lease, including Lessee's failure to make any necessary or required repairs to the Leased Property, or (iii) retain all amounts remaining in the Reserve at the expiration or termination of the Lease.

9.3. **Required Repairs**. Without limiting Lessee's obligations under Section 9.1, Lessee agrees that it shall commence and complete in a good and workmanlike manner certain repairs, improvements and remodeling to the Leased Property, as more particularly described on ***Schedule 9.3*** attached hereto (the "**Required Repairs**"). Lessor shall have no obligation to advance or to reimburse to Lessee any amounts or costs related to the Required Repairs. To the extent that any of the Required Repairs shall constitute Capital Additions to the Leased Property, such Required Repairs shall revert to and become the property of Lessor upon the expiration or termination of this Lease.

9.4. **Encroachments; Restrictions**. If any of the Leased Improvements shall, at any time, encroach upon any property, street or right-of-way adjacent to the Leased Property, or shall violate the agreements or conditions contained in any federal, state or local law, restrictive covenant or other agreement affecting the Leased Property, or any part thereof, or shall impair the rights of others under any easement or right-of-way to which the Leased Property is subject, then, promptly upon the request of Lessor, Lessee shall, at its expense, subject to its right to contest the existence of any encroachment, violation or impairment, (a) obtain valid and effective waivers or settlements of all claims, liabilities and damages resulting from each such encroachment, violation or impairment, whether the same shall affect Lessor or Lessee or (b) make such changes in the Leased Improvements, and take such other actions, as Lessor in the reasonable, good faith exercise of its judgment requires, to remove such encroachment, or to end such violation or impairment, including, if necessary, the alteration of any of the Leased Improvements, and, in any event, take all such actions as may be necessary to continue the operation of the Facility without such violation, encroachment or impairment. Any such alteration shall be made in conformity with the applicable requirements of Article X. Lessee's obligations under this Section 9.4 shall be in addition to, and shall in no way discharge or diminish any obligation of, any insurer under any policy of title or other insurance, and Lessee shall be entitled to a credit for any sums paid by Lessee and recovered by Lessor under any such policy of title or other insurance, less Lessor's costs and expenses to recover such sums.

ARTICLE X.
CAPITAL ADDITIONS

10.1. **Construction of Capital Additions to the Leased Property**.

(a) If no Event of Default has occurred, Lessee shall have the right (but not the obligation) upon and subject to the terms and conditions set forth below, to construct or install Capital Additions on any Property with the prior written consent of Lessor, not to be unreasonably withheld, conditioned or delayed (*provided that* such consent is not required with respect to any Capital Addition that will cost less than One Million Dollars ($1,000,000)). Lessee shall not be permitted to create any Lien on such Property in connection with such Capital Addition, except as provided in Section 10.2. In order to obtain Lessor's prior written consent, Lessee shall submit to Lessor in writing a proposal setting forth in reasonable detail any such proposed Capital Addition. In addition, Lessee shall promptly furnish to Lessor such additional information relating to such proposed Capital Addition as Lessor may reasonably request. Lessor shall have ten (10) days following receipt of the last information so requested relating to the proposed Capital Addition to respond whether Lessor has approved of such proposed Capital Addition, it being agreed that failure to timely respond shall be deemed a rejection of the proposed Capital Addition.

(b) Prior to commencing construction of any Capital Addition on any Property for which Lessee intends to finance, Lessee shall first grant to Lessor a right of first offer to provide funds to pay for such Capital Addition in accordance with the provisions of Section 10.3. If Lessor declines or is unable to provide such funding, or if the ROFO Exercise Notice is not accepted by Lessee, the provisions of Section 10.2 shall apply. Notwithstanding any other provision of this Article X to the contrary, no Capital Additions shall be made without the consent of Lessor, which consent may be withheld in Lessor's sole discretion, if the costs for such Capital Addition, when aggregated with the costs of all Capital Additions made by Lessee, would exceed Twenty-Five Percent (25%) of the then Fair Market Value of the applicable Property. Furthermore, no Capital Addition shall be made which would tie in or connect any portion of a particular Property and/or any Leased Improvements thereon with any other improvements on property adjacent to such Property (and not part of the Land covered by this Lease) including, without limitation, tie-ins of buildings or other structures or utilities, unless Lessee shall have obtained the prior written approval of Lessor, which approval may be granted or withheld in Lessor's sole discretion. As to all other Capital Additions which are not described in the immediately preceding two sentences, Lessor's consent, if required, shall not be unreasonably withheld, conditioned or delayed. All proposed Capital Additions shall be architecturally integrated and consistent with the applicable Property as determined in the reasonable discretion of Lessor.

10.2. **Capital Additions Financed by Lessee**. If Lessee provides or arranges to finance any Capital Addition (except for Capital Additions arranged by Lessee but funded by Lessor), this Lease shall be and hereby is amended to provide as follows:

(a) There shall be no adjustment in the Base Rent by reason of any such Capital Addition.

(b) Such Capital Addition shall revert to, and become the property of Lessor upon the expiration or termination of this Lease with respect to the applicable Property.

In connection with any such Capital Addition financed by Lessee (or any Person other than Lessor), Lessee shall be permitted to place (or cause to be placed) a Lien on such Capital Addition as collateral for Lessee's financing, *provided, that*, in the reasonable determination of Lessor such Lien shall not materially interfere with Lessor's ability to finance the applicable Property; it being understood and agreed that (i) Lessor and Lessee shall cooperate in good faith to properly divide such Capital Addition from the applicable Property and to grant such easements and use restrictions as shall be necessary to avoid any disruption of Lessee's Business on such Property; (ii) to the extent not inconsistent with the provisions of this Section 10.2, such Capital Addition shall remain subject to the other terms and provisions of this Lease; and (ii) upon the expiration or termination of this Lease with respect to such Property, Lessee, at its sole cost and expense, shall cause all such Lien(s) to be released from such Capital Addition and within ten (10) Business Days after such expiration or termination.

10.3. **Capital Additions Funded by Lessor**. If Lessee desires to obtain third party purchase money, project-based financing (and specifically excluding any corporate level financing) to fund a Capital Addition on the Property, Lessee shall request the same by submitting to Lessor a written request, including a written proposal setting forth in reasonable detail any such proposed Capital Addition (a "**Request**"). In addition, Lessee shall promptly furnish to Lessor such additional information relating to such proposed Capital Addition as Lessor may reasonably request. Lessor shall have thirty (30) days following receipt of the last of the information so requested to respond by delivering to Lessee (the "**ROFO Exercise Notice**") a written offer to fund the proposed Capital Addition, including the proposed terms thereof and the terms of any amendments to this Lease to be executed in connection therewith; it being agreed that Lessor's failure to timely deliver a ROFO Exercise Notice shall be deemed a rejection of the Request to provide the funding for such proposed Capital Addition. If Lessee accepts the offer set forth in the ROFO Exercise Notice, the parties shall consummate the financing contemplated thereby within sixty (60) days on the terms and conditions set forth in the ROFO Exercise Notice. If Lessee does not accept the offer set forth in a ROFO Exercise Notice, Lessee may, for a period of one hundred eighty (180) days from the date of receipt by Lessee of the ROFO Exercise Notice, obtain a commitment to finance a Capital Addition from any Person on terms and conditions no more favorable, in the aggregate, to the applicable lender than those set forth in such ROFO Exercise Notice. If Lessee does not obtain a commitment for third-party financing before the end of such one hundred eighty (180) day period, Lessee may not finance such Capital Addition without repeating the foregoing procedures of this Article X.

10.4. **Salvage**. All materials that are scrapped or removed in connection with the making of either Capital Additions or repairs hereunder shall be or become the property of Lessee, and Lessee shall remove the same at its sole cost and expense.

10.5. **Completion of Required Capital Additions**. Without limiting the foregoing provisions of this Article X or any other provisions of this Lease, Lessee, at its own cost and expense, will complete all of the Capital Addition and construction projects with respect to the Leased Property described in the attached ***Schedule 10.5*** no later than the outside completion date set forth thereon. The Capital Additions and construction projects described on the attached ***Schedule 10.5*** are referred to herein as "**Required Ongoing Capital Projects**." All such Required Ongoing Capital Projects shall otherwise be completed in accordance with the provisions of this Article X. Until completion of all Required Ongoing Capital Projects, Lessee shall provide Lessor

a quarterly report with respect to the status and progress of each outstanding Required Ongoing Capital Project no later than thirty (30) days after the end of each calendar quarter. The Required Ongoing Capital Projects shall constitute Capital Additions paid for or financed by Lessee as described in Section 10.2. With respect to the Required Ongoing Capital Projects, without limiting the generality of Section 9.1, Lessee shall use commercially reasonably efforts to pursue and exercise for Lessor's benefit any warranty claims or rights Lessee shall have under any construction, engineering, and architecture contracts or agreements with respect to such Required Ongoing Capital Projects.

ARTICLE XI.
LIENS

Subject to the provisions of Article XII relating to permitted contests, Lessee and its Affiliates who are directly or indirectly controlled by Guarantor will not directly or indirectly create or allow to remain and will promptly discharge at its expense any lien, encumbrance, attachment, title retention agreement or claim upon any Property (including, without limitation, any liens, encumbrances, attachments, title retention agreements, or claims with respect to any Required Ongoing Capital Projects or any Major Repairs) or any attachment, levy, claim or encumbrance in respect of the Rent, any amounts held in the Reserve, or any funds or amounts that are or will be provided by Lessor or its Affiliates to Lessee at any time during the Term in accordance with this Lease; excluding, however, (a) this Lease (and with respect to any Pass-Through Lease Land, the applicable Pass-Through Lease); (b) the Permitted Exceptions; (c) restrictions, liens and other encumbrances which are consented to in writing by Lessor, or any easements granted pursuant to the provisions of Section 7.3; (d) liens for those taxes of Lessor which Lessee is not required to pay hereunder; (e) liens for Impositions or for sums resulting from noncompliance with Legal Requirements so long as (i) the same are not yet payable or are payable without the addition of any fine or penalty or (ii) such liens are in the process of being contested as permitted by Article XII; (f) liens of mechanics, laborers, materialmen, suppliers or vendors for sums either disputed or not yet due, *provided that* (i) the payment of such sums shall not be postponed for more than sixty (60) days after the completion of the action giving rise to such lien and such reserve or other appropriate provisions as shall be required by law or GAAP shall be been made therefore, or (ii) any such liens are in the process of being contested as permitted by Article XII; (g) the Tenant Leases; (h) Liens which are permitted in accordance with Section 10.2 hereof; and (i) any liens which are the responsibility of Lessor pursuant to the provisions of Article XXXVI of this Lease. Lessee shall not mortgage or grant any interest or security interest in, or otherwise assign, any part of Lessee's rights and interests in this Lease or any Property during the Term.

ARTICLE XII.
PERMITTED CONTESTS

12.1. **Permitted Contests**. After obtaining prior written approval from Lessor, not to be unreasonably withheld, conditioned or delayed, Lessee, at Lessee's expense, may contest, by appropriate legal proceedings conducted in good faith and with due diligence, the amount, validity or application, in whole or in part, of any Imposition, Legal Requirement, Insurance Requirement, lien, attachment, levy, encumbrance, charge or claim not otherwise permitted by Article XI, *provided that* (a) in the case of an unpaid Imposition, lien, attachment, levy, encumbrance, charge

or claim, the commencement and continuation of such proceedings shall suspend the collection thereof from Lessor and from the Leased Property (or if not so suspended, clause (b) shall be true); (b) neither the Leased Property nor any Rent therefrom nor any part thereof or interest therein would, as determined in Lessor's reasonable discretion, be in any immediate danger of being sold, forfeited, attached or lost; (c) in the case of a Legal Requirement, Lessor would not be in any immediate danger of civil or criminal liability for failure to comply therewith pending the outcome of such proceedings; (d) in the event that any such contest shall involve a sum of money or potential loss in excess of One Million and No/100 Dollars ($1,000,000.00), then, in any such event, the applicable Facility Lessee shall deliver to Lessor an Officer's Certificate from a duly authorized officer of the applicable Facility Lessee regarding the matters set forth in clauses (a), (b) and (c), to the extent applicable (it being understood if the relevant amount involved in such contest (or the potential loss) is less than such amount, no such certification is required); (e) in the case of a Legal Requirement and/or an Imposition, lien, encumbrance or charge involving potential loss in excess of One Million and No/100 Dollars ($1,000,000.00), Lessee shall give such reasonable security as may be demanded by Lessor to insure ultimate payment of the same and to prevent any sale or forfeiture of the affected Property or the Rent by reason of such non-payment or non-compliance; *provided, however*, the provisions of this Article XII shall not be construed to permit Lessee to contest the payment of Rent (except as to contests concerning the method of computation or the basis of levy of any Imposition or the basis for the assertion of any other claim) or any other sums payable by Lessee to Lessor hereunder; (f) in the case of an Insurance Requirement, the coverage required by Article XIII shall be maintained; and (g) if such contest be finally resolved against Lessor or Lessee, Lessee shall, as Additional Charges due hereunder, promptly pay the amount required to be paid, together with all interest and penalties accrued thereon, or comply with the applicable Legal Requirement or Insurance Requirement. Lessor, at Lessee's expense, shall execute and deliver to Lessee such authorizations and other documents as may reasonably be required in any such contest and, if reasonably requested by Lessee, or if Lessor so desires, Lessor shall join as a party therein. Lessee shall indemnify and hold Lessor harmless against any liability, cost or expense of any kind that may be imposed upon Lessor in connection with any such contest and any loss resulting therefrom.

ARTICLE XIII.
INSURANCE

13.1. **General Insurance Requirements**. During the Term, Lessee shall at all times keep the Leased Property and Lessee's Personal Property, insured against loss or damage from such causes as are customarily insured against, by prudent owners of similar facilities. Without limiting the generality of the foregoing, throughout the Term, Lessee shall maintain at its sole cost and expense (except as otherwise provided in this Article XIII), at a minimum, the insurance coverages required herein. This insurance shall be written in form reasonably satisfactory to Lessor and by insurance companies (i) reasonably acceptable to Lessor, (ii) that are rated at least an "A-VIII" or better by Best's Insurance Guide, and (iii) unless otherwise approved by Lessor, authorized, licensed and qualified to do insurance business in the state in which the Leased Property is located. The aggregate amount of coverage by a single company must not exceed Five Percent (5%) of the insurance company's policyholders' surplus. The minimum limits required herein may be met through a combination of self-insurance and underlying and excess policies. With respect to each Property, the policies required hereunder relating to such Property shall insure against the following:

(a) Commercial Property insurance written on a broad "all risk" or special cause of loss policy form covering physical loss or damage to each Leased Property including building and improvements and betterments at 100% replacement cost. Such coverage shall be written on a blanket limit basis. Any deductible or retention shall not exceed Four Percent (4%) of the insurable value of the Leased Property, to the extent that such a deductible is commercially available. In the event of a loss, Lessee shall abide by all provisions of the insurance contract, including proper and timely notice of the loss to insurer. The policy shall also include the following coverages: (i) Flood and Earthquake insurance with limits not less than Twenty Percent (20%) of the replacement cost of each building; (ii) Named Wind / Wind coverage for the full replacement cost of each building; (iii) Business interruption insurance covering rents and other impositions otherwise payable to Lessor for a period of not less than twenty-four (24) months and shall be written on an "actual loss sustained" form; and (iv) Equipment Breakdown coverage.

(b) Commercial General Liability insurance in a minimum amount of One Million Dollars ($1,000,000) per occurrence for bodily injury or death of any one person and for Property Damage for damage to or loss of the property of others, subject to a Two Million Dollar ($2,000,000.00) annual aggregate policy limit per Leased Property for all bodily injury and property damage claims, occurring on or about such Property or in any way related to such Property, including but not limited to, any swimming pools or other rehabilitation and recreational facilities or areas that are located on such Property or otherwise related to such Property.

(c) Professional liability insurance for Lessee and all employed professionals (including any physicians) in an amount of not less than One Million Dollars ($1,000,000) per individual claim and Three Million Dollars ($3,000,000) annual aggregate. All contractors, agents and other persons (including physicians) who perform professional services for Lessee shall meet such required minimum insurance requirements of One Million Dollars ($1,000,000) per individual claim and Three Million Dollars ($3,000,000) annual aggregate.

(d) Worker's Compensation insurance for all persons employed by Lessee on such Property with statutory limits in accordance with the requirements of the particular State(s) in which they are operating and Employer's Liability insurance with minimum limits of One Million Dollars ($1,000,000) each accident and disease.

(e) Automobile Liability insurance for all owned, non-owned, leased or hired automobiles with a minimum limit of One Million Dollars ($1,000,000) per accident for bodily injury and property damage.

(f) Umbrella/Excess Liability insurance in the minimum amount of Twenty Million Dollars ($20,000,000) for each claim and annual aggregate. The Umbrella Liability policy shall name in its underlying schedule the Commercial General Liability, Professional Liability, Automobile Liability and Employer's Liability insurance policies. The Umbrella policy shall provide coverage at least as broad as each of the underlying policies.

(g) Pollution Liability/Environmental Impairment Liability insurance with minimum limits of Five Million Dollars ($5,000,000) per claim covering bodily injury or death of any one person and for property damage to, loss of use of, or clean-up costs of the property of others, as well as first party clean-up costs, subject to a minimum annual aggregate of Ten Million

Dollars ($10,000,000). Coverage shall include but not limited to, liability from storage tanks, healthcare medical waste (including at non-owned disposal sites), mold, fungi and /or Legionella Pneumophilia conditions, or other exposures typical to healthcare facilities.

(h) Cyber Liability insurance with minimum limits of Ten Million Dollars ($10,000,000) per claim and in the aggregate covering Lessee and its employees. Such policy shall include coverage for claims, demands and regulatory investigations resulting from Lessee's or its subcontractor's wrongful acts in the performance of or failure to perform all services or support for services including but not limited to claims, demands, fines, penalties and other payments Lessor may be legally or contractually obligated to pay for infringement of intellectual property, failures in systems and information security, breach of confidentiality and invasion of or breach of privacy. Reasonable sublimits for ancillary coverages shall be allowed as commercially available.

(i) Crime/Employee Dishonesty insurance covering all employees with a minimum limit of Two Hundred Fifty Thousand Dollars ($250,000) per claim.

(j) Non-Owned Aviation/Helipad Liability insurance (if applicable) including coverage for the helipad and any other aviation exposures at the premises with minimum limits of Five Million Dollars ($5,000,000) per occurrence.

13.2. **Endorsements and Other Requirements**. The insurance as required in this Article XIII shall comply with the following:

(a) Except for Worker's Compensation/Employer's Liability and Crime insurance policies, all other insurance policies required herein shall name Lessor (and any other entity that Lessor may deem reasonably necessary) as Additional Insureds with respect to any liability arising from Lessee's use, occupancy or maintenance of the Leased Property.

(b) All policies of insurance required herein (i) shall include clauses providing that each underwriter shall waive its rights of recovery, under subrogation or otherwise, against Lessor or any of Lessor's affiliates or subsidiary companies; and (ii) shall be primary and non-contributory to the extent commercially available (except for Worker's Compensation/ Employer's Liability) to any other insurance available to Lessor.

(c) All policies of insurance required to be obtained by Lessee hereunder shall provide at least thirty (30) days' prior written notice for cancellation, non-renewal or material change, or ten (10) days' prior written notice for non-payment of premium to Lessor's notice address as specified in this Lease (the "**Lessor's Notice Address**"), with a simultaneous copy to (A) MPT Operating Partnership, L.P., Attention: Asset Management/Insurance Department, 1000 Urban Center Drive, Suite 501, Birmingham, Alabama 35242, and (B) McGriff, Seibels & Williams, Inc., Attention: John F. Carter, 2211 7th Avenue South, Birmingham, Alabama 35233.

(d) Lessee shall be responsible for funding all premiums, deductibles and retentions, including those which may be applicable to Lessor as an additional insured or named insured thereunder. All such deductibles and retentions shall be in amounts that are reasonably acceptable to Lessor.

13.3. **Additional Insurance**. Notwithstanding anything contained herein to the contrary, Lessor shall not be prohibited, at its sole cost and expense, from purchasing and maintaining such additional insurance as it may reasonably determine to be necessary to protect its interest in all or any portion of the Leased Property.

13.4. **Evidence of Insurance**. Lessee shall deliver "verification" of insurance to Lessor as set forth below:

(a) Prior to the Commencement Date and at least ten (10) Business Days prior to any insurance policy expiration date, Lessee shall provide verification of the renewal for the required insurance coverage for the following year which shall include the following:

(i) Insurance certificates acceptable to Lessor evidencing coverage for the renewed insurance policies, including evidence of specific coverage requirements and endorsements as required herein;

(ii) A summary of insurance program showing significant coverage limits, sublimits, deductibles and retentions.

(b) No later than ninety (90) days, after the renewal date of such policies, or such other reasonable timeframe as mutually agreed upon by Lessor and Lessee, Lessee shall provide true and certified copies of all required insurance policies, including evidence of specific coverage requirements and endorsements as stated herein.

(c) In the event Lessee does not provide timely or proper verification, or does not maintain the insurance required hereunder or pay the premiums as required hereunder, Lessor shall be entitled after notice to Lessee, but shall have no obligation, to obtain such insurance and pay the premiums therefor, which premiums shall be repayable to Lessor promptly following request by Lessor (but in no event later than fifteen (15) days after delivery of such request).

13.5. **Increase in Limits and Coverages**. In the event that Lessor shall at any time in its reasonable discretion deem the limits or insurance coverages required herein to be insufficient, upon written notice from Lessor with respect to the same, Lessee shall acquire such additional insurance and/or limits provided that the types and amounts of any such insurance required by Lessor is customarily maintained by the operators of similar healthcare facilities.

13.6. **No Separate Insurance**. Lessee shall not, on Lessee's own initiative or pursuant to the request or requirement of any third party, take out separate insurance concurrent in form or contributing in the event of loss with that required in this Article XIII to be furnished by, or which may reasonably be required to be furnished by, Lessee, or increase the amounts of any then-existing insurance by securing an additional policy or additional policies, unless all parties having an insurable interest in the subject matter of the insurance, including in all cases Lessor and all Facility Lenders, are included therein as additional insureds and the loss is payable under said insurance in the same manner as losses are required to be payable under this Lease. Lessee shall promptly notify Lessor of the taking out of any such separate insurance or of the increasing of any of the amounts of the then existing insurance by securing an additional policy or additional policies.

13.7. **Insurance Required under Pass-Through Leases**. Lessee shall also obtain and maintain all insurance required to be maintained by the "tenant" or "lessee" pursuant to the Pass-Through Leases and provide Lessor with evidence of the same.

ARTICLE XIV.
FIRE AND CASUALTY

14.1. **Insurance Proceeds**. All proceeds payable by reason of any loss or damage to the Leased Property, or any portion thereof, and insured under any policy of insurance required by Article XIII shall, subject to the provisions of the Intercreditor Agreement, and with respect to properties subject to a Pass-Through Lease, subject to the terms of the applicable Pass-Through Lease, be paid to Lessor and held by Lessor in trust (subject to the provisions of Section 14.7) and shall be made available for reconstruction or repair, as the case may be, of any damage to or destruction of the Leased Property, or any portion thereof, and shall be paid out by Lessor from time to time for the actual cost of such reconstruction or repair; *provided, however*, that Lessee shall have the right in all events, but subject to the rights of the lessor under any Pass-Through Lease, to be reimbursed for amounts expended to repair and restore the Leased Property (including funds expended to modernize, update and improve the Leased Property following a casualty) up to the amount of the proceeds paid to Lessor hereunder and not otherwise used by Lessor for the restoration or reconstruction of the Leased Property (if an to the extent Lessor is entitled to such proceeds in accordance with the terms of this Lease). Any excess proceeds of insurance remaining after the completion of the restoration or reconstruction of the Leased Property, or any portion thereof, shall be paid to and retained by Lessor free and clear upon completion of any such repair and restoration. In the event neither Lessor nor Lessee is required or elects to repair and restore, all such insurance proceeds shall be retained by Lessor free and clear upon completion of any such repair and restoration. All salvage resulting from any risk covered by insurance shall belong to Lessor except that any salvage relating to Capital Additions paid for by Lessee as described in Section 10.2 or to Lessee's Personal Property shall belong to Lessee as provided in Section 10.4. In the case of any Leased Property that is subject to a Pass-Through Lease, the terms of this Article XIV shall in all cases be subject to the terms of the applicable Pass-Through Lease.

14.2. **Reconstruction in the Event of Damage or Destruction Covered by Insurance**.

(a) Except as provided in Section 14.7, with respect to any Property, if during the Term such Property is totally or partially destroyed from a risk covered by the insurance described in Article XIII and such Property is thereby rendered Unsuitable for its Primary Intended Use (the "**Casualty Impacted Property**"), Lessee shall restore such Casualty Impacted Property to substantially the same condition as existed immediately before the damage or destruction. Such damage or destruction shall not terminate this Lease with respect to such Property.

(b) Except as provided in Section 14.7, with respect to any Property, if, during the Term, such Property is totally or partially destroyed from a risk covered by the insurance described in Article XIII, but such Property is not thereby rendered Unsuitable for its Primary Intended Use, Lessee shall restore such Property to substantially the same condition as existed immediately before the damage or destruction. Such damage or destruction shall not terminate this Lease with respect to such Property.

(c) With respect to each Property, if the cost of the repair or restoration of such Property exceeds the amount of insurance proceeds received by Lessor, Lessee shall be obligated to pay any such excess amount needed to restore such Property prior to use of the insurance proceeds; *provided, that*, from and after the date on which Lessee expends amounts required to cover such deficiency, Lessor shall make the insurance proceeds available to Lessee for the completion of the restoration.

14.3. **Reconstruction in the Event of Damage or Destruction Not Covered by Insurance**. Except as provided in Section 14.7, if during the Term a Property is totally or partially damaged or destroyed from a risk not covered by the insurance described in Article XIII but that would have been covered if Lessee carried the insurance customarily maintained by, and generally available to, the operators of reputable health care facilities in the region in which such Property is located, then, whether or not such damage or destruction renders such Property Unsuitable for its Primary Intended Use, Lessee shall, at its sole cost and expense, restore such Property to substantially the same condition it was in immediately before such damage or destruction and such damage or destruction shall not terminate this Lease with respect to such Property.

14.4. **Lessee's Personal Property**. All insurance proceeds payable by reason of any loss of or damage to any Lessee's Personal Property or any Capital Addition financed by Lessee shall be paid to Lessee to pay the cost of repairing or replacing the damage to Lessee's Personal Property or the Capital Additions financed by Lessee.

14.5. **Restoration of Lessee's Property**. In connection with a restoration of any Property as provided in Sections 14.2 or 14.3, Lessee shall also restore all alterations and improvements made to Lessee's Personal Property with respect thereto and all Capital Additions paid for by Lessee with respect thereto.

14.6. **No Abatement of Rent**. This Lease shall remain in full force and effect, and Lessee's obligation to pay Rent and all other charges required by this Lease shall remain unabated during any period required for repair and restoration; *provided, however*, the proceeds of all rental stream insurance, if any, will first be paid to or retained by Lessor in satisfaction of Lessee's obligations to pay Rent.

14.7. **Damage Near End of Term**. Notwithstanding any provisions of Sections 14.2 or 14.3 to the contrary, if damage to or destruction of any Property occurs during the last twenty-four (24) months of the Term, and if such damage or destruction cannot be fully repaired and restored within six (6) months immediately following the date of such loss as determined in Lessor's reasonable discretion, either party shall have the right to terminate this Lease with respect to such Property by giving notice to the other within thirty (30) days after the date of damage or destruction, in which event Lessor shall be entitled to retain the insurance proceeds and Lessee shall pay to Lessor on demand the amount of any deductible or uninsured loss arising in connection therewith; *provided, however*, that any such notice given by Lessor shall be void and of no force and effect if Lessee exercises an available option to extend the Term for one (1) Extension Term within thirty (30) days following receipt of such termination notice. Upon any such partial termination of this Lease as to a Casualty Impacted Property, the total Base Rent payable hereunder shall be reduced in accordance with Section 5.2.

14.8. **Waiver**. Lessee hereby waives any statutory or common law rights of termination which may arise by reason of any damage to or destruction of any portion of the Leased Property.

14.9. **Termination of Right to Purchase**. Any partial termination of this Lease as to any Property pursuant to this Article XIV shall cause any right to purchase such Property granted to Lessee under any other provisions of this Lease to be terminated and to be without further force and effect.

ARTICLE XV.
CONDEMNATION

15.1. **Parties' Rights and Obligations**. If during the Term there is any Taking of all or any part of a Property or any interest in this Lease relating to such Property by Condemnation, the rights and obligations of the parties shall be determined by this Article XV.

15.2. **Total Taking**. If there is a Taking of all of a Property by Condemnation, this Lease shall terminate with respect to such Property on the Date of Taking.

15.3. **Partial Taking**. If there is a Taking of a part, but not all, of a Property by Condemnation (a "**Partial Taking**"), this Lease shall remain in effect with respect to such Property if such Property is not thereby rendered Unsuitable for its Primary Intended Use. If, however, such portion of such Property is thereby rendered Unsuitable for its Primary Intended Use, Lessee shall elect either (a) to restore such portion of such Property, at its own expense and to the extent possible, to substantially the same condition as existed immediately before the partial Taking, or (b) to terminate this Lease with respect to such Property (in which event the Base Rent payable hereunder shall be reduced in accordance with Section 5.2 and Lessee shall be obligated to make the Make-Up Payment to Lessor as provided in Section 15.6). Lessee shall exercise such election by giving Lessor notice thereof within sixty (60) days after Lessee receives notice of the Taking; provided, that, no termination pursuant to Section 15.3(b) shall be effective until the payment to Lessor of any applicable Make-Up Payment pursuant to Section 15.6. If there is a partial Taking of the Leased Property and this Lease remains in full force and effect pursuant hereto, Lessee shall accomplish all necessary restoration of the impacted Property at Lessee's expense, Lessor shall make the entire Award (less any reasonable costs of Lessor incurred with respect thereto) available to fund the costs of restoration, and any portion of the Award remaining after restoration shall be the sole property of the Lessor.

15.4. **Award Distribution**. In the event of a Taking, the entire Award shall belong to Lessor; *provided, however*, that (a) if this Lease is terminated pursuant to this Article XV with respect to such Property, Lessee shall be entitled to receive a sum attributable to Lessee's Personal Property relating thereto and any reasonable removal and relocation costs, provided in each case the Award specifically includes such items, and (b) if Lessee is required or elects to restore such Property, Lessor agrees to make the Award available to be paid to Lessee to be used for that restoration, and Lessor shall hold such portion of the Award in trust for application to the cost of the restoration.

15.5. **Temporary Taking**. The Taking of any Property or any part thereof by military or other public authority shall constitute a Taking by Condemnation only when the use and

occupancy by the Taking authority has continued for longer than six (6) months. During any such six (6)-month period all the provisions of this Lease shall remain in full force and effect and the Rent with respect to such Property shall not be abated or reduced during such period of Taking, and Lessee shall be entitled to all compensation or Award granted in connection with such temporary Taking.

15.6. **Make-Up Payments**. If, as a result of a Partial Taking, Lessee elects to terminate this Lease with respect to a Property (the "**Partial Taking Property**") pursuant to Section 15.3(b), then Lessee shall pay Lessor the amount, if any, by which (a) the Lease Base with respect to such Partial Taking Property exceeds (b) the sum of (i) the amount of the Award plus (ii) the amount determined to be the Fair Market Value Purchase Price of the remaining portion of the Partial Taking Property (the "**Make-Up Payment**"). The Fair Market Value Purchase Price of the remaining portion of the Partial Taking Property shall be determined by the appraisal process set forth in Article XXXIII hereof which shall be undertaken and completed within sixty (60) days following the date of Lessee's election to terminate the Lease with respect to any such Partial Taking Property (*provided, however*, that Lessee shall be responsible for and shall pay all costs and expenses of such appraisal process). Lessee shall make the Make-Up Payment to Lessor by wire transfer of immediately available funds no later than ten (10) days after the Fair Market Value Purchase Price of the remaining portion of the Partial Taking Property is finally determined pursuant to the appraisal process.

ARTICLE XVI.
DEFAULT

16.1. **Events of Default**. The occurrence of any one or more of the following events (individually, an "**Event of Default**") shall constitute Events of Default hereunder:

(a) if Lessee shall fail to make a payment of the Rent or any other monetary obligation when the same becomes due and payable by Lessee under this Lease (including, but not limited to, any failure to maintain the amount of the Reserve or the failure to pay Insurance Premiums or Impositions, other than those that are being disputed by Lessee in good faith pursuant to Article XII) and the same shall remain unpaid for more than five (5) days following receipt by Lessee of written notice thereof from Lessor; *provided, however*, in no event shall Lessor be required to give more than two (2) such written notices hereunder during any consecutive twelve (12) month period; or

(b) if Lessee shall fail to observe or perform in any material respect (without duplication of any materiality qualifier herein) any other term, covenant or condition of this Lease and such failure is not cured by Lessee within a period of thirty (30) days after receipt by Lessee of written notice thereof from Lessor (except that in the event Lessee shall fail to comply with any request pursuant to Sections 38.3 and 38.4 hereof, and such failure shall continue for five (5) days after receipt by Lessee of such request from Lessor), unless such failure cannot with due diligence be cured within a period of thirty (30) days (in Lessor's reasonable discretion), in which case such failure shall not be deemed to continue so long as Lessee commences to cure such failure within the thirty (30) day period and proceeds with due diligence to complete the curing thereof within sixty (60) days after receipt by Lessee of Lessor's notice of default (or such longer period as is reasonably required in the determination of Lessor to effect such cure if Lessee is diligently

proceeding to do so); *provided, however*, in no event shall Lessor be required to give more than two (2) notices and cure period for Lessee's failure to observe or perform the same (or repetitive) covenant or condition in any consecutive twelve (12) month period; or

(c) if (i) any Facility Lessee or the Guarantor shall admit in writing its inability to pay its debts as they become due; or (ii) any Facility Lessee or the Guarantor shall file a petition in bankruptcy as a petition to take advantage of any insolvency act; or (iii) any Facility Lessee or the Guarantor shall be declared insolvent according to any law; or (iv) any Facility Lessee or the Guarantor shall make any general assignment for the benefit of its creditors; or (v) if the estate or interest of any Facility Lessee in the Leased Property or any part thereof shall be levied upon or attached in any proceeding and the same shall not be vacated or discharged within the later of ninety (90) days after commencement thereof or sixty (60) days after receipt by Lessee of written notice thereof from Lessor (unless Lessee shall be contesting such lien or attachment in good faith in accordance with Article XII); or (vi) any petition shall be filed against any Facility Lessee or the Guarantor to declare such Facility Lessee or the Guarantor bankrupt, to take advantage of any insolvency act, or to delay, reduce or modify such Facility Lessee's or the Guarantor's capital structure and the same shall not be removed or vacated within ninety (90) days from the date of its creation, service or attachment; or (vii) any Facility Lessee or the Guarantor shall, after a petition in bankruptcy is filed against it, be adjudicated a bankrupt, or a court of competent jurisdiction shall enter an order or decree, with or without the consent of such Facility Lessee or the Guarantor, as the case may be, appointing a trustee, examiner or receiver of such Facility Lessee or the Guarantor or the whole or substantially all of its property, or approving a petition filed against such Facility Lessee or the Guarantor seeking reorganization or arrangement of such Facility Lessee or the Guarantor under the federal bankruptcy laws or any other applicable law or statute of the United States of America or any state thereof, and such judgment, order or decree shall not be vacated or set aside or stayed within ninety (90) days from the date of the entry thereof (notwithstanding anything to the contrary set forth herein, in the event the provisions of this Section 16.1(c) are triggered with respect to the Guarantor, then prior to an Event of Default arising hereunder or as a cure for any such Event of Default, the Guarantor shall have the right and option within twenty (20) days after the occurrence of such an Event of Default or such event which, with the giving of notice or the passage of time or both, would constitute such an Event of Default, to cause an Acceptable Replacement Guarantor to join in and be bound by the Guaranty and to contemporaneously therewith cause such Acceptable Replacement Guarantor to deliver a fully executed Replacement Intercreditor, executed by such Acceptable Replacement Guarantor and any lender (excluding any purchase money lender) or agent or trustee acting on behalf of such lender that has any Lien on a material portion of the assets or properties of any Facility Lessee; or

(d) if any Facility Lessee shall have (i) any of its Licenses (as defined in Article XXXVIII), or (ii) its participation or certification in Medicare or Medicaid or any material other third party payor program, in either case of clause (i) or clause (ii) above, terminated by the applicable government program for fraud or violation of the terms of such program; or

(e) if a Change of Control Transaction shall occur with respect to any Facility Lessee or Guarantor which is not approved by Lessor in advance;

(f) if, with respect to any Property, (i) in the case of any Property for which the Primary Intended Use is as a licensed general acute care hospital facility or a critical access

hospital, the applicable Facility Lessee that operates the Business at such Property abandons or vacates same (such Facility Lessee's absence therefrom for thirty (30) consecutive days shall constitute abandonment), or (ii) the applicable Facility Lessee fails to operate such Business on such Property in accordance with the terms of this Lease;

(g) if any Facility Lessee or the Guarantor shall be liquidated or dissolved, or shall begin proceedings toward such liquidation or dissolution, or shall, in any manner, permit the sale or divestiture of substantially all of its assets, or any such Facility Lessee or the Guarantor shall enter into an agreement respecting same; or

(h) if any monetary or material non-monetary default or event of default occurs under any Obligation Document (other than this Lease) and such default is which is not waived in writing or cured within the cure period as provided therein; or

(i) if any monetary or material non-monetary default or event of default occurs with respect to any Material Obligation of any Facility Lessee or Guarantor which is not waived in writing or cured within the applicable cure period provided by the document evidencing the Material Obligation;

(j) Lessee shall fail to obtain, maintain, and replenish the Letter of Credit as required by Section 39.15 or Lessee fails to provide Lessor with a replacement letter of credit as and when required under this Lease; or

(k) if any monetary or material non-monetary default or event of default shall occur with respect to (i) the tenant's or lessee's obligations under any Pass-Through Lease or (ii) the landlord's or lessor's obligations under any MOB Ground Lease, in either case, which is not waived in writing or cured within the cure period as provided in such Pass-Through Lease or MOB Ground Lease.

(l) if, at any time during the Term, for two (2) consecutive calendar quarters:

(i) EBITDAR (calculated on a Pro Forma Basis) shall be less than One Hundred Fifty Percent (150%) of the Lease Payments (as determined utilizing the trailing twelve (12) month operating and financial results of Lima Holdco and its Subsidiaries and measured on a calendar quarterly basis); or

(ii) EBITDAR (calculated on a Pro Forma Basis) shall be less than One Hundred Twenty-Five Percent (125%) of Consolidated Fixed Charges (as determined utilizing the trailing twelve (12) month operating and financial results of Lima Holdco and its Subsidiaries and measured on a calendar quarterly basis).

(iii) Notwithstanding the foregoing, in the event that Lessee fails (or, but for the operation of this paragraph, would fail) to comply with the requirements of Section 16.1(l)(i) or (ii), until the thirtieth (30th) day subsequent the earlier of (1) the date that Lessee becomes aware of such non-compliance or (2) the date of delivery of written notice from Lessor relating to such failure (the "**Equity Cure Expiration Date**"), Lima Holdco shall have the right to issue its equity interests for cash or to receive an equity contribution in respect of its equity interests (the

"**Equity Cure Right**"), and upon the receipt by Lima Holdco of such cash (the "**Specified Equity Contribution**"), EBITDAR shall be recalculated giving effect to the following pro forma adjustments:

(A) EBITDAR for the applicable calendar quarter (and any four-quarter period that contains such quarter) shall be increased, solely for the purpose of determining compliance with Section 16.1(l)(i) and (ii), by an amount equal to the Specified Equity Contribution; and

(B) if, after giving effect to the foregoing recalculations, Lessee shall then be in compliance with the requirements of Section 16.1(l)(i) and (ii), Lessee shall be deemed to have satisfied the requirements of such section as of the relevant date of determination with the same effect as though there had been no failure to comply therewith at such date, and the applicable Event of Default that had occurred shall be deemed cured for purposes of this Lease.

(iv) Notwithstanding anything herein to the contrary, after the failure to comply with the requirements of Section 16.1(l), if Lessee has given Lessor notice that Lessee intends to cure such failure with the proceeds of a Specified Equity Contribution, Lessor shall not exercise any rights or remedies under Section 16 available during the continuance of any Event of Default on the basis of any actual or purported failure to comply with Section 16.1(l) until such failure is not cured on or prior to the Equity Cure Expiration Date.

(v) For the avoidance of doubt, the Equity Cure Rights provided for herein shall only arise in connection with the failure to comply with the requirements of Section 16.1(l), and no Equity Cure Right shall be available in connection with any other Event of Default.

(vi) It is understood and agreed that Lessor and Lessee agree to work together in good faith to adjust Section 16.1(l) after the Effective Date to reflect future acquisitions of real property joined under this Lease.

If an Event of Default has occurred, Lessor shall have the right at its election, then or at any time thereafter, to pursue any one or more of the following remedies, in addition to any remedies which may be permitted by law, by other provisions of this Lease or otherwise, without notice or demand, except as hereinafter provided:

A. If Lessee deserts, abandons or vacates any Property for which the Primary Intended Use is a licensed general acute care hospital facility or a critical access hospital (the "**Vacated Property**"), Lessor may enter upon and take possession of either (i) the Vacated Property; or (ii) if there has occurred a Major Event of Default, any one or more (including all, if so elected by Lessor) of the Properties, regardless of whether such Event of Default emanated from or related primarily to a single Property (whether one or more, and whether pursuant to clause (i) or (ii), the "**Entered Property**"), to protect it from deterioration and continue to demand from Lessee Rent and other charges as provided in this Lease, without any obligation to relet (except to the extent required by

applicable law); but if Lessor does relet the Entered Property (on such terms and conditions as Lessor, in its sole discretion, shall deem reasonable), such action by Lessor shall not be deemed an acceptance of Lessee's surrender of the Entered Property unless Lessor expressly notifies Lessee of such acceptance in writing, Lessee hereby acknowledging that Lessor shall otherwise be reletting as Lessee's agent and Lessee furthermore hereby agreeing to pay to Lessor on demand any deficiency that may arise between the Rent and other charges as provided in this Lease and that are actually collected by Lessor relating to the Entered Property.

B. Lessor, or anyone acting on Lessor's behalf, may without notice or demand to Lessee, either (i) enter the Property from which such Event of Default emanated or to which such Event of Default related primarily; or (ii) if there has occurred a Major Event of Default, enter any one or more (including all, if so elected by Lessor) of the Properties, regardless of whether such Event of Default emanated from or related primarily to a single Property (whether one or more, and whether pursuant to clause (i) or (ii), the "**Defaulted Property**"), by force, if necessary, to the extent permitted by applicable laws and regulations without liability to action for prosecution or damages for such entry or for the manner thereof, and do whatever Lessee is obligated or permitted to do under this Lease. Lessee hereby releases and discharges Lessor and its agents from all claims, actions, suits, damages and penalties for or by reason of any such entry. Lessee agrees to reimburse Lessor on demand for all expenses, including, without limitation, reasonable attorneys' fees and expenses, that Lessor may incur in effecting compliance with Lessee's obligations under this Lease, and Lessee further agrees that Lessor shall not be liable for any damages resulting to Lessee from such action.

C. Lessor may immediately terminate Lessee's right of possession of the Defaulted Property, but not terminate this Lease with respect to the Defaulted Property, and without notice or demand, except as may be required by applicable law, enter upon such Defaulted Property or any part thereof and take absolute possession of the same, and at Lessor's sole option may relet such Defaulted Property or any part thereof for such terms and such rents as Lessor may reasonably elect. In the event of such reletting, the rent received by Lessor from such reletting shall be applied in the manner set forth in Section 16.4, and Lessee shall satisfy and pay any deficiency upon demand therefor from time to time. Any entry into and possession of the Defaulted Property by Lessor shall be without liability or responsibility to Lessee and shall not be in lieu of or in substitution for any other legal rights of Lessor hereunder. Lessee further agrees that Lessor may file suit to recover any sums due under the terms of this Lease and that no recovery of any portion due Lessor hereunder shall be any defense to any subsequent action brought by Lessor for any other amounts not reduced to judgment in favor of Lessor. Reletting any portion of the Defaulted Property relating to any one or more of the Properties shall not be construed as an election on the part of Lessor to terminate this Lease with respect to such Defaulted Property and, notwithstanding any such reletting without termination, Lessor may at any time thereafter elect to terminate this Lease for default with respect to the Defaulted Property.

D. Lessor may terminate this Lease with respect to the Defaulted Property (whether one or more, the "**Terminated Property**"), by written notice to Lessee, in which event Lessee shall immediately surrender to Lessor such Terminated Property, and if Lessee fails to do so, Lessor may, without prejudice to any other remedy which Lessor may have for possession or arrearages in Rent or any other payments under this Lease (including any interest and payment penalty which may have accrued pursuant to the terms of this Lease), enter upon and take

possession of such Terminated Property and expel or remove the applicable Facility Lessee and any other Person who may be occupying such Terminated Property or any part thereof, by force, if necessary, to the extent permitted by applicable laws and regulations without being liable for prosecution or any claim for damages therefor. Except as otherwise may be required by applicable law or as otherwise expressly required under this Lease, Lessee hereby waives any statutory requirement of prior written notice for filing eviction or damage suits for nonpayment of Rent or any other payments under this Lease. In addition, Lessee agrees to pay to Lessor on demand the amount of all loss and damage which Lessor may suffer by reason of any termination effected pursuant to this Section 16.1D, which loss and damage shall be determined, at Lessor's option, by either of the following alternative measures of damages:

(vii) Until Lessor is able to relet such Terminated Property, although Lessor shall be under no obligation to attempt to do so (unless required by applicable law), Lessee shall pay to Lessor, on or before the first day of each calendar month, the monthly rentals and other charges provided in this Lease relating to such Terminated Property. After such Terminated Property has been relet by Lessor, Lessee shall pay to Lessor on the tenth (10th) day of each calendar month the amount, if any, by which the monthly rentals and other charges provided in this Lease related to such Terminated Property for the preceding calendar month (had this Lease not been terminated) exceed those actually collected by Lessor with respect to such reletting for that month. If it is necessary for Lessor to bring suit to collect any deficiency, Lessor shall have the right to allow such deficiencies to accumulate and to bring an action on several or all of the accrued deficiencies at one time. Any such suit shall not prejudice in any way the right of Lessor to bring a similar action for any subsequent deficiency or deficiencies. Any amount collected by Lessor from subsequent Tenants related to such Terminated Property for any calendar month in excess of the monthly Rent (including Additional Charges) herein allocated to such Terminated Property had this Lease not been terminated with respect thereto shall be credited to Lessee in reduction of Lessee's liability for any calendar month for which the amount collected by Lessor will be less than the monthly Rent (including Additional Charges) herein allocated to such Terminated Property had this Lease not been terminated with respect thereto such Terminated Facility, but Lessee shall have no right to any excess other than the above described credit.

(viii) When Lessor desires, Lessor may demand a final settlement with respect to such Terminated Property. Upon demand for a final settlement, Lessor shall have a right to, and Lessee hereby agrees to pay, the difference between the total of all monthly Rent (including Additional Charges) allocated to such Terminated Property for the remainder of the Term and the reasonable rental value thereof for such period, with such difference to be discounted to present value at a rate equal to the 5-Year U.S. Treasury Rate plus Two Percent (2%) per annum in effect upon the date of determination.

If Lessor elects to exercise the remedies prescribed in subsections A or B above, this election shall in no way prejudice Lessor's right at any time thereafter to cancel said election in favor of the remedy prescribed in subsection D or elsewhere in this Lease. Similarly, if Lessor

elects to compute damages in the manner prescribed by subsection D(i) above, this election shall in no way prejudice Lessor's right at any time thereafter to demand a final settlement in accordance with subsection D(ii). Pursuit of any of the above remedies shall not preclude pursuit of any other remedies prescribed in other sections of this Lease and any other remedies provided by law or equity. Forbearance by Lessor to enforce one or more of the remedies herein provided upon an Event of Default shall not be deemed or construed to constitute a waiver of such default.

E. In the event that Lessor has either repossessed a Vacated Property pursuant to subsection A, repossessed a Defaulted Property pursuant to subsection C, or terminated this Lease with respect to one or more (or all, if so elected by Lessor) Defaulted Properties pursuant to subsection D, and Lessor elects to enter upon such portion of the Leased Property as provided herein, Lessor may change, alter, and/or modify the door locks on all entry doors of such portion of the Leased Property, thereby permanently excluding Lessee and its officers, principals, agents, employees, representatives and invitees therefrom. Lessor shall not thereafter be obligated to provide Lessee with a key to such portion of Leased Property at any time, regardless of any amounts subsequently paid by Lessee; *provided, however*, that in any such instance, during Lessor's normal business hours and at the convenience of Lessor, and upon receipt of written request from Lessee accompanied by such written waivers and releases as Lessor may reasonably require, Lessor may either (at Lessor's option) (1) escort Lessee or its authorized personnel to such Leased Property to retrieve any personal belonging or other property of Lessee not subject to Lessor's right of purchase as provided in Section 34.1, or (2) obtain a list from Lessee of such personal property not subject to Lessor's right of purchase as provided in Section 34.1, whereupon Lessor shall remove such property and make it available to Lessee at a time and place designated by Lessor. However, if Lessor elects option (2), Lessee shall pay, in cash in advance, all reasonable costs and expenses estimated by Lessor to be incurred in removing such property and making it available to Lessee and all moving and/or storage charges theretofore incurred by Lessor with respect to such property (plus an additional Seven Percent (7%) thereof to cover Lessor's administrative costs). If Lessor elects to exclude Lessee from any Defaulted Property (or all of the Defaulted Properties if so elected by Lessor) without repossessing or terminating pursuant to the foregoing provisions of this Lease, then Lessor shall not be obligated to provide Lessee a key to re-enter such Property or Properties until such time as all delinquent Rent has been paid in full and all other defaults, if any, have been completely cured to Lessor's satisfaction (if such cure occurs prior to any actual repossession or termination), and Lessor has been given assurance reasonably satisfactory to Lessor evidencing Lessee's ability to satisfy its remaining obligations under this Lease. To the extent permitted by law, the foregoing provision shall override and control any conflicting provisions of any applicable statute governing the right of a lessor to change the door locks of commercial leases.

F. In addition to any other available remedies, at Lessor's option, with respect to each Defaulted Property or Entered Property, Lessor shall have those rights (i) to purchase Lessee's Personal Property in the manner provided in Section 34.2 hereof and (ii) to effect a transfer of the Licenses pursuant to the terms of Article XXXVIII hereof.

G. Exercise any and all other rights and/or remedies granted or allowed to landlords by any existing or future statute or other law of the applicable State where the Entered Property or the Defaulted Property, as applicable, is located.

H. In the event, and only in the event, that applicable law requires Lessor to attempt to mitigate damages following the termination of Lessee's rights under this Lease with respect to any one or more of the Properties as provided in subsection D(i) above, Lessor shall use reasonable efforts to the extent required by applicable law to relet such Property or Properties on such terms and conditions as Lessor, in its sole good faith judgment, may determine (including, without limitation, a lease term different than the Term, rental concessions, alterations and repair any such Property); *provided, however*, that, with respect to any such Property or Properties (i) Lessor shall not be obligated to relet such Property before leasing other vacant space owned or operated by Lessor, (ii) Lessor reserves the right to refuse to lease such Property to any potential tenant that does not meet Lessor's reasonable standards and criteria for leasing any other comparable space owned or operated by Lessor (it being understood and agreed that it shall be deemed reasonable for Lessor to refuse to lease to a prospective tenant who owns, leases or operates a business similar to that conducted on such Property in the County where such Property is located), and (iii) Lessor shall not be obligated to undertake any greater efforts to relet such portion of the Leased Property than Lessor utilizes to lease any other vacant space owned or operated by Lessor. In any proceeding in which Lessor's efforts to mitigate damages and/or its compliance with this subsection is at issue, Lessor shall be presumed to have used reasonable efforts to mitigate damages and Lessee shall bear the burden of proof to establish that such reasonable efforts were not used.

I. No receipt of moneys by Lessor from Lessee after a termination of this Lease with respect to any one or more of the Properties or of Lessee's rights under this Lease by Lessor with respect thereto shall reinstate, continue or extend the Term of this Lease with respect to such one or more Properties or affect any notice theretofore given to Lessee, or operate as a waiver of the right of Lessor to enforce the payment of Rent and any related amounts to be paid by Lessee to Lessor then due or thereafter falling due, it being agreed that after the commencement of suit for possession of any such Property, or after final order or judgment for the possession of any such Property, Lessor may demand, receive and collect any moneys due or thereafter falling due without in any manner affecting such suit, order or judgment, all such money collected being deemed payments on account of the use and occupation of any such Property or, at the election of Lessor, on account of Lessee's liability hereunder. Lessee hereby waives any and all rights of redemption provided by any law, statute or ordinance now in effect or which may hereafter be enacted.

J. No right or remedy herein conferred upon or reserved to Lessor is intended to be exclusive of any other right or remedy, and every right and remedy shall be cumulative and in addition to any other legal or equitable right or remedy given hereunder, or at any time existing. The failure of Lessor to insist upon the strict performance of any provision or to exercise any option, right, power or remedy contained in this Lease shall not be construed as a waiver or a relinquishment thereof for the future, and no acceptance of full or partial payment of Rent or any other payment due under the terms of this Lease during the continuance of any such breach shall constitute a waiver of any such breach or any such term. To the extent permitted by law, no waiver of any breach shall affect or alter this Lease, which shall continue in full force and effect with respect to any other then existing or subsequent breach. Lessor and Lessee agree that no waiver shall be effective hereunder unless it is in writing.

K. **Additional Expenses**. It is further agreed that, in addition to payments required pursuant to Section 16.1 above and the provisions of Section 39.3, Lessee shall compensate Lessor and its Affiliates for (a) all reasonable expenses incurred by Lessor and its Affiliates in enforcing

the provisions of this Lease and in repossessing the Leased Property or any portion thereof (including among other expenses, any increase in insurance premiums caused by the vacancy of all or any portion of the Leased Property); (b) all reasonable expenses incurred by Lessor and its Affiliates in reletting (including among other expenses, repairs, remodeling, replacements, advertisements and brokerage fees); (c) all concessions granted to a new Tenant or Tenants upon reletting (including among other concessions, renewal options); (d) Lessor's and its Affiliates' reasonable attorneys' fees and expenses arising from or related to an Event of Default; (e) all losses incurred by Lessor and its Affiliates as a direct or indirect result of such Event of Default (including, among other losses, any adverse action by Facility Lenders); and (f) a reasonable allowance for Lessor's administrative efforts, salaries and overhead attributable directly or indirectly to such Event of Default and Lessor's pursuing the rights and remedies provided herein and under applicable law.

16.2. **Waivers**.

(a) If this Lease is terminated pursuant to Section 16.1, Lessee waives, to the extent permitted by applicable law, (i) any right of redemption, re-entry or repossession; (ii) any right to a trial by jury in the event of summary proceedings to enforce the remedies set forth in this Article XVI; (iii) the benefit of any laws now or hereafter in force exempting property from liability for rent or for debt; and (iv) any statutory requirement of prior written notice for filing eviction or damage suits for nonpayment of Rent or any other payments under this Lease. Lessee acknowledges and agrees that no waiver by Lessor of any provision of this Lease shall be deemed to have been made unless made under signature of an authorized representative of Lessor.

(b) To the extent permitted by applicable law, Lessee waives any and all rights or defenses arising by reason of: (i) any "one action" or "anti-deficiency" law or any other law which may prevent Lessor from bringing any action, including a claim for deficiency, against Lessee or any one or more of the Facility Lessees or Guarantor, before or after Lessor's commencement or completion of any foreclosure or similar action or actions, either judicially or by exercise of a power of sale; (ii) any election of remedies by Lessor which destroys or otherwise adversely affects Lessee or any one or more of the Facility Lessee's or Guarantor's subrogation rights or rights to proceed against any Person for reimbursement, including, without limitation, any loss of rights Lessee or Guarantor may suffer by reason of any law limiting, qualifying, or discharging Lessee's and Guarantor's obligations under this Lease or the other Obligation Documents (as applicable), (iii) any disability or other defense of any other Person, other than payment in full in legal tender, of Lessee's and Guarantor's obligations under this Lease or the other Obligation Documents (as applicable); (iv) any defenses given to guarantors, sureties, and/or co-makers at law or in equity other than actual payment and performance of Lessee's and Guarantor's obligations under this Lease or the other Obligation Documents (as applicable); or (vi) any action by Lessor or its Affiliates to enforce its rights and remedies under this Lease and the other Obligation Documents.

16.3. **Application of Funds**. Any payments otherwise payable by Lessee which are received by Lessor under any of the provisions of this Lease during the existence or continuance of any Event of Default shall be applied to Lessee's obligations in the order which Lessor may reasonably determine.

16.4. **Notices by Lessor**. The provisions of this Article XVI concerning notices shall be liberally construed insofar as the contents of such notices are concerned, and any such notice shall be sufficient if reasonably designed to apprise Lessee of the nature and approximate extent of any default, it being agreed that Lessee is in as good or a better position than Lessor to ascertain the exact extent of any default by Lessee hereunder.

ARTICLE XVII.
LESSOR'S RIGHT TO CURE

Subject to the provisions of Article XII relating to permitted contests, if Lessee shall fail to make any payment, or to perform any act required to be made or performed under this Lease and to cure the same within the relevant time periods provided in Section 16.1, after written notice to Lessee, Lessor, without waiving or releasing any obligation or Event of Default, may (but shall be under no obligation to) at any time thereafter make such payment or perform such act for the account and at the expense of Lessee, and may, to the extent permitted by law, enter upon any portion of the Leased Property for such purpose and take all such action thereon as, in Lessor's opinion, may be necessary or appropriate therefor. No such entry shall be deemed an eviction of Lessee. All sums so paid by Lessor and all reasonable costs and expenses (including, without limitation, reasonable, documented, out-of-pocket attorneys' fees and expenses, in each case, to the extent permitted by law) so incurred, together with a late charge thereon (to the extent permitted by law) at the Overdue Rate from the date on which such sums or expenses are paid or incurred by Lessor until reimbursed, shall be paid by Lessee to Lessor on demand.

ARTICLE XVIII.
PURCHASE OF THE LEASED PROPERTY

In the event Lessee purchases any Property pursuant to the terms of this Lease, Lessor shall, upon receipt from Lessee of the applicable purchase price, together with full payment of any unpaid Rent, including, without limitation, any unpaid Additional Charges and any other amounts owed by Lessee or its Affiliates who are directly or indirectly controlled by Guarantor to Lessor and any of its respective Affiliates, due and payable with respect to any period ending on or before the date of the purchase, deliver to Lessee an appropriate special warranty deed or other instrument of conveyance conveying the entire interest of Lessor in and to the Leased Property of such Property to Lessee in the condition as received from Lessee, free and clear of all encumbrances other than (a) those that Lessee has agreed hereunder to pay or discharge, (b) those mortgage liens, if any, which Lessee has agreed in writing to accept and to take title subject to, (c) any other Encumbrances permitted to be imposed on the Leased Property under the provisions of Article XXXVI which are assumable at no cost to Lessee or to which Lessee may take subject without cost to Lessee, and (d) any matters affecting such portion of the Leased Property relating to such Property on or as of the Commencement Date. The positive difference, if any, between the applicable purchase price and the total of the monetary encumbrances assigned or taken subject to shall be paid in cash to Lessor, or as Lessor may direct, in federal or other immediately available funds except as otherwise mutually agreed by Lessor and Lessee. The closing of any such sale shall be contingent upon and subject to Lessee obtaining all required governmental consents and approvals for such transfer and if such sale shall fail to be consummated by reason of the inability of Lessee to obtain all such approvals and consents, any options to extend the Term of this Lease which otherwise would have expired during the period from the date when Lessee elected or

became obligated to purchase such Property until Lessee's inability to obtain the approvals and consents is confirmed shall be deemed to remain in effect for thirty (30) days after the end of such period. All expenses of such conveyance, including, without limitation, the cost of title examination or standard coverage title insurance, survey, reasonable attorneys' fees incurred by Lessor in connection with such conveyance, transfer taxes, prepayment penalties, and any other fees of any Facility Lender with respect to any Facility Instrument, recording fees and similar charges shall be paid by Lessee. Notwithstanding anything contained herein to the contrary, Lessee understands, acknowledges and agrees that the purchase of the Pass-Through Lease Land or Improvements located thereof will only be a purchase of Lessor's leasehold interest in such Pass-Through Lease Land and, as applicable, any leased Improvements, and shall be subject to all of the terms, provisions and conditions of the applicable Pass-Through Lease (which shall be assumed by Lessee). Contemporaneously with the closing of any such sale, the rent payable under this Lease shall be reduced by the Allocated Base Rent (as the same may have been increased pursuant to Section 3.1(b) hereof) of the applicable Leased Property to reflect the deletion of the applicable Property.

ARTICLE XIX.
HOLDING OVER

If Lessee shall for any reason remain in possession of any Property after the expiration of the Term or any earlier termination of the Term with respect to thereto, such possession shall be as a tenancy at will, during which time Lessee shall pay, as rental each month, one and one-half (1-1/2) times the aggregate of (a) one-twelfth (1/12) of the aggregate Allocated Base Rent relating to such Property payable with respect to the last complete twelve (12)-month period prior to the expiration of the Term; (b) all Additional Charges relating to such Property accruing during the month, and (c) all other sums, if any, payable by Lessee pursuant to the provisions of this Lease with respect to such Property. During such period of tenancy, Lessee shall be obligated to perform and observe all of the terms, covenants and conditions of this Lease, but shall have no rights hereunder other than the right, to the extent given by law to tenancies at will, to continue its occupancy and use of such Property. Nothing contained herein shall constitute the consent, express or implied, of Lessor to the holding over of Lessee after the expiration or earlier termination of this Lease.

ARTICLE XX.
INTENTIONALLY OMITTED

ARTICLE XXI.
RISK OF LOSS

Subject to the terms of Article XIV and Article XV hereof, during the Term, the risk of loss of, or decrease in, the enjoyment and beneficial use of the Leased Property in consequence of the damage or destruction thereof by fire, the elements, casualties, thefts, riots, wars or otherwise, or in consequence of foreclosures, attachments, levies or executions (other than by Lessor and those claiming from, through or under Lessor) is assumed by Lessee and, Lessor shall in no event be answerable or accountable therefor nor shall any of the events mentioned in this Article XXI entitle Lessee to any abatement of Rent except as specifically provided in this Lease.

ARTICLE XXII.
INDEMNIFICATION

NOTWITHSTANDING THE EXISTENCE OF ANY INSURANCE OR SELF INSURANCE PROVIDED FOR IN ARTICLE XIII, AND WITHOUT REGARD TO THE POLICY LIMITS OF ANY SUCH INSURANCE OR SELF INSURANCE, IN ADDITION TO ANY OTHER INDEMNIFICATION OBLIGATIONS OF LESSEE AND GUARANTOR AS PROVIDED IN THIS LEASE, LESSEE WILL PROTECT, INDEMNIFY, SAVE HARMLESS AND DEFEND LESSOR FROM AND AGAINST ALL LIABILITIES, OBLIGATIONS, CLAIMS, DAMAGES, PENALTIES, CAUSES OF ACTION, COSTS AND EXPENSES (INCLUDING, WITHOUT LIMITATION, REASONABLE ATTORNEYS' FEES AND EXPENSES) TO THE EXTENT PERMITTED BY LAW, IMPOSED UPON OR INCURRED BY OR ASSERTED AGAINST LESSOR BY REASON OF: (A) ANY ACCIDENT, INJURY TO OR DEATH OF PERSONS OR LOSS OF PERSONAL PROPERTY OCCURRING ON OR ABOUT THE LEASED PROPERTY OR ADJOINING SIDEWALKS, INCLUDING WITHOUT LIMITATION ANY CLAIMS OF MALPRACTICE, (B) ANY USE, MISUSE, NO USE, CONDITION, MAINTENANCE OR REPAIR BY LESSEE OF THE LEASED PROPERTY, (C) ANY IMPOSITIONS (WHICH ARE THE OBLIGATIONS OF LESSEE TO PAY PURSUANT TO THE APPLICABLE PROVISIONS OF THIS LEASE), (D) ANY FAILURE ON THE PART OF LESSEE TO PERFORM OR COMPLY WITH ANY OF THE TERMS OF THIS LEASE, (E) THE NON-PERFORMANCE OF ANY OF THE TERMS AND PROVISIONS OF ANY AND ALL EXISTING AND FUTURE SUBLEASES OF THE LEASED PROPERTY TO BE PERFORMED BY THE LANDLORD (LESSEE) THEREUNDER, (F) ANY AND ALL LAWFUL ACTION THAT MAY BE TAKEN BY LESSOR IN CONNECTION WITH THE ENFORCEMENT OF THE PROVISIONS OF THIS LEASE, WHETHER OR NOT SUIT IS FILED IN CONNECTION WITH SAME, OR IN CONNECTION WITH LESSEE OR GUARANTOR AND/OR ANY PARTNER, JOINT VENTURER, MEMBER OR SHAREHOLDER THEREOF BECOMING A PARTY TO A VOLUNTARY OR INVOLUNTARY FEDERAL OR STATE BANKRUPTCY, INSOLVENCY OR SIMILAR PROCEEDING, (G) WITH RESPECT TO EACH PROPERTY, (i) ENCROACHMENTS ONTO OR FROM ADJACENT PROPERTIES; (ii) VIOLATIONS OF SET-BACK, BUILDING OR SIDE LINES; (iii) ENCROACHMENTS ONTO ANY EASEMENTS OR SERVITUDES LOCATED ON SUCH PROPERTY; (iv) PENDING OR THREATENED BOUNDARY LINE DISPUTES; (v) PORTIONS OF SUCH PROPERTY LOCATED IN A FLOOD PLAIN OR IN AN AREA DEFINED AS A WETLAND UNDER APPLICABLE STATE OR FEDERAL LAW; (vi) CEMETERIES OR GRAVESITES LOCATED ON, WITHIN OR UNDER SUCH PROPERTY; OR (vii) MINE SHAFTS UNDER SUCH PROPERTY OR ANY OTHER LATENT DEFECTS, SUCH AS SINKHOLES, REGARDING OR AFFECTING SUCH PROPERTY, (H) ANY GRANTS, CONVEYANCES OR TRANSFERS OF ANY INTERESTS OR RIGHTS IN OR TO THE LEASED PROPERTY (INCLUDING, WITHOUT LIMITATION, EASEMENTS, RIGHTS-WAY, RESTRICTIONS) MADE BY LESSEE OR ANY OTHER PERSON WHICH ARE NOT APPROVED BY LESSOR PRIOR TO PLACING THE SAME OF RECORD ON THE LEASED PROPERTY, INCLUDING, WITHOUT LIMITATION, THOSE PRIOR TO THE LESSOR TAKING TITLE TO THE LEASED PROPERTY, (I) THE IMPROVEMENTS HAVING INSUFFICIENT ACCESS TO A PUBLIC RIGHT

OF WAY OR FAILING TO BE IN COMPLIANCE WITH ALL RULES, REGULATIONS AND ORDINANCES OF ALL GOVERNMENTAL AUTHORITIES HAVING JURISDICTION OVER THE IMPROVEMENTS AND THE LAND, INCLUDING, WITHOUT LIMITATION, THOSE PERTAINING TO ZONING AND PARKING, (J) ANY FAILURE ON THE PART OF LESSEE TO PERFORM OR COMPLY WITH ANY OF THE TERMS OF ANY OF THE PASS-THROUGH LEASES; (K) ANY REVERSION OF THE APPLICABLE LEASED IMPROVEMENTS UNDER ANY OF THE PASS-THROUGH LEASES TO THE "LANDLORD" OR "LESSOR" THEREUNDER; AND (L) ANY FAILURE ON THE PART OF LESSEE TO PERFORM OR COMPLY WITH ANY OF THE TERMS OF ARTICLE XLI OR THE MOB GROUND LEASES. ANY AMOUNTS WHICH BECOME PAYABLE BY LESSEE UNDER THIS ARTICLE XXII SHALL BE PAID WITHIN FIFTEEN (15) DAYS AFTER DEMAND THEREFOR BY LESSOR AND, IF NOT TIMELY PAID, SHALL BEAR A LATE CHARGE (TO THE EXTENT PERMITTED BY LAW) AT THE OVERDUE RATE FROM THE EXPIRATION OF SAID FIFTEEN (15) DAY PERIOD UNTIL THE DATE OF PAYMENT AND A LATE PAYMENT PENALTY ON SUCH AMOUNT. LESSEE, AT ITS EXPENSE, SHALL CONTEST, RESIST AND DEFEND ANY SUCH CLAIM, ACTION OR PROCEEDING ASSERTED OR INSTITUTED AGAINST LESSOR AND MAY COMPROMISE OR OTHERWISE DISPOSE OF THE SAME, SUBJECT TO THE APPROVAL OF LESSOR. NOTHING HEREIN SHALL BE CONSTRUED AS INDEMNIFYING LESSOR (I) AGAINST LESSOR'S OWN GROSSLY NEGLIGENT ACTS OR OMISSIONS OR WILLFUL MISCONDUCT OR (II) WITH RESPECT TO ANY ACTS OR OMISSIONS WHICH OCCUR AFTER THE EARLIER OF (X) SUBJECT TO ARTICLE XIX WITH RESPECT TO THE APPLICABLE LEASED PROPERTY, THE TERMINATION OR EXPIRATION OF THIS LEASE OR (Y) LESSEE'S DISPOSSESSION OF THE APPLICABLE LEASED PROPERTY IN ACCORDANCE WITH THIS LEASE.

ARTICLE XXIII.
ASSIGNMENT, SUBLETTING AND SUBLEASE SUBORDINATION

23.1. **Assignment and Subletting**.

(a) Lessee shall not assign this Lease without Lessor's prior written consent. Lessor shall not unreasonably withhold, condition or delay its consent to any assignment, *provided, that*: (i) such assignee shall assume in writing and agree to keep and perform all of the terms of this Lease on the part of Lessee to be kept and performed; and (ii) an original counterpart of the assignment, duly executed by Lessee and such assignee in form and substance reasonably satisfactory to Lessor, shall be delivered promptly to Lessor; it being understood and agreed, however, that if, in connection with any such assignment, Lessee desires that Lessor release Lessee from its obligations under this Lease, Lessor's review and approval of any assignee shall be in Lessor's sole and absolute discretion. The parties agree that Lessor's failure or refusal to approve an assignment to an assignee that does not have the operating characteristics reasonably satisfactory to Lessor shall be reasonable on its face. Notwithstanding anything contained in this Lease to the contrary, any assignment must be of all of Lessee's right, title and interest in and to this Lease and the Leased Property such that this Lease is not severed with respect to any one or more of the Properties. Notwithstanding the foregoing or anything else contained in this Lease to

the contrary, Lessee shall not collaterally assign its leasehold interest or any of its rights and interests in this Lease or the Leased Property to any lender of Lessee without the prior written consent of Lessor, which consent may be withheld in Lessor's sole discretion.

(b) Lessee shall not sublease any portion of a particular Property if such Tenant Lease would exceed Two Hundred Fifty Thousand and No/100 Dollars ($250,000.00) in annual rent without Lessor's prior written consent, which consent shall not be unreasonably withheld, conditioned or delayed. Lessee agrees that (i) each Tenant Lease shall comply with the provisions of this Article XXIII, (ii) subject to Section 23.4, a copy of each such Tenant Lease, duly executed by Lessee and such Tenant in form and substance reasonably satisfactory to Lessor, shall be delivered promptly to Lessor, (iii) if applicable, Lessee shall obtain (at Lessee's sole cost and expense) all consents and approvals required for the sublease of any Pass-Through Lease), and (iv) Lessee shall remain primarily liable, as principal rather than as surety, for the prompt payment of the Rent and for the performance and observance of all of the obligations, covenants and conditions to be performed by Lessee hereunder (and, if applicable, under the Pass-Through Lease) and under all of the other documents executed in connection herewith. Any modifications, amendments and restatements of any Tenant Leases (but excluding renewals and extensions) hereafter entered into (other than those having less than Two Hundred Fifty Thousand and No/100 Dollars ($250,000.00) in annual rent) must be approved by Lessor in accordance with this Article XXIII. In no event shall Lessee sublease all or substantially all of any Property without Lessor's prior written consent, which may be withheld in Lessor's sole discretion.

23.2. **Sublease Limitations**. In addition to the sublease limitations as set forth in Section 23.1, above, and notwithstanding anything contained in this Lease to the contrary, Lessee shall not sublet the Leased Property on any basis such that the rental to be paid by the Tenant thereunder would be based, in whole or in part, on either (a) the income or profits derived by the business activities of the Tenant, or (b) any other formula such that any portion of the Tenant Lease rental received by Lessor would fail to qualify as "rents from real property" within the meaning of Section 856(d) of the Code, or any similar or successor provision thereto. Moreover, Lessee shall not sublet any portion of the Leased Property for a term extending beyond the Fixed Term without the express consent of Lessor. In addition, all Tenant Leases shall comply in all material respects with the Healthcare Laws, as applicable. Lessor and Lessee acknowledge and agree that all Tenant Leases entered into relating to the Leased Property, whether or not approved by Lessor, shall not, without the prior written consent of Lessor, be deemed to be a direct lease between Lessor and any Tenant. Lessee agrees that all Tenant Leases must include provisions to the effect that (i) such sublease is subject and subordinate to all of the terms and provisions of this Lease, to the rights of Lessor hereunder, and to all financing documents relating to any Facility Loan in connection with the Leased Property, (ii) in the event this Lease shall terminate or be terminated before the expiration of the Tenant Lease, the Tenant will, at Lessor's option, exercisable at any time in Lessor's discretion, attorn to Lessor and waive any right the Tenant may have to terminate the sublease or to surrender possession thereunder as a result of the termination of this Lease, (iii) in the event of a termination of this Lease with respect to all or the applicable Property, at Lessor's option, exercisable at any time in Lessor's discretion, the sublease may be terminated or left in place by Lessor, (iv) Tenant shall from time to time upon request of Lessee or Lessor furnish within twenty (20) days from request an estoppel certificate in form and content reasonably acceptable to Lessor or any Facility Lender relating to the Tenant Lease, and (v) such Tenant Lease shall at all times be subject to the obligations and requirements as set forth in this Article XXIII.

23.3. **Sublease Subordination and Non-Disturbance**.

(a) At any time during the Term, except with respect to the Existing Subleases, within twenty (20) days following written request by Lessor with respect to any Tenant, Lessee shall cause any applicable Tenant to execute and deliver to Lessor (a) an estoppel certifying such matters as Lessor may reasonably request, including, without limitation, that such Tenant Lease is unmodified and in full force and effect (or setting forth the modifications), the term and expiration thereof and the dates to which the Rent has been paid; and/or (b) a subordination, non-disturbance and attornment agreement relating to the applicable Tenant Lease, which subordination, non-disturbance and attornment agreement shall be in form mutually satisfactory to Lessor and Lessee.

(b) Within twenty (20) days from the date of request of Lessor, a Facility Lender or Lessee, with respect to any Tenant, Lessee shall use commercially reasonable efforts to cause such Tenant and Lessor shall cause such Facility Lender to enter into a written agreement in a form reasonably acceptable to such Facility Lender and such Tenant whereby (i) such Tenant subordinates the Tenant Lease and all of its rights and estate thereunder to each such mortgage or deed of trust that encumbers the Leased Property or any part thereof and agrees with each such Facility Lender that such Tenant will attorn to and recognize such Facility Lender or the purchaser at any foreclosure sale or any sale under a power of sale contained in any such mortgage or deed of trust, as the case may be, as Lessor under this Lease for the balance of the Term then remaining, subject to all of the terms and provisions of the Tenant Lease and (ii) such Facility Lender shall agree that Tenant shall not be disturbed in peaceful enjoyment of the applicable portion of the Leased Property nor shall the applicable Tenant Lease be terminated or canceled at any time, except as specified in the applicable Tenant Lease.

23.4. **Existing Subleases**. Notwithstanding anything contained herein to the contrary, Lessor and Lessee acknowledge that (a) there currently exist certain leases or subleases on the Leased Property as described on ***Exhibit E*** (collectively the "**Existing Subleases**"), (b) Lessee and not Lessor is the landlord under such Existing Sublease, and (c) to the extent that any Existing Subleases were assigned to Lessor in connection with the Transaction due to application of law, Lessor hereby assigns and Lessee hereby accepts such assignment of such Existing Subleases. Lessor hereby consents to the Existing Subleases. Any material modifications, amendments and restatements of the Existing Subleases or any Tenant Lease hereafter entered into (but excluding renewals and extensions that do not otherwise materially modify or amend the relevant Existing Sublease or Tenant Lease) must be approved by Lessor in accordance with this Article XXIII.

ARTICLE XXIV.
OFFICER'S CERTIFICATES; FINANCIAL STATEMENTS; NOTICES AND OTHER CERTIFICATES

(a) At any time and from time to time within twenty (20) days following written request by Lessor, each Facility Lessee shall furnish to Lessor an Officer's Certificate certifying that this Lease is unmodified and in full force and effect (or that this Lease is in full force and effect as modified and setting forth the modifications) and the dates to which the Rent has been paid. Any such Officer's Certificate furnished pursuant to this Article may be relied upon by Lessor and any prospective purchaser of the Leased Property.

(b) Each Facility Lessee shall furnish, or cause to be furnished, to Lessor the following statements, notices and certificates in such form and detail as Lessor may reasonably require:

(i) within the earlier of (A) one hundred twenty (120) days after the end of each year, or (B) any applicable deadline imposed by the Securities and Exchange Commission for filing thereof, audited Financial Statements of such Facility Lessee and LifePoint (which Financial Statements may be provided on a consolidated basis so long as such consolidated Financial Statements provide a supplementary schedule of such Facility Lessee's operating results and balance sheet and statements of operations and of cash flows and consolidating information reflecting material differences between LifePoint and its Subsidiaries, on the one hand, and Lima Holdco and its Subsidiaries, on the other hand) and, if such Facility Lessee owns any assets or conducts any other operations other than the Business, then of its Facility separately), prepared by a nationally recognized accounting firm or an independent certified public accounting firm reasonably acceptable to Lessor, which statements shall include balance sheets and statements of operations and of cash flows, all in accordance with GAAP for the year then ended; and

(ii) within the earlier of (A) sixty (60) days after the end of each quarter, or (B) any applicable deadline imposed by the Securities and Exchange Commission for filing thereof, current balance sheets and quarterly statements of operations (the "**Quarterly Statements**") of such Facility Lessee and LifePoint (including consolidating information reflecting material differences between LifePoint and its Subsidiaries, on the one hand, and Lima Holdco and its Subsidiaries, on the other hand), and, if such Facility Lessee owns any assets or conducts any other operations other than the Business, then of its Facility separately, and quarterly statements of cash flows from LifePoint (including consolidating information reflecting material differences between LifePoint and its Subsidiaries, on the one hand, and Lima Holdco and its Subsidiaries, on the other hand), certified to be true and correct by the principal accounting officer of LifePoint while Lima Holdco is Controlled By LifePoint (or a similarly responsible officer for any successor) and such Facility Lessee; and

(iii) within thirty (30) days after the end of each month, current balance sheets, monthly income statements and cash flows (if available or produced in the ordinary course of business) of such Facility Lessee and statistics of its Facility, including, but not limited to, the number of patient discharges, the number of inpatient days, the case mix index, the payor sources for inpatient days (by inpatient days), outpatient utilization by service (ER, non-ER), and, statements of Cash Collections for each such month; and

(iv) within thirty (30) days after the end of each calendar year, a list of the names, specialties, and ages of all active medical staff members of the Facility operated by such Facility Lessee, certified to be true and correct by an officer of such Facility Lessee; and

(v) within ten (10) days after receipt, any and all notices (regardless of form) from any and all licensing and/or certifying agencies that any license or certification, including, without limitation, the Medicare and/or Medicaid certification and/or managed care contract relating to the Facility operated by such Facility Lessee is being downgraded to a substandard category, revoked, or suspended, or that action is pending or being considered to downgrade to a substandard category, revoke, or suspend such Facility's license or certification; and

(vi) with reasonable promptness, such other information respecting the financial condition and affairs of such Facility Lessee, Lima Holdco, and their respective Subsidiaries, as Lessor may reasonably request from time to time; and

(vii) within the time period specified for delivery of the Quarterly Statements set forth in Article XXIV(b)(ii), the written calculation (and supporting materials) (in form reasonably acceptable to Lessor) of the Consolidated Net Income and EBITDAR of Lima Holdco and its Subsidiaries for such quarter, on a consolidated basis, certified to be true and correct by the principal accounting officer of LifePoint while Lima Holdco is Controlled By LifePoint (and a similarly responsible officer for any successor) and such Facility Lessee.

(c) Upon Lessor's request, each Facility Lessee and Lima Holdco shall furnish to Lessor a certificate in form reasonably acceptable to Lessor certifying that no Event of Default then exists and to Lessee's knowledge no event has occurred (that has not been cured) and no condition currently exists that would, but for the giving of any required notice or expiration of any applicable cure period, constitute an Event of Default, or disclosing that such an event or condition, if any, exists.

(d) Within five (5) Business Days after receipt, each Facility Lessee shall furnish to Lessor copies of all written notices and demands from any third-party payor, including, without limitation, Medicare and/or Medicaid, concerning any overpayment which will or could reasonably be expected to require a repayment or a refund in excess of Three Million and No/100 Dollars ($3,000,000.00) with respect to such Facility Lessee.

(e) Each Facility Lessee shall furnish to Lessor prompt written notice of, and any information related to, any governmental investigations of such Facility Lessee or the Guarantor (or any of its Subsidiaries), or any inspections or investigations of the Facility operated by such Facility Lessee which are conducted by the United States Attorney, State Attorney General, the Office of the Inspector General of the Department of Health and Human Services, or any other Governmental Body, and provide to Lessor, on a monthly basis, ongoing status reports (in form and content acceptable to Lessor) of any such government investigations;

(f) Each Facility Lessee shall furnish to Lessor within five (5) Business Days after receipt thereof copies of all pre-termination notices from Medicare and/or Medicaid, all notices of adverse events or deficiencies as defined by the regulations and standards of the state Medicare and/or Medicaid certification agency, the Joint Commission (formerly known as the Joint Commission on the Accreditation of Healthcare Organizations) (the "**Joint Commission**") or the equivalent accrediting body relied upon by such Facility Lessee in the operation of the Facility operated by such Facility Lessee or any part thereof, except if any termination, adverse event or deficiency referenced in such notice would not result in a material adverse effect on Lessee, the Properties and the Business taken as a whole.

(g) With respect to each Facility, such Facility Lessee shall furnish to Lessor promptly upon receipt thereof copies of all notices that such Facility Lessee, the Guarantor or their respective Subsidiaries are not, with respect to such Facility, in compliance with the Standards for Privacy of Individually Identifiable Health Information and the Transaction and Code Set Standards which were promulgated pursuant to HIPAA.

(h) Each Facility Lessee shall provide to Lessor prompt written notice of any monetary or material non-monetary default or event of default with respect to any Material Obligation of such Facility Lessee or the Guarantor and, upon Lessor's request, such Facility Lessee or the Guarantor shall furnish to Lessor a certificate in form reasonably acceptable to Lessor certifying that, with respect to each Material Obligation, no monetary or material non-monetary event of default or, to such Facility Lessee or Guarantor's knowledge, monetary or material non-monetary default, then exists thereunder.

(i) Lessor reserves the right to require such other financial information from Lessee at such other times as it shall deem reasonably necessary. All financial statements and information must be in such form and detail as Lessor shall from time to time, but not unreasonably, request.

(j) As to any information provided by any Facility Lessee to Lessor pursuant to this Article XXIV ("**Proprietary Information**"), neither Lessor, or its agents, representatives, employees, partners, members, officers or directors will disclose any Proprietary Information unless prior consent to such disclosure is obtained from Lessee, which consent may be withheld, conditioned or delayed at Lessee's sole discretion. Lessor shall hold in strict confidence and shall disclose Proprietary Information only to Lessor's employees, agents, attorneys, accountants, consultants, investors, potential investors, lenders, potential lenders, purchasers, potential purchasers and service providers who have a reason to know such Proprietary Information in order to assist Lessor. Neither Lessor nor any of its employees, agents, attorneys, accountants, consultants, investors, potential investors, lenders, potential lenders, purchasers, potential purchasers, or service providers shall disclose Proprietary Information to any other person or entity except in connection with any tax, regulatory, or loan securitization obligations or use Proprietary Information for its or their benefit or for any purpose not expressly agreed upon in writing by Lessee. The obligation hereunder to maintain the confidentiality of Proprietary Information shall not apply to any Proprietary Information which (i) is disclosed in a printed publication available to the public or is otherwise in the public domain through no act of the party to whom the Proprietary Information has been provided, (ii) is approved for release by written authorization of an officer of the party to whom the Proprietary Information belongs or (iii) is required to be

disclosed by proper order of a court of competent jurisdiction after adequate notice to the party to whom the Proprietary Information belongs in order to allow that party to seek a protective order therefor.

ARTICLE XXV.
INSPECTIONS

Upon reasonable prior written notice, Lessee shall permit Lessor, or its designated Affiliate, and their respective authorized representatives to inspect the Leased Property during usual business hours subject to any security, health, safety or confidentiality requirements of Lessee, any governmental agency, any Insurance Requirements relating to the Leased Property, or imposed by law or applicable regulations, except that, in the event of an emergency, Lessor shall have the right to inspect the Leased Property upon reasonable notice (which in this circumstance may be verbal) under the circumstances to Lessee.

ARTICLE XXVI.
NO WAIVER

Any provision of this Lease or Exhibits hereto may be amended or waived only in a writing signed by the parties hereto. No waiver of any provision hereunder or any breach or default thereof shall extend to or affect in any way any other provision or prior or subsequent breach or default.

ARTICLE XXVII.
REMEDIES CUMULATIVE

To the extent permitted by law, each legal, equitable or contractual right, power and remedy of Lessor or Lessee now or hereafter provided either in this Lease or by statute or otherwise shall be cumulative and concurrent and shall be in addition to every other right, power and remedy and the exercise or beginning of the exercise by Lessor or Lessee of any one or more of such rights, powers and remedies shall not preclude the simultaneous or subsequent exercise by Lessor or Lessee of any or all of such other rights, powers and remedies.

ARTICLE XXVIII.
SURRENDER

No surrender to Lessor of this Lease or of the Leased Property, or of any part thereof or interest therein, shall be valid or effective unless agreed to and accepted in writing by Lessor, and no act by Lessor or any representative or agent of Lessor, other than such a written acceptance by Lessor, shall constitute an acceptance of any such surrender.

ARTICLE XXIX.
NO MERGER OF TITLE

There shall be no merger of this Lease or of the leasehold estate created hereby by reason of the fact that the same person, firm, corporation or other entity may acquire, own or hold, directly or indirectly, (a) this Lease or the leasehold estate created hereby or any interest in this Lease or such leasehold estate and (b) the fee estate in the Leased Property.

ARTICLE XXX.
TRANSFERS BY LESSOR; SEVERANCE RIGHTS

30.1. **Transfers by Lessor**. Lessee acknowledges that Lessor may sell its interest in the Leased Property in whole or in part, and that Lessor may assign its interest in this Lease in whole or in part, in any such case, without Lessee's prior written consent or approval. If Lessor or any successor owner of any Property shall convey such Property in accordance with the terms hereof, other than as security for a debt, the grantee or transferee of such Property shall expressly assume all obligations of Lessor hereunder arising or accruing from and after the date of such conveyance or transfer, and Lessor or such successor owner, as the case may be, shall thereupon be released from all future liabilities and obligations of Lessor under this Lease relating to such Property arising or accruing from and after the date of such conveyance or other transfer and all such future liabilities and obligations shall thereupon be binding upon the new owner. Lessee agrees that any successor purchaser may exercise any and all rights of Lessor; *provided, however*, such successor purchaser shall be subject to the same restrictions imposed upon Lessor hereunder. Subject to the execution by a prospective purchaser of a written confidentiality agreement on terms reasonably acceptable to Lessee, Lessor may divulge to any such prospective purchaser all information, reports, financial statements, certificates and documents obtained by it from Lessee (including all such information and documents relating to the Guarantor).

30.2. **Severance Rights**. Notwithstanding the unitary nature of this Lease, Lessor may at any time and from time to time, cause this Lease to be severed with respect to any one or more of the Properties (each, a "**Severed Property**"). If Lessor shall desire to sever this Lease pursuant to this Section 30.2, Lessor shall deliver written notice (each, a "**Severance Notice**") to Lessee not less than thirty (30) days prior to the date that this Lease shall be severed with respect to the Severed Property or Severed Properties identified in the Severance Notice (such date identified in a Severance Notice, a "**Severance Date**"). The Severance Notice shall specify the Severed Property and the Severance Date. Effective upon a Severance Date, the applicable Severed Property shall no longer be part of the Leased Property under this Lease and such Severed Property shall be deemed to be and shall be leased by Lessor to Lessee for the amount of Rent allocable to such Severed Property pursuant to a separate lease (a "**Severed Lease**") upon the same terms and conditions as provided in this Lease (except for such provisions as by their terms are not applicable to such Severed Property); it being agreed, however, that the liability of the applicable lessor under the Severed Lease shall be limited to such lessor's interest in the Severed Property. The portion of the Base Rent allocable to the Severed Property shall be the Allocated Base Rent for such Severed Property. Effective upon the Severance Date, (a) the Rent payable with respect to each Severed Property shall no longer be payable by Lessee under this Lease and shall instead be payable under the Severed Lease applicable to such Severed Property, and (b) the parties shall enter into the Severed Lease, an amendment of this Lease, an amendment of the applicable other Obligation Documents that assures that Lessor receives a guaranty of payment and performance and security deposits for both the Severed Lease and this Lease as so amended, comparable to the Guaranty and Allocated Reserve existing for such Severed Property prior to the severance (the "**Other Credit Enhancements**"), and any reasonably necessary amendment to the Intercreditor Agreement to reflect the Severed Lease. For so long as Lessor under this Lease shall be the lessor under a Severed Lease, any such Severed Lease and the related Other Credit Enhancements shall be deemed "**Obligation Documents**" for all purposes under this Lease, any Event of Default under such Severed Lease or Other Credit Enhancements shall constitute an Event of Default under this

Lease, and any Event of Default under this Lease or the other Obligation Documents shall constitute an Event of Default under such Severed Lease. Lessor will prepare the Severed Lease, the Other Credit Enhancements, the Lease amendment and, if necessary, the amendments to the other applicable Obligation Documents with respect to each Severed Property consistent with the provisions of this Section 30.2 and the parties agree to execute and deliver or cause to be executed and delivered at Lessor's sole cost (subject to Section 16.1K).

ARTICLE XXXI.
QUIET ENJOYMENT

So long as Lessee shall pay all Rent as the same becomes due and shall fully comply with all of the terms of this Lease and fully perform its obligations hereunder, Lessee shall peaceably and quietly have, hold and enjoy the Leased Property for the Term hereof, free of any claim or other action by Lessor or anyone claiming by, through or under Lessor, but subject to the Permitted Exceptions, any Facility Loan and all liens and encumbrances of record. No failure by Lessor to comply with the foregoing covenant shall give Lessee any right to cancel or terminate this Lease, or to fail to pay any other sum payable under this Lease, or to fail to perform any other obligation of Lessee hereunder. Notwithstanding the foregoing, Lessee shall have the right by separate and independent action to pursue any claim it may have against Lessor as a result of a breach by Lessor of the covenant of quiet enjoyment contained in this Article XXXI.

ARTICLE XXXII.
NOTICES

All notices, demands and other communications to be given or delivered under or by reason of the provisions of this Lease shall be in writing and shall be deemed to have been given or delivered (a) when personally delivered, (b) when transmitted via telecopy (or other facsimile device) to the number set out below if the sender on the same day sends a confirming copy of such notice by a recognized overnight delivery service (charges prepaid), (c) the day following the day (except if not a Business Day then the next Business Day) on which the same has been delivered prepaid to a reputable national overnight air courier service or (d) the third Business Day following the day on which the same is sent by certified or registered mail, postage prepaid. Notices, demands and communications, in each case to the respective parties, shall be sent to the applicable address set forth below, unless another address has been previously specified in writing:

if to Lessee:

c/o LifePoint Health, [Inc.]
330 Seven Springs Way
Brentwood, Tennessee 37027
Attn: General Counsel
Fax: [redacted]

with a copy to:

Sidley Austin LLP
787 Seventh Avenue
New York, New York 10019
Attn: [redacted]
Fax: [redacted]

with a copy to:	Waller Lansden Dortch & Davis, LLP 511 Union Street, Suite 2700 Nashville, TN 37219 Attn: [redacted] Fax: [redacted]
if to Lessor:	c/o MPT Operating Partnership, L.P. 1000 Urban Center Drive, Suite 501 Birmingham, Alabama 35242 Attn: Legal Department Fax: [redacted]
with a copy to:	Baker, Donelson, Bearman, Caldwell & Berkowitz, PC 420 20th Street North, Suite 1400 Birmingham, Alabama 35203 Attn: [redacted] Fax: [redacted]

or to such other address with respect to a party as such party notifies the other in writing as above provided.

ARTICLE XXXIII.
APPRAISAL

If it becomes necessary to determine the Fair Market Value of any Property, each party, within ten (10) Business Days following the date of the event which makes such determination necessary, shall, by notice to the other, appoint an appraiser (each of whom must be a member of the AIREA and adhere to the USPAP standards in the preparation of the appraisal). The appraisers thus appointed shall appoint a third appraiser (such third appraiser must also be a member of the AIREA and adhere to the USPAP standards in the preparation of the appraisal) and such third appraiser shall appraise such Property to determine the Fair Market Value thereof; *provided, however*, that if a party fails to appoint an appraiser within such required period, the sole appraiser appointed shall conduct the appraisal and the parties shall use commercially reasonable efforts to cause such appraisal to be completed within forty-five (45) days following the event which makes such determination necessary. This provision for determination by appraisal shall be specifically enforceable to the extent such remedy is available under applicable law, and any determination hereunder shall be final and binding upon the parties except as otherwise provided by applicable law. Except as provided in Section 15.6, Lessor and Lessee shall each pay one-half (1/2) of all costs and expenses incurred in connection with such appraisal. Any appraisal shall assess the Fair Market Value of the applicable Property or Lessee's Personal Property as of the date of the event which makes such assessment necessary.

ARTICLE XXXIV.
PURCHASE RIGHTS

34.1. **Lessor's Option to Purchase Lessee's Personal Property**. With respect to any Facility, upon prior written notice to Lessee, Lessor shall have the option to purchase all (but not

less than all) of the Facility Lessee's Personal Property relating to such Facility, if any, at the expiration or earlier termination of this Lease with respect to such Facility, for an amount equal to the then fair market value of the Lessee's Personal Property as determined by independent, third party appraisal reasonably acceptable to Lessor and Lessee, subject in all cases to, and with appropriate price adjustments for, all equipment leases, conditional sale contracts, security interests and other encumbrances to which such Lessee's Personal Property is subject. Notwithstanding anything contained in this Section 34.1 to the contrary, the options to purchase granted under this Section 34.1 do not pertain to any of the Licenses, it being understood and agreed that all matters relating to the transfer of the Licenses are addressed in Article XXXVIII.

34.2. **Lessee's First Right of Refusal**.

(a) Subject to the limitations described in Section 34.2(b) below, following the expiration of the Fixed Term and during the continuation of any Extension Terms, and so long as no Event of Default has occurred and is continuing and no event has then occurred which has not been cured and with the giving of notice or the passage of time or both would constitute an Event of Default under Section 16.1(a), Lessee shall have a first refusal option to purchase the Leased Property or Lessor's Equity Interests, as applicable, as provided herein. In the event that Lessor or its Affiliate receives a bona fide written offer during the Extension Terms from an unaffiliated third party in a letter of intent form (which offer the Lessor or its Affiliate intends to accept) to: (i) purchase the Leased Property, or (ii) acquire record ownership or direct beneficial ownership of any Equity Interests in Lessor, such that after giving effect thereto, MPT Operating Partnership, L.P. or its Affiliate shall cease to beneficially own and control at least 51% of the Equity Interests of Lessor (in each case, a "**Third Party Offer**"), then Lessor shall promptly (but in no event later than ten (10) Business Days following Lessor's delivery to Lessee of an executed letter of intent) provide Lessee with a copy of such Third Party Offer (the "**Third Party Offer Notice**") and Lessee shall have the Decision Period (as hereinafter defined) in which to confirm in writing its intention to purchase the Leased Property or the Equity Interest, as applicable, on the same terms and conditions contained in the Third Party Offer. If Lessee shall fail to provide a written response to Lessor within the Decision Period, then Lessee shall be deemed to have elected not to exercise its option and Lessor and the third party shall be entitled to proceed with the sale of the Leased Property or Equity Interests (as applicable) on the same terms as those set forth in the letter of intent, free and clear of any Lessee rights of first refusal to purchase the Leased Property or Equity Interests. As used herein, the term "**Decision Period**" shall mean the period of time commencing on the date that Lessee receives the Third Party Offer Notice and ending on the later to occur of (i) the thirtieth (30th) day immediately following the date that Lessee receives the Third Party Offer Notice, or (ii) the fifteenth (15th) day immediately following the date that the Lessor or its Affiliate enters into a binding definitive agreement accepting the Third Party Offer (the "**Binding Agreement**").

(b) If, prior to the closing of any such sale of the Leased Property or Equity Interests in accordance with the Third Party Offer, Lessor agrees to reduce the offering price set forth in the Third Party Offer to an amount which is less than ninety-eight (98%) of the original offered amount, or to modify or amend any material terms or conditions set forth in the Third Party Offer or the Binding Agreement such that they are materially more favorable to the third party purchaser than those terms and conditions initially set forth in the Third Party Offer on which the sale of the Leased Property or Equity Interests was initially offered to Lessee, then Lessor shall

give Lessee written notice thereof and all supporting documentation (the "**Revised Sale Terms**"). Lessee shall have ten (10) days after the receipt of said notice and Revised Sale Terms in which to confirm in writing its intention to purchase the Leased Property or the Equity Interest, as applicable, on the same terms and conditions contained in the Third Party Offer or Binding Agreement, as applicable and as modified by the Revised Sale Terms. If Lessee shall fail to provide a written response to Lessor within such ten (10) day time period, then Lessee shall be deemed to have elected not to exercise its option and Lessor and the third party shall be entitled to proceed with the sale of the Leased Property or Equity Interests (as applicable) free and clear of any Lessee rights of first refusal to purchase the Leased Property or Equity Interests.

(c) If Lessee exercises the foregoing option, then such purchase shall be consummated in accordance with the provisions of Article XVIII hereof to the extent not inconsistent herewith. The closing of any such purchase by the Lessee shall occur on the later of (i) the closing date specified in the Third Party Offer or Binding Agreement, as applicable, or (ii) the thirtieth (30th) day immediately following Lessor's receipt of Lessee's written confirmation of Lessee's intent to exercise its option as provided herein.

(d) In the event that such sale of the Leased Property or Equity Interests to such third party fails to close for whatever reason, Lessee shall be entitled to exercise its right of first refusal as provided in this Section 34.2 as to any subsequent Third Party Offer that occurs during the Term of this Lease, or with respect to such adjusted Third Party Offer or Binding Agreement, as applicable. In the event that Lessee shall fail to exercise its option as provided herein, and Lessor shall consummate a sale of the Leased Property or Equity Interests to such third party during the Term, then the right of first refusal as provided in this Section 34.2 shall no longer be in effect as to any subsequent sale or transfer during the Term by such third party of the Leased Property or Lessor's Equity Interests.

(e) In addition to the conditions and limitations set forth in Section 34.2(a), Lessee's first refusal option with respect to the Leased Property shall not apply to or otherwise restrict any actions, negotiations or agreements in respect of (i) the sale, transfer of other disposition of the Leased Property or the Equity Interest in Lessor to any unaffiliated third party third party prior to the expiration of the Fixed Term, (ii) the sale, transfer or other disposition of the Leased Property which constitutes a Portfolio Sale, or (iii) the sale of equity, merger, combination, sale of all or substantially all of its assets or similar transaction involving Medical Properties Trust, Inc., MPT Operating Partnership, L.P., or their respective Affiliates and any other Person in connection with a Portfolio Sale.

ARTICLE XXXV.
SUBSTITUTION RIGHTS

35.1. **Lessee's Property Substitution Right.** Subject to Lessor's prior written consent, in its sole and absolute discretion, and further subject to satisfaction of the conditions precedent set forth in Section 35.2 and to all other terms and conditions hereof, Lessee may request that Lessor substitute one (1) Property (such Property, an "**Eliminated Property**"), a Substitute Property, for any commercially reasonable business purpose, including in connection with any default or Event of Default (a "**Property Substitution**").

35.2. **Conditions Precedent to Lessee's Property Substitution Right**. The right of Lessee to effect a Property Substitution is subject to satisfaction by Lessee, or waiver by Lessor, in its sole and absolute discretion, of each of the following:

(a) Lessee shall have given Lessor notice of such proposed Property Substitution not less than sixty (60) days prior to the proposed Property Substitution Date. Any notice from Lessee to Lessor concerning a proposed Property Substitution shall include the following (each of which must be satisfactory to Lessor, in its sole and absolute discretion):

(i) notice of the Property Substitution Date proposed by Lessee and Lessee's Affiliate proposed to be the operator of the Substitute Property;

(ii) the Fair Market Value of the Substitute Property is not less than the Fair Market Value of such Eliminated Property, as determined in the good faith, reasonable discretion of Lessor;

(iii) a title insurance commitment from a title insurance company of recognized standing undertaking to issue to Lessor or its designee, at Lessee's expense, an ALTA Owner's extended coverage policy of title insurance with respect to the proposed fee real property interests included in the Substitute Property and in the amount of the Fair Market Value thereof, confirming that upon conveyance thereof to Lessor or its designee, such transferee will hold good and marketable title to the proposed Substitute Property, free and clear of title defects, liens, encumbrances and burdens which are not acceptable to such transferee in its sole discretion;

(iv) a written Phase I Environmental Assessment (and if necessary, a Phase II Assessment) of the proposed Substitute Property, prepared by an environmental consulting firm reasonably acceptable to Lessor not more than one hundred twenty (120) days prior to the proposed Property Substitution Date;

(v) a current as-built survey of the real property included in the proposed Substitute Property;

(vi) an engineering and architectural inspection of the buildings and other improvements included in the proposed Substitute Property prepared by an engineering firm reasonably acceptable to Lessor not more than one hundred twenty (120) days prior to the proposed Property Substitution Date, confirming that the proposed Substitute Property is in a good and safe condition and does not require modifications or repairs costing more than Two Percent (2%) of the Fair Market Value thereof during the first (1st) twelve (12) months after the effective date of such Property Substitution;

(vii) a list of all material leases and contracts pertaining to the proposed Substitute Property, together with copies of any such agreements which have a term of more than one (1) year or which involve payment of consideration in excess of Fifty Thousand and No/100 Dollars ($50,000) in any twelve (12) month period;

(viii) a list of all material accreditations, permits, authorizations and approvals of accreditation agencies and federal, state and local agencies pertaining to the proposed Substitute Property and to the Hospital location and related facilities located and operated thereon, together with copies of all such accreditation, permits, authorizations and approvals;

(ix) a copy of the most recent Joint Commission survey of the Hospital location operated on the proposed Substitute Property; and

(x) financial information concerning the Substitute Property sufficient to demonstrate the financial performance of the Substitute Property either (A) in form and level of detail acceptable to Lessor in its sole and absolute discretion, or (B) if Lessee's Affiliate shall have operated the Substitute Property for at least the preceding two (2) fiscal years, presented in a form and level of detail reasonably acceptable to Lessor; and

(b) the proposed Substitute Property shall have a Fair Market Value of no less than the Fair Market Value of the Eliminated Property, as determined in the good faith, reasonable discretion of Lessor.

35.3. **Procedures for Property Substitution**. On the Property Substitution Date, Lessee and Lessor and/or their respective applicable Affiliates shall take the following actions:

(a) Lessee and Lessor will execute instruments in mutually agreeable form (i) terminating the Lease with respect to the Eliminated Property, except for such obligations which expressly survive any such termination, and adding such Substitute Property to the Leased Property under this Lease;

(b) Lessor will convey the Eliminated Property to Lessee or its designee on an "as is" and "where is" basis in the manner and on the terms set forth in Article XVIII;

(c) Lessee or its Affiliate will convey the Substitute Property to Lessor or its Affiliate by special warranty deed, which conveyance will be accompanied by ALTA Owner's title insurance policy as contemplated by Section 35.2(a)(iii) above; and

(d) Lessee, its Affiliates and the Guarantor shall deliver to Lessor the Other Credit Enhancements as shall be necessary to provide Lessor with the security and credit enhancements comparable, in Lessor's reasonable discretion, to those provided in the other Obligation Documents which pertain to the Substitute Lease.

As soon as practicable after the Property Substitution Date, Lessee will reimburse Lessor and its Affiliates for all documented, out-of-pocket expenses incurred by Lessor and its Affiliates in connection with such Property Substitution.

ARTICLE XXXVI.
FINANCING OF THE LEASED PROPERTY

Lessor agrees that, if it grants or creates any mortgage, lien, encumbrance or other title retention agreement ("**Liens**") upon any Property after the applicable Commencement Date, Lessor will obtain an agreement from the holder of each such Lien whereby such holder agrees (a) to give the Facility Lessee which operates such Property the same notice, if any, given to Lessor of any default or acceleration of any obligation underlying any such Lien or any sale in foreclosure of such Lien, (b) to permit such Facility Lessee, after twenty (20) days' prior written notice, to cure any such default on Lessor's behalf within any applicable cure period, (c) to permit such Facility Lessee to appear with its representatives and to bid at any foreclosure sale with respect to any such Lien, (d) that, if subordination by such Facility Lessee is requested by the holder of each such Lien, to enter into an agreement with such Facility Lessee containing the provisions described in Article XXXVII, and (e) to execute and deliver to such Facility Lessee a written agreement consenting to this Lease and agreeing that, notwithstanding any such other Facility Instrument or any default, expiration, termination, foreclosure, sale, entry or other act or omission thereunder, such Facility Lessee shall not be disturbed in peaceful enjoyment of such portion of the Leased Property nor shall this Lease be terminated or canceled at any time, except in accordance with Article XVI as a result of an Event of Default. No Facility Lessee shall be subordinated to the holder of a Lien unless both conditions of clause (d) and (e) above are met.

ARTICLE XXXVII.
SUBORDINATION AND NON-DISTURBANCE

At the request from time to time by one or more Facility Lenders with respect to any Facility Lessee, within twenty (20) days from the date of request, such Facility Lessee shall execute and deliver within such twenty (20)-day period, to such Facility Lender, an estoppel certificate along with a written agreement in form and content reasonably acceptable to such Facility Lender and Facility Lessee whereby, as to any Property of such Facility Lessee encumbered by a Facility Instrument of such Facility Lender, such Facility Lessee subordinates this Lease and all of its rights and estate hereunder to each such Facility Instrument and agrees with each such Facility Lender that such Facility Lessee will attorn to and recognize such Facility Lender or the purchaser at any foreclosure sale or any sale under a power of sale contained in any such Facility Instrument, as the case may be, as Lessor under this Lease with respect to such Property for the balance of the Term then remaining, subject to all of the terms and provisions of this Lease; *provided, however*, that each such Facility Lender simultaneously executes and delivers to such Facility Lessee a written agreement in form and content reasonably acceptable to such Facility Lender and Facility Lessee consenting to this Lease and agreeing that, notwithstanding any such other mortgage, deed of trust, right, title or interest, or any default, expiration, termination, foreclosure, sale, entry or other act or omission under, pursuant to or affecting any of the foregoing, such Facility Lessee shall not be disturbed in peaceful enjoyment of such Property nor shall this Lease be terminated or canceled at any time, except as a result of an Event of Default.

ARTICLE XXXVIII.
LICENSES

38.1. **Maintenance of Licenses**. With respect to each Facility, each Facility Lessee (a) shall maintain at all times during the Term and any holdover period, (i) the Operating Agreements, (ii) the Participation Agreements and (iii) all applicable federal, state and local governmental licenses, approvals, qualifications, variances, certificates of need, franchises, accreditations, certificates, certifications, consents, permits and other authorizations and contracts, necessary for the operation of the Facility operated by such Facility Lessee for the Primary Intended Use or required for certification or participation under Medicare or Medicaid (the items described in this subsection (iii), collectively, the "**Licenses**") (*provided, however*, no Facility Lessee shall be required to maintain any Operating Agreements or Participation Agreements unless such agreements are required for participation in Medicare and Medicaid programs and/or required for the maintenance of federal, state and local licenses); (b) shall remain in substantial compliance with all state and federal laws, rules, regulations and procedures with regard to the operation of the Facility operated by such Facility Lessee, including, without limitation, HIPAA and the regulations promulgated by the State Regulatory Authorities, as applicable for each such Facility, as they may from time to time exist; and (c) shall operate the Facility operated by such Facility Lessee in a manner substantially consistent with quality acute care services and sound reimbursement principles under the Medicare and/or Medicaid programs and as required under state and federal law.

38.2. **No Transfers or Alterations of Licenses**. Except in connection with a permitted assignment of this Lease, Lessee covenants and agrees that during the Term it shall not, without the prior written consent of Lessor, which consent shall not be unreasonably withheld, conditioned or delayed: (a) sell, move, modify (including, without limitation, the establishment of a "provider based" network or similar arrangement), cancel, surrender, transfer, assign, sell, relocate, pledge, secure, convey or in any manner encumber any License necessary for the operation of the Facility for the Primary Intended Use, or (b) effect or attempt to effect any change in the license category or status of any Facility or any part thereof.

38.3. **Notifications; Corrective Actions**. Each Facility Lessee shall notify Lessor in writing within five (5) Business Days after such Facility Lessee's receipt of any notice, action, proceeding or inquiry of any governmental agency, bureau or other authority, whether federal, state or local, of any kind, nature or description, which could adversely affect any material License for the Facility operated by such Facility Lessee, or the ability of such Facility Lessee to maintain its status as the licensed and accredited operator of such Facility, or which alleges any material noncompliance with any law. At the time of delivery of such notification to Lessor, such Facility Lessee shall furnish Lessor with a copy of any and all such notices or inquiries. Each Facility Lessee shall act diligently to correct any deficiency or deal effectively with any "adverse action" or other proceedings, inquiries or other governmental actions, so as to maintain the Licenses and Medicare and/or Medicaid certification, status for the Facility operated by such Facility Lessee in good standing at all times. No Facility Lessee shall agree to any settlement exceeding Four Million and No/100 Dollars ($4,000,000.00) or other action with respect to such proceedings or inquiries which affects the use of all or any portion of the Leased Property or any part thereof for the Primary Intended Use without the prior written consent of Lessor, which consent shall not be unreasonably conditioned or delayed.

38.4. **Termination of Lease**. UPON THE TERMINATION OF THIS LEASE OR LESSEE'S RIGHT OF POSSESSION HEREUNDER WITH RESPECT TO ANY ONE OR MORE PROPERTIES (ASSUMING LESSEE DOES NOT PURCHASE THE LEASED PROPERTY AS PROVIDED HEREIN), WITHOUT ANY ADDITIONAL CONSIDERATION TO ANY FACILITY LESSEE, THE APPLICABLE FACILITY LESSEE SHALL, FOR REASONABLE PERIODS OF TIME AFTER SUCH TERMINATION, USE ITS BEST EFFORTS TO FACILITATE AN ORDERLY TRANSFER OF THE OPERATION AND OCCUPANCY OF SUCH PROPERTY TO LESSOR OR ITS DESIGNEE, AND SUCH COOPERATION SHALL INCLUDE, WITHOUT LIMITATION, (1) SUCH FACILITY LESSEE'S EXECUTION AND SUBMISSION TO THE APPROPRIATE AUTHORITY OF ANY AND ALL DOCUMENTS REQUIRED TO EFFECT THE TRANSFER, ISSUANCE OR ASSIGNMENT TO LESSOR OR ITS DESIGNEE OF ANY AND ALL LICENSES, INCLUDING ALL MEDICARE AND MEDICAID PROVIDER NUMBERS AND PROVIDER AGREEMENTS, (2) SUCH FACILITY LESSEE'S MAINTENANCE OF THE EFFECTIVENESS OF ANY AND ALL SUCH LICENSES UNTIL SUCH TIME AS ANY NEW LICENSES NECESSARY FOR ANY NEW LESSEE OR OPERATOR TO OPERATE THE FACILITY OPERATED BY SUCH FACILITY LESSEE HAVE BEEN ISSUED, AND (3) THE TAKING OF SUCH OTHER ACTIONS AS REASONABLY REQUESTED BY LESSOR OR REQUIRED BY APPLICABLE LAW; IT BEING UNDERSTOOD AND AGREED THAT THE PERFORMANCE OR EXERCISE OF ANY OF THE FOREGOING RIGHTS, REMEDIES, DUTIES AND OBLIGATIONS SHALL BE WITHOUT ANY ADDITIONAL CONSIDERATION TO SUCH FACILITY LESSEE.

38.5. **Material Condition of Lease**. IT IS AN INTEGRAL CONDITION OF THIS LEASE, AND A MATERIAL INDUCEMENT TO LESSOR'S AGREEMENT TO ENTER INTO THIS LEASE, THAT EACH FACILITY LESSEE ACKNOWLEDGES AND AGREES TO COOPERATE WITH AND ASSIST LESSOR AND/OR ITS DESIGNEE IN CONNECTION WITH ANY TRANSFER OF THE LICENSES OR THE OPERATIONS OF THE FACILITIES IN ACCORDANCE WITH THIS ARTICLE XXXVIII, INCLUDING, WITHOUT LIMITATION, IN CONNECTION WITH A TERMINATION OF THIS LEASE OR REMOVAL OF LESSEE FROM POSSESSION OF ONE OR MORE PROPERTIES IN THE MANNER SET FORTH IN SECTION 38.4 ABOVE, WHICH COOPERATION AND ASSISTANCE SHALL BE WITHOUT ANY ADDITIONAL CONSIDERATION TO LESSEE.

ARTICLE XXXIX.
MISCELLANEOUS

39.1. **General**. If any term or provision of this Lease or any application thereof shall be invalid or unenforceable, the remainder of this Lease and any other application of such term or provision shall not be affected thereby. If any late charges provided for in any provision of this Lease are based upon a rate in excess of the maximum rate permitted by applicable law, the parties agree that such charges shall be fixed at the maximum permissible rate. All the terms and provisions of this Lease shall be binding upon and inure to the benefit of the parties and their respective successors and assigns (subject to Article XXIII); *provided, however*, that (a) this Lease shall not inure to the benefit of any assignee pursuant to an assignment which violates the terms of this Lease and (b) neither this Lease nor any other document or agreement contemplated under this Lease shall be deemed to confer upon any Person not a party to this Lease any rights or

remedies contained in this Lease. The headings in this Lease are for convenience of reference only and shall not limit or otherwise affect its meaning.

39.2. **Bankruptcy Waivers**.

(a) **Unitary and Non-Severable Lease**. The parties agree that for the purposes of any assumption, rejection or assignment of this Lease under 11 U.S.C. Section 365 or any amendment or successor section thereof, this is one indivisible and non-severable lease dealing with and covering one legal and economic unit which must be assumed, rejected or assigned as a whole with respect to all (and only all) the Leased Property covered hereby.

(b) **Relief from Stay**. Lessee acknowledges and agrees that in the event any Lessee or any Leased Property relating to any Facility shall become the subject of any bankruptcy or insolvency estate, then (i) Lessee shall not oppose any request by Lessor to obtain an order from the court granting relief from the automatic stay pursuant to Section 362 of the Bankruptcy Code so as to permit the exercise of all rights and remedies pursuant to this Lease, and (ii) the occurrence or existence of any Event of Default under this Lease shall, in and of itself, constitute "cause" for relief from the automatic stay pursuant to the provisions of Section 362(d)(1) of the Bankruptcy Code, based on the fact that the non-existence of a bankruptcy proceeding was a material inducement for the entry by Lessor into this Lease.

(c) **Automatic Stay**. Lessee hereby waives the stay imposed by 11 U.S.C. Section 362(a) as to actions by the Lessor against each Facility. Lessee acknowledges and agrees that in the event of the filing of any voluntary or involuntary petition in bankruptcy by or against Lessee, it shall not assert or request that any other party assert that the automatic stay provided by Section 362 of the Bankruptcy Code shall operate or be interpreted to stay, interdict, condition, reduce or inhibit the ability of Lessor to enforce any rights or remedies held by virtue of the Lease or applicable law.

(d) **Patient Care Ombudsman**. Lessee hereby agrees (i) to use its reasonable efforts to contest the necessity of the appointment of a Patient Care Ombudsman for such Facility as that term is defined in 11 U.S.C. Section 333, and/or (ii) to join with Lessor in requesting a waiver of or contesting the appointment of such a Patient Care Ombudsman.

39.3. **Lessor's Expenses**. In addition to the other provisions of this Lease, including, without limitation, Section 16.2 hereof, Lessee agrees and shall pay and/or reimburse Lessor and its Affiliates' reasonable documented, out-of-pocket costs and expenses, including, without limitation, the costs and expenses of reports and investigations and reasonable legal fees and expenses attributable to an Event of Default and Lessor's pursuing the rights and remedies provided herein and under applicable law, incurred or resulting from or relating to (a) requests by Lessee for approval or consent under this Lease or any other Obligation Document (including any consents relating to any intercreditor issues which arise in connection with any Material Obligations), (b) any circumstances or developments which give rise to Lessor or its Affiliates' right of consent or approval under this Lease or any other Obligation Document, (c) circumstances resulting from any action or inaction by Lessee contrary to the lease provisions, (d) a request for changes, including, but not limited to, (i) the permitted use of the Leased Property, (ii) alterations and improvements to the Leased Improvements, (iii) subletting or assignment, and (iv) any other

changes in the terms, conditions or provisions of this Lease or any other Obligation Document, and (e) enforcement by Lessor or its Affiliates of any of the provisions of this Lease or any other Obligation Document. Such expenses and fees shall be paid by Lessee within thirty (30) days of the submission of a statement for the same or such amount(s) shall be subject to a late charge computed at the Overdue Rate from the expiration of said thirty (30) day period to the date of payment, plus a Late Payment Penalty with respect to such unpaid amount.

39.4. **Entire Agreement; Modifications**. This Lease, together with all exhibits, schedules and the other documents referred to herein, embody and constitute the entire understanding between the parties with respect to the transactions contemplated herein, and all prior and contemporaneous agreements, understandings, representations and statements (oral or written) are merged into this Lease. Neither this Lease, any exhibit or schedule attached hereto, nor any provision hereof or thereof may be modified or amended except by an instrument in writing signed by Lessor and Lessee.

39.5. **Lessor Securities Offering and Filings**. Notwithstanding anything contained herein to the contrary, Lessee shall, at Lessor's sole costs and expense, cooperate with Lessor in connection with any securities offerings and filings, or Lessor's efforts to procure or maintain financing for, or related to, the Leased Property, or any portion thereof and, in connection therewith, Lessee shall furnish Lessor, in a timely fashion, with such financial and other information (including audited financial statements and consents of auditors) as Lessor shall reasonably request; *provided that* Lessee shall under no circumstances be required to provide (i) any internally prepared reports, (ii) attorney-client privileged communications and work product, or (iii) information subject to a written confidentiality obligation or otherwise restricted by agreement or law from delivery. Lessor shall reimburse the Lessee for any and all reasonable incremental costs (i.e., reasonable costs not otherwise incurred by the Lessee with respect to the normal preparation of such financial statements for other purposes) incurred in furnishing, or causing its accountants to furnish, such financial statements and consents. Lessor may disclose that Lessor has entered into this Lease with Lessee and may provide and disclose information regarding this Lease, Lessee, the Guarantor, the Leased Property and each Facility, and such additional information which Lessor may reasonably deem necessary, to its proposed investors in such public offering or private offering of securities, or any current or prospective lenders with respect to such financing, and to investors, analysts and other parties in connection with earnings calls and other normal communications with investors, analysts, and other parties. Upon reasonable advance notice, Lessor, its legal and financial representatives, and any lender providing financing for all or any portion of the Leased Property (each, a "**Requesting Party**") shall have the right, subject to the execution of a written confidentiality agreement on terms reasonably acceptable to Lessor, such lender and Lessee, to access, examine and copy all agreements, records, documentation and information relating to Lessee, the Guarantor, and such Leased Property, and to discuss such affairs and information with the officers, employees and independent public accountants of Lessee; *provided, however*, that (a) such access or furnishing of information shall be conducted during normal business hours, under the supervision of the Lessee, and in such a manner as to not unreasonably disrupt the normal operations of the Property, (b) Lessee is not under any obligation to disclose to the Requesting Party any information, the disclosure of which is restricted by contract or applicable Law or would result in the waiver of any attorney-client privilege. The additional costs of Lessee in complying with the foregoing shall be reimbursed to Lessee by Lessor.

39.6. **Non-Recourse as to Parties**.

(a) Anything contained herein to the contrary notwithstanding, any claim based on, or in respect of, any liability of Lessor under this Lease shall be enforced only against the Leased Property and any proceeds therefrom and not against any other assets, properties or funds of (i) Lessor, (ii) any director, officer, general partner, member, shareholder, limited partner, beneficiary, employee, representative, contractor or agent of Lessor or any of its Affiliates (collectively, the "**Lessor Parties**") (or any legal representative, heir, estate, successor or assign of Lessor or any of the Lessor Parties), (iii) any predecessor or successor partnership or corporation (or other entity) of Lessor or any of the Lessor Parties, either directly or through Lessor or the Lessor Parties, or (iv) any person or entity affiliated with any of the foregoing.

(b) Anything contained herein to the contrary notwithstanding, any claim based on, or in respect of, any liability of Lessee under this Lease shall be enforced only against Lessee or the Guarantor and not against (i) any director, officer, general partner, member, shareholder, limited partner, beneficiary, employee, representative, contractor or agent of Lessee, any Permitted Holder or any of their respective Affiliates other than the Guarantor (collectively, the "**Lessee Parties**") (or any legal representative, heir, estate, successor or assign of any Lessee or any of the Lessee Parties), (ii) any predecessor or successor partnership or corporation (or other entity) of any Lessee or any of the Lessee Parties, either directly or through any Lessee or the Lessee Parties or (iii) any person or entity affiliated with any of the foregoing. In no event shall Lessor, any Lessee, any of the Lessor Parties or any of the Lessee Parties be liable for indirect, incidental, consequential, special, punitive or exemplary damages, regardless of the form of action, whether in contract, tort or otherwise, and even if such party has been advised of the possibility of such damages.

39.7. **Covenants, Restrictions and Reciprocal Easements**. Subject to the Pass-Through Leases (as applicable) and Lessee's consent, which consent shall not be unreasonably withheld, conditioned, or delayed, and notwithstanding anything herein to the contrary, Lessor shall have the right, but not the obligation, to place of record all covenants, restrictions and reciprocal easements on all or any portion of the Land (collectively, the "**Declarations**") which Lessor deems reasonably necessary for the ownership of any Property, with such Declarations to be in form and content acceptable to Lessor, in its reasonable discretion, and Lessee, whose consent shall not be unreasonably withheld, conditioned, or delayed.

39.8. **Force Majeure**. Except for Rent and other monetary obligations payable pursuant to the terms of this Lease (which shall not be extended or excused), in the event that Lessor or Lessee shall be delayed, hindered in or prevented from the performance of any act required under this Lease by reason of strikes, lockouts, labor troubles, or other industrial disturbances, inability to procure materials, failure of power, unavailability of any utility service, restrictive governmental laws or regulations, acts of public enemies, war, blockades, riots, insurrections, earthquakes, fires, storms, floods, civil disturbances, weather-related acts of God, failure to act, or default of another party, or other reason beyond Lessor's or Lessee's control (individually "**Force Majeure**"), then performance of such act shall be excused for the period of the delay, and the period of the performance of any such act shall be extended for a period equivalent to the period of such delay. Within ten (10) Business Days following the occurrence of Force Majeure, the party claiming a

delay due to such event shall give written notice to the other setting forth a reasonable estimate of such delay.

39.9. **Management Agreements**. Lessee shall not engage, terminate, remove, or replace any Management Agreement without Lessor's prior written consent, which consent shall be in Lessor's sole discretion; *provided, however*, that notwithstanding the foregoing, (A) Lessee may, without Lessor's consent, enter into any Management Agreement so long as, at Lessee's sole cost and expense, the applicable Management Company is a Qualified Manager, and (B) Lessee may, without Lessor's consent, terminate any Management Agreement so long as, at Lessee's sole cost and expense, (i) the replacement Management Company is a Qualified Manager engaged pursuant to a replacement Management Agreement, and (ii) the replacement Management Agreement is entered into concurrently with the termination of the prior Management Agreement. At the request of Lessor from time to time, Lessee and any Management Company shall execute and deliver a subordination agreement relating to any Management Agreement, which shall be in substantially the form attached to this Lease as ***Exhibit G***, within ten (10) Business Days after Lessor's request. Lessee shall also require any Management Company to execute and deliver to Lessor within ten (10) Business Days after Lessor's request an estoppel certificate, as required by Lessor and/or any Facility Lender, in such form and content as is reasonably acceptable to Lessor and/or such Facility Lender.

39.10. **Lessee Non-Competition**.

(a) Each Facility Lessee agrees that while the Lease remains in effect and, if such Lease is terminated due to an Event of Default by Lessee, then for a period of three (3) years thereafter (the "**Noncompete Period**"), no Facility Lessee shall, directly or indirectly, acquire, finance, guarantee indebtedness, own, lease, manage, develop or provide services in connection with the acquisition, ownership, operation or development of any real estate located within ten (10) miles of any point on or within any Property, which real estate is used in a Competing Business (other than, for the avoidance of doubt, a Permitted Activity) (a "**Restricted Activity**"), *provided, however,* that the restrictions in this Section 39.10 shall not apply to real estate described on Exhibit H hereto (the "**Non-Core Real Estate**") with respect to Restricted Activities in which any Facility Lessee is performing, conducting or otherwise involved as of the date hereof or otherwise reasonably related to the divestiture of such Non-Core Real Estate. Any violation of the provisions of this Section 39.10 shall suspend and toll the Noncompete Period for the duration of such violation. The term "**Competing Business**" means any healthcare business which involves the operation of a facility other than on the Leased Property in which general acute care services, long term care services, rehabilitation or skilled nursing services are provided; *provided, however*, that the foregoing shall not prohibit any Facility Lessee from conducting, performing or otherwise being involved in any Restricted Activity that will not as of the time such Restricted Activity is commenced have a material and adverse effect on the relevant Market of the effected Facility or the ability of any Facility Lessee to perform its obligations under this Lease, all as determined in the reasonable discretion of Lessor (a "**Permitted Activity**"). The term "**Market**" shall mean with respect to: (a) any of the Johnstown Facility, the Meyersdale Facility, the Hastings Facility, or the Roaring Springs Facility, the business conducted by all such Facilities taken together as a single market, (b) any of the Lander Facility or the Riverton Facility, the business conducted by all such Facilities taken together as a single market, and (c) with respect to any other Facility, the business conducted by such Facility as a single market.

(b) Lessee agrees that the restrictions contained herein are reasonable and necessary to protect the legitimate interests of Lessor, and that any violation of the provisions would result in damages which cannot be adequately compensated by money alone. Lessee agrees that Lessor will be entitled to injunctive or other equitable relief without proving actual damages or posting any bond in the event of any violation of the restrictions contained herein; *provided, however*, that the foregoing shall not limit or be construed to prohibit or limit the right of Lessor to pursue any other legal and equitable remedies available to it on account of such breach or violation, including the recovery of damages from Lessee.

(c) If any court shall hold that the duration or scope of this Section 39.10 (geographic or otherwise) is unreasonable or invalid, then the provisions of this Section 39.10 shall remain in effect for whatever time period or geographic area that such court does not declare to be unreasonable or invalid. In addition, if any court shall hold that the duration or scope (geographic or otherwise) of this Section 39.10 is unreasonable or invalid, then, to the extent permitted by law, the court may prescribe a maximum duration or scope (geographic or otherwise) that is judicially enforceable and not unreasonable and the parties agree to accept such judicial determination, which the parties agree shall be substituted in place of any and every judicially unenforceable provision of this Section 39.10, and that this Section 39.10, as so modified, shall be fully enforceable as if originally executed in such manner.

(d) The terms of this Section 39.10 are intended to comply with all applicable rules and regulations of all governmental and regulating authorities. Accordingly, the parties agree to renegotiate, in good faith, any term, condition or provision of this Section 39.10 determined to be in contravention of any regulation, policy or law of any such authority. All other provisions hereof shall remain enforceable to the fullest extent permitted by law.

39.11. **Intentionally Omitted**.

39.12. **Governing Law**. THIS LEASE SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF DELAWARE APPLICABLE TO CONTRACTS EXECUTED AND PERFORMED IN SUCH STATE, WITHOUT GIVING EFFECT TO CONFLICTS OF LAW PRINCIPLES. NOTWITHSTANDING THE FOREGOING, ALL PROVISIONS OF THIS LEASE RELATING TO THE CREATION OF THE LEASEHOLD ESTATE AND ALL REMEDIES SET FORTH IN ARTICLE XVI RELATING TO THE RECOVERY OF POSSESSION OF THE LEASED PROPERTY (SUCH AS AN ACTION FOR UNLAWFUL DETAINER OR OTHER SIMILAR ACTION) SHALL BE GOVERNED BY, CONSTRUED AND ENFORCED IN ACCORDANCE WITH THE LAWS OF THE STATE IN WHICH THE LEASED PROPERTY IS LOCATED.

39.13. **Jurisdiction and Venue**. LESSOR AND LESSEE CONSENT TO PERSONAL JURISDICTION IN THE STATE OF DELAWARE. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION 39.13, LESSOR AND LESSEE AGREE THAT ANY ACTION OR PROCEEDING ARISING FROM OR RELATED TO THIS LEASE SHALL BE BROUGHT AND TRIED EXCLUSIVELY IN THE STATE OR FEDERAL COURTS OF DELAWARE. EACH OF THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY OBJECTION TO THE LAYING OF VENUE OF ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. LESSOR AND LESSEE EXPRESSLY

ACKNOWLEDGE THAT DELAWARE IS A FAIR, JUST AND REASONABLE FORUM AND AGREE NOT TO SEEK REMOVAL OR TRANSFER OF ANY ACTION FILED BY THE OTHER PARTY IN SAID COURTS. FURTHER, LESSOR AND LESSEE IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY CLAIM THAT SUCH SUIT, ACTION OR PROCEEDING HAS BEEN BROUGHT IN AN INCONVENIENT FORUM. SERVICE OF ANY PROCESS, SUMMONS, NOTICE OR DOCUMENT BY CERTIFIED MAIL ADDRESSED TO A PARTY AT THE ADDRESS DESIGNATED PURSUANT TO ARTICLE XXXII SHALL BE EFFECTIVE SERVICE OF PROCESS AGAINST SUCH PARTY FOR ANY ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. A FINAL JUDGMENT IN ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT MAY BE ENFORCED IN ANY OTHER COURT TO WHOSE JURISDICTION ANY OF THE PARTIES IS OR MAY BE SUBJECT. NOTWITHSTANDING THE FOREGOING, THE PARTIES FURTHER AGREE THAT ALL ACTIONS AND PROCEEDINGS RELATING TO THE CREATION OF THE LEASEHOLD ESTATE AND ALL REMEDIES RELATING TO THE RECOVERY OF POSSESSION OF ALL OR ANY PORTION OF THE LEASED PROPERTY (SUCH AS AN ACTION FOR UNLAWFUL DETAINER OR OTHER SIMILAR ACTION) MAY BE BROUGHT IN ANY STATE OR FEDERAL COURT OF THE STATE WHERE THE APPLICABLE PORTION OF THE LEASED PROPERTY IS LOCATED.

39.14. **True Operating Lease**. Lessor and Lessee agree that this Lease is intended as, and shall for all purposes (except in certain respects for accounting purposes under GAAP) constitute a true operating lease and not a capital lease or financing and nothing herein shall be construed as conveying to Lessee any right, title or interest in or to the Leased Property or to any remainder or reversionary estates in the Leased Property held by any Person, except, in each instance, as a lessee. Under no circumstances shall this Lease be regarded as an assignment of all of Lessor's interest in and to the Leased Property; instead, Lessor and Lessee shall have the relationship between them of Lessor and Lessee, pursuant to the terms and provisions of this Lease. In no event shall Lessee, LifePoint, Lima Holdco or any of their respective Subsidiaries claim depreciation, amortization or interest deductions as owner of any portion of the Leased Property for United States federal, state or local income tax purposes (except as to Capital Additions not funded by Lessor). It is an integral condition of this Lease, and a material inducement to Lessor's agreement to enter into this Lease, that Lessee agrees (except in certain respects for accounting purposes under GAAP) this Lease is an operating lease and not a capital lease or financing. Neither Lessor nor Lessee shall assert, and each hereby waives, any right to demand, request or plead for the re-characterization of this Lease or any other Obligation Document, whether or not in a proceeding related to any bankruptcy or insolvency of Lessor or Lessee. If any governmental or taxing authority challenges the characterization of the Lease as a true operating lease, the party receiving notice thereof shall promptly notify the other party and the parties shall cooperate in good faith in responding to such challenge.

39.15. **Letter of Credit**. Contemporaneously with the execution of this Lease, and as security for the obligations of Lessee under this Lease, Lessee shall obtain and deliver to Lessor an irrevocable letter of credit at a financial institution reasonably acceptable to Lessor naming Lessor as beneficiary thereunder (the "**Letter of Credit**"), which Letter of Credit shall be upon such other terms, conditions and provisions acceptable to Lessor (including, without limitation, an "evergreen" provision requiring no less than ninety (90) days' prior written notice to Lessor of any failure or refusal to renew the Letter of Credit). The Letter of Credit shall be in an amount equal

to two (2) months' Base Rent (as the amount such Base Rent is adjusted from time to time pursuant to this Lease). In the event Lessor receives a notice of termination or nonrenewal of the Letter of Credit, Lessee shall provide a replacement letter of credit no later than sixty (60) days prior to the expiration of the Letter of Credit, which replacement letter of credit (i) shall confirm that it shall take effect immediately upon the expiration of the Letter of Credit (or such other then-current replacement letter of credit), and (ii) shall be in form and substance satisfactory to Lessor in its reasonable discretion; it being understood and agreed that Lessee shall maintain throughout the Term a letter of credit conforming to the requirements of this Section 39.15. The Letter of Credit, or any replacement letter of credit, shall provide, among other things, that Lessor shall be entitled to draw upon the Letter of Credit upon the occurrence of an Event of Default under this Lease. In the event that Lessor draws upon the Letter of Credit, Lessee shall deposit with applicable financial institution an amount sufficient to replenish (or otherwise cause to be reinstated) the Letter of Credit to such amount as required herein within thirty (30) days following any such draw. At Lessee's request, and from time to time, the Lessor shall return any Letter of Credit delivered, or caused to be delivered, to Lessor by Lessee and Lessee shall simultaneously deliver, or cause to be a delivered, to Lessor a replacement Letter of Credit conforming to the requirements of this Section 39.15 (such Letter of Credit, a "**Substitute Letter of Credit**"); provided that a Letter of Credit issued by a financial institution with assets and credit quality substantially similar to the issuer of Letter of Credit in effect immediately prior to the delivery of the Substitute Letter of Credit on terms and conditions substantially similar to the Letter of Credit being replaced and otherwise complying with the requirements of this Section 39.15 shall be deemed to be acceptable under this Section 39.15.

39.16. **Compliance with Anti-Terrorism Laws**. Lessor hereby notifies Lessee that pursuant to the requirements of certain Anti-Terrorism Laws (including, without limitation, the Patriot Act) and Lessor's policies and practices, Lessor is required to obtain, verify and record certain information and documentation that identifies Lessee, which information includes the name, address and identification number of Lessee. Lessee will not, directly or indirectly, knowingly enter into any lease for the operation of any part of a Facility or any other lease or any material contracts with any person listed on the OFAC List. Lessee shall promptly notify Lessor if Lessee has knowledge that Lessee or any of its principals or Affiliates or the Guarantor is listed on the OFAC List or (a) is convicted on, (b) pleads nolo contendere to, (c) is indicted on, or (d) is arraigned and held over on charges involving money laundering or predicate crimes to money laundering. Lessee will not, directly or indirectly (i) conduct any business or engage in any transaction or dealing with any Blocked Person, including, without limitation, the making or receiving of any contribution of funds, goods or services to or for the benefit of any Blocked Person, (ii) deal in, or otherwise engage in any transaction relating to, any property or interests in property blocked pursuant to Executive Order No. 13224, any similar executive order or other Anti-Terrorism Law, or (iii) engage in or conspire to engage in any transaction that evades or avoids, or has the purpose of evading or avoiding, or attempts to violate, any of the prohibitions set forth in Executive Order No. 13224, or other Anti-Terrorism Law.

39.17. **Electronically Transmitted Signatures**. In order to expedite the execution of this Lease, telecopied signatures or signatures sent by electronic mail may be used in the place of original signatures on this Lease. The parties intend to be bound by the signatures of the telecopied or electronically mailed signatures, and hereby waive any defenses to the enforcement of the terms of this Lease based on the form of the signature. Following any facsimile or electronic mail

transmittal, the party shall promptly deliver the original instrument by reputable overnight courier in accordance with the notice provisions of this Lease.

39.18. **Waiver of Jury Trial**. TO THE MAXIMUM EXTENT PERMITTED BY LAW, LESSOR AND LESSEE HEREBY KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVE THE RIGHT TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION BASED HEREON, ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS LEASE, OR ANY COURSE OF CONDUCT, COURSE OF DEALING, STATEMENT (WHETHER VERBAL OR WRITTEN) OR ACTION OF EITHER PARTY OR ANY EXERCISE OF ANY PARTY OF THEIR RESPECTIVE RIGHTS HEREUNDER OR IN ANY WAY RELATING TO THIS LEASE OR THE LEASED PROPERTY (INCLUDING ANY CLAIM OR DEFENSE ASSERTING THAT THIS LEASE WAS FRAUDULENTLY INDUCED OR IS OTHERWISE VOID OR VOIDABLE). THIS WAIVER IS A MATERIAL INDUCEMENT FOR LESSOR TO ENTER INTO THIS LEASE.

39.19. **Counterparts**. This Lease may be executed in any number of counterparts, each of which shall be an original, but all of which together shall constitute one and the same instrument.

39.20. **Survival**. Notwithstanding any provision of this Lease to the contrary, the parties acknowledge and agree that, all claims against, and liabilities of, Lessee or Lessor which relate to acts or omissions prior to the date of expiration or termination of this Lease, and the covenants and obligations under this Lease which expressly relate to periods after the expiration or earlier termination of Lessee's tenancy under this Lease, including, without limitation, all indemnification obligations and those covenants and obligations described in Sections 8.1(final sentence only), 8.2(b), 8.3(c) (final sentence only), 16.2, 38.4, 38.5 and 39.3, and Articles XVIII, XIX and XXII, shall survive such expiration or earlier termination.

39.21. **Continuation of Defaults**. Notwithstanding any provision hereof to the contrary, whenever in this Lease the phrases "continuing," "continuation of" or similar words or phrases are used in connection with Events of Default, defaults, or events which with notice or passage of time would constitute Events of Default, such phrases or words shall not be construed to create any right in the Lessee to have additional periods of time to cure such defaults or Events of Default other than those specific cure periods provided in this Lease.

39.22. **Specific Performance**. In addition to any rights and remedies available to the parties hereunder or at law, each party shall be entitled to bring an action for specific performance and to seek other equitable relief in connection with any breach or violation, or any attempted breach or violation, of the provisions of this Lease.

39.23. **Joint Drafting**. The parties hereto and their respective counsel have participated in the drafting and redrafting of this Lease and the general rules of construction which would construe any provisions of this Lease in favor of or to the advantage of one party as opposed to the other as a result of one party drafting this Lease as opposed to the other or in resolving any conflict or ambiguity in favor of one party as opposed to the other on the basis of which party drafted this Lease are hereby expressly waived by all parties to this Lease.

39.24. **Joint and Several Obligations**. Each Facility Lessee shall be jointly and severally liable for all of the liabilities and obligations of Lessee under this Lease. Additionally, each Facility Lessee acknowledges and agrees that all of the representations, warranties, covenants, obligations, conditions, agreements and other terms contained in this Lease shall be applicable to and shall be binding upon and enforceable against any one or more Facility Lessees.

39.25. **Representations, Agreements and Covenants relating to Certain Properties**. Further representations, agreements and covenants regarding certain of the Properties are set forth on ***Schedule 39.25*** attached hereto and are hereby incorporated herein by reference.

39.26. **Arbitration**. If Lessee disputes Lessor's determination of Fair Market Value Rent, Lessee shall give notice to Lessor of such dispute within ten (10) Business Days after Lessee's receipt of the Rent Notice, and such dispute shall be determined by arbitration in accordance with the then prevailing Expedited Procedures of the Arbitration Rules for the Real Estate Industry of the American Arbitration Association or its successor for arbitration of commercial disputes, except that the rules shall be modified as follows:

(a) In its demand for arbitration, Lessee shall specify the name and address of the person to act as the arbitrator on Lessee's behalf. The arbitrator shall be a real estate broker with at least ten (10) years full-time commercial retail brokerage experience who is familiar with the fair market value of comparable healthcare facility space in the county in which the Property is located. Failure on the part of Lessee to make the timely and proper demand for such arbitration shall constitute a waiver of the right thereto, and the Allocated Base Rent shall be as set forth in the Rent Notice. Within ten (10) Business Days after the service of the demand for arbitration, Lessor shall give notice to Lessee specifying the name and address of the person designated by Lessor to act as arbitrator on its behalf, which arbitrator shall be similarly qualified. If Lessor fails to notify Lessee of the appointment of its arbitrator within such ten (10) Business Day period, and such failure continues for three (3) Business Days after Lessee delivers a second notice to Lessor, then the arbitrator appointed by Lessee shall be the arbitrator to determine the Fair Market Value Rent for the Property.

(b) If two (2) arbitrators are chosen pursuant to Section 39.26(a), the arbitrators so chosen shall meet within ten (10) Business Days after the second arbitrator is appointed and shall seek to reach agreement on Fair Market Value Rent as to the applicable Property. If, within twenty (20) Business Days after the second arbitrator is appointed, the two (2) arbitrators are unable to reach agreement on Fair Market Value Rent, then the two (2) arbitrators shall appoint a third (3rd) arbitrator, who shall be a competent and impartial person with qualifications similar to those required of the first two (2) arbitrators pursuant to Section 39.26(a). The third (3rd) arbitrator shall decide the dispute, if it has not been previously resolved, by following the procedures set forth in Section 39.26(c). Each party shall pay the fees and expenses of its respective arbitrator, and both shall share the fees and expenses of the third (3rd) arbitrator. Attorneys' fees and expenses of counsel and of witnesses for the respective parties shall be paid by the respective party engaging such counsel or calling such witnesses.

(c) Fair Market Value Rent shall be fixed by the third (3rd) arbitrator in accordance with the following procedures. Concurrently with the appointment of the third (3rd) arbitrator, each of the arbitrators selected by the parties shall state, in writing, his or her

determination of the Fair Market Value Rent supported by the reasons therefor. The third (3rd) arbitrator shall have the right to consult experts and competent authorities for factual information or evidence pertaining to a determination of Fair Market Value Rent, but any such determination shall be made in the presence of both parties with full right on their part to cross-examine. The third (3rd) arbitrator shall conduct such hearings and investigations as he or she deem appropriate and shall, within thirty (30) days after being appointed, select which of the two (2) proposed determinations most closely approximates his or her determination of Fair Market Value Rent. The third (3rd) arbitrator shall have no right to propose a middle ground or any modification of either of the two proposed determinations. The determination he or she chooses as that most closely approximating his or her determination of the Fair Market Value Rent shall constitute the decision of the third (3rd) arbitrator and shall be final and binding upon the parties. The third (3rd) arbitrator shall render the decision in writing with counterpart copies to each party. The third (3rd) arbitrator shall have no power to add to or modify the provisions of this Lease. Promptly following receipt of the third (3rd) arbitrator's decision, the parties shall enter into an amendment to this Lease evidencing the extension of the Lease Term for the applicable Extension Term and confirming the Allocated Base Rent for such Extension Term, but the failure of the parties to do so shall not affect the effectiveness of the third arbitrator's determination.

(d) In the event of a failure, refusal or inability of any arbitrator to act, his or her successor shall be appointed by him or her, but in the case of the third (3rd) arbitrator, his or her successor shall be appointed in the same manner as that set forth herein with respect to the appointment of the original third (3rd) arbitrator.

ARTICLE XL.
PASS-THROUGH LEASES

40.1. **Sublease of Pass-Through Lease Land**. With respect to Pass-Through Lease Land (and leased Improvements located thereon), the Pass-Through Lessor hereby subleases such Pass-Through Lease Land and Improvements to Lessee subject to all of the terms and conditions of the applicable Pass-Through Lease and, solely for the purpose of using the Pass-Through Lease Land and related Improvements in connection with the operation of the applicable Facility located on the Pass-Through Lease Land. Lessee shall fulfill and perform all of the applicable Pass-Through Lessor's duties, obligations, and responsibilities under each Pass-Through Lease and Lessee accepts, assumes, and agrees to comply with, perform, and observe all of the terms, conditions, provisions, duties, covenants, limitations, obligations, and undertakings contained in the Pass-Through Lease to be performed during the term of this Lease or for so long as Lessee is in possession of the Pass-Through Lease Land on the part of such Pass-Through Lessor as lessee/tenant therein, including, without limitation, the payment of the applicable Pass-Through Lease Rent and all other charges and amounts of any kind due and payable under the Pass-Through Leases as required under Article III and Article IV hereof. Lessee shall not assign, transfer, convey, or encumber any interest, right, or obligation in, to, or under the Pass-Through Lease or sublease any portion of the Pass-Through Lease Land or related Improvements, except in compliance with and as permitted under Article XXIII. Lessee shall not, without Lessor's prior written consent, which consent shall not be unreasonably withheld, conditioned, or delayed, (a) terminate, modify, amend, restate, or change in any way the Pass-Through Lease, or (b) exercise, attempt to exercise, or purport to exercise, any, right of offer, right of refusal or purchase option relating to any Pass-Through Lease Land or related Improvement (if available

under the applicable Pass-Through Lease). Lessor shall not, without Lessee's prior written consent, which consent shall not be unreasonably withheld, conditioned, or delayed, terminate, modify, amend, restate, or change in any way the Pass-Through Lease, provided that Lessee's consent shall not be required for the termination, modification, amendment, restatement, or change of any Pass-Through Lease to the extent such termination, modification, amendment, restatement, or change does not (A) take effect during the term of this Lease or (B) result in any material increase in the monetary or non-monetary obligations of Lessee under this Lease or the applicable Pass-Through Lease.

40.2. **Other Terms and Provisions Relating to the Pass-Through Leases**.

(a) Lessor and Lessee agree that each will, immediately upon receipt, forward to the other copies of all notices, requests, demands, and other correspondence and documents directed to and/or received from the "landlord" or "lessor" under any of the Pass-Through Leases.

(b) In connection with any transfer or conveyance of the Leased Improvements situated on any of the Pass-Through Lease Land, any assignment of Lessor's right, title, and interest in the Pass-Through Lease Land shall be subject to Section 30.1 hereof and to any reversionary rights under the Pass-Through Leases.

(c) So long as no Event of Default then exists, and no event then exists which with the giving of notice or the passage of time or both would constitute an Event of Default, upon written request from Lessee, Lessor shall exercise any applicable renewal options under each of the Pass-Through Leases, extending the term thereof; provided, however, that Lessor shall not be required to extend the term of any of the Pass-Through Leases for a period extending beyond the Term of this Lease (which shall include any duly exercised extensions of the Term under this Lease). Lessee may cause Lessor to exercise each such renewal options by giving written notice to Lessor at least three hundred sixty (360) days prior to the expiration of the Pass-Through Lease term.

(d) Any and all purchase options, rights of first refusal or rights of first offer under the Pass-Through Leases shall be exercised in the sole discretion of Lessor and, upon any purchase by Lessor of all or any portion of the Pass-Through Lease Land, such Pass-Through Lease Land shall remain subject to the terms and conditions of this Lease and the applicable purchase price shall be added to the Lease Base with respect to the Pass-Through Lease Land and related Improvements.

40.3. **Termination of Lease or Possession**. In the event of a termination of this Lease or the termination of Lessee's right of possession with respect to any Pass-Through Lease Land (or related Improvements), (a) all right, title, and interest in and to the Pass-Through Lease and the leasehold estate thereunder shall automatically revert to the applicable Pass-Through Lessor, and (b) Lessee shall, promptly after request by such Pass-Through Lessor, sign, acknowledge, provide, and deliver to such Pass-Through Lessor (unless such termination is due to an Event of Default, on a non-recourse basis, without any representations of warranties whatsoever) (and if Lessee fails to do so upon request of Lessor, Lessee hereby irrevocably appoints such Pass-Through Lessor as agent and attorney-in-fact of Lessee for such express purposes) any and all reasonable and customary documents, instruments, affidavits, or other writings (all in recordable form) which are

or may become necessary, proper, and/or advisable to cause the Pass-Through Lease and the leasehold estate thereunder to revert to the applicable Pass-Through Lessor as provided herein.

40.4. **Assignment of Pass-Through Lease Interest**. Notwithstanding any provision in this Lease to the contrary, Lessee acknowledges and agrees that, in the event Lessee purchases the Leased Property pursuant to any purchase option or privilege provided to Lessee under the terms of this Lease, with respect to any Pass-Through Lease Land, such purchase shall include only Lessor's leasehold estate under the applicable Pass-Through Lease and Lessor's leasehold interest in such Pass-Through Lease Land (and related leased Improvements), and shall be subject to all of the terms, provisions, and conditions of such applicable Pass-Through Lease (including any necessary consent to assignment). In such event, with respect to such Pass-Through Lease, Lessor shall assign the leasehold estate under such Pass-Through Lease to Lessee, and Lessee shall assume such Pass-Through Lease from Lessor, pursuant to an assignment and assumption agreement reasonably satisfactory to the parties. In connection with such assignment and assumption of any Pass-Through Lease, Lessee shall pay all of the costs and expenses of obtaining any necessary consent or approval to such assignment and assumption from the "landlord" or "lessor" under such Pass-Through Lease.

ARTICLE XLI.
MOB GROUND LEASES

41.1. **MOB Ground Leases**.

(a) With respect to the Lawton MOB Ground Leases, Lawton Lessee, with respect to the Ottumwa MOB Ground Lease, Ottumwa Lessee, and with respect to the Roaring Springs Ambulance Facility Lease, Roaring Springs Lessee, shall perform all of the terms, conditions, covenants and obligations imposed upon Lawton Lessor, Ottumwa Lessor, and Roaring Springs Lessor under the applicable MOB Ground Lease, in each case, to be performed by such Facility Lessors, as landlord, thereunder until the earlier of (i) the expiration or earlier termination of this Lease (or Lessee's right of possession hereunder) (subject to Article XIX for any holdover periods), and (ii) the termination of any such MOB Ground Lease, as applicable. It is hereby acknowledged and agreed that all such obligations as lessor or landlord under the MOB Ground Leases that accrue or arise prior to the expiration or earlier termination of this Lease (or Lessee's right of possession hereunder) (including any holdover period pursuant to Article XIX) shall remain the obligations and liabilities of Lessee. Notwithstanding anything contained in this Section 41.1 to the contrary, during the Term, Lawton Lessor, Ottumwa Lessor, and Roaring Springs Lessor shall reasonably cooperate with Lawton Lessee, Ottumwa Lessee, and Roaring Springs Lessee in their performance of all applicable terms, conditions, covenants and obligations under the MOB Ground Leases to the extent such terms, conditions, covenants and obligations are only capable of being performed by such Facility Lessor, as the fee owner of such portions of the Leased Property; provided, however, that (A) Lessor shall be reimbursed by Lessee for any actual and reasonable out of pocket costs or expenses incurred by Lessor with respect to the performance of any such obligations undertaken at the request of Lessee, (B) Lessee understands and is familiar with the extent to which such terms, conditions, covenants and obligations are only capable of being performed by the applicable Facility Lessor as the fee owner thereof, (C) Lessee shall use commercially reasonable efforts to provide Lessor reasonable advanced written notice to enable Lessor to perform any such terms, conditions, covenants and obligations in a timely manner, and

(D) Lessee shall consult, assist, and otherwise cooperate with Lessor in the performance thereof. So long as no Event of Default has occurred and is continuing, (I) Lawton Lessee, Ottumwa Lessee, and Roaring Springs Lessee, respectively, shall be entitled to collect the rental payments due under the respective MOB Ground Leases directly from the tenant thereunder, and (II) Lessor shall reasonably cooperate with Lessee to notify the tenants under the respective MOB Ground Leases that rental payments should be made directly to the applicable Facility Lessee, including, without limitation, by executing and delivering an instruction letter to such tenant instructing them to pay such rental payments directly to such Facility Lessee; *provided, that*, Lawton Lessee, Ottumwa Lessee, and Roaring Springs Lessee agree and acknowledge that upon the occurrence of an Event of Default, Lessor shall be authorized to revoke any such tenant instruction letter and instruct such tenant to pay all rental payments directly to Lessor during the continuation of such Event of Default.

(b) If any MOB Ground Lease expires or terminates prior to the expiration of the Term, then any property and improvements subject thereto shall be subject to the terms and conditions of this Lease. For the avoidance of doubt, the parties agree that (i) during the Term and prior to the termination and/or expiration of any MOB Ground Lease, the applicable Facility Lessor shall have the right to receive and apply all condemnation awards or insurance proceeds with respect to such Ground Leased MOB Property in accordance with the ground lessor's obligations under the applicable MOB Ground Lease, and (ii) during the Term and following the termination and/or expiration of any applicable MOB Ground Lease, any such condemnation awards and insurance proceeds shall be applied in accordance with the provisions of this Lease.

41.2. **Other Terms and Provisions Relating to the MOB Ground Leases**.

(a) Lessee shall not, without Lessor's prior written consent, (i) terminate, modify, amend, or restate any MOB Ground Lease or attempt to do any of the same, or (ii) exercise or attempt to exercise any right of offer, right of refusal or purchase option relating to any MOB Ground Lease or related MOB Ground Leased Improvements (if available under the applicable MOB Ground Lease).

(b) Lessor and Lessee agree that each will, promptly upon receipt, forward to the other copies of all notices, requests, demands, and other correspondence and documents directed to and/or received from the "tenant" or "lessee" under any MOB Ground Lease.

(c) Any and all purchase options, rights of first refusal or rights of first offer under the MOB Ground Leases shall be exercised in the sole discretion of Lessor and, upon any purchase by Lessor of all or any portion of the MOB Ground Leased Improvements, such MOB Ground Leased Improvements shall remain subject to the terms and conditions of this Lease and the applicable purchase price shall be added to the Lease Base for the applicable Property.

(d) Notwithstanding any provision in this Lease to the contrary, in the event Lessee purchases the Lawton Property or Ottumwa Property pursuant to any purchase option or privilege provided to Lessee under the terms of this Lease, with respect to any applicable Ground Leased MOB Property, such purchase shall be subject to all terms, provisions, and conditions of the applicable MOB Ground Lease. In such event, with respect to such MOB Ground Lease, Lessor shall assign to Lessee its right, title and interest in such MOB Ground Lease and Lessee shall

assume such MOB Ground Lease from Lessor, pursuant to an assignment and assumption agreement reasonably satisfactory to the parties.

41.3. **Reversionary and Other Rights**. In the event that there is any purchase option, right of first refusal, reversionary right, or other similar right in favor of the applicable Facility Lessor with respect to any Ground Leased MOB Property, then Lessee shall (i) provide Lessor notice of the accrual of any rights with respect thereto, (ii) provide such other related information as Lessor may reasonably request, (iii) cooperate with Lessor to ensure that the Lessor receives the benefit thereof (including the benefit of any reversionary rights or purchase option or receipt of any option purchase price, it being understood and agreed that it is Lessor who shall be entitled to exercise all purchase options and receive all reversions), and (iv) take such actions and deliver such documents as shall be necessary to effect the foregoing. Lessor agrees to cooperate with Lessee in connection herewith.

ARTICLE XLII.
MEMORANDUM OF LEASE

Lessor and Lessee shall, promptly upon the request of either, enter into a short form memorandum of this Lease, in form suitable for recording under the laws of the state in which the Leased Property is located, in which reference to this Lease, the Term and all options contained herein, shall be made. The party requesting recording shall pay any recording taxes and other costs in connection therewith.

[Signatures appear on following pages.]

IN WITNESS WHEREOF, the parties have caused this Lease to be executed by their respective officers thereunto duly authorized.

LESSOR:

MPT OF DODGE CITY-LIMA, LLC
MPT OF HASTINGS-LIMA, LLC
MPT OF JOHNSTOWN-LIMA, LLC
MPT OF LANDER-LIMA, LLC
MPT OF LAWTON-LIMA, LLC
MPT OF MEYERSDALE-LIMA, LLC
MPT OF OTTUMWA-LIMA, LLC
MPT OF PALESTINE-LIMA, LLC
MPT OF RIVERTON-LIMA, LLC
MPT OF ROARING SPRINGS-LIMA, LLC

By: MPT Operating Partnership, L.P
Its: Sole Member of each above-referenced entity

By:_____
Name:_____
Its:_____

4850-8732-8417

LESSEE:

DODGE CITY HEALTHCARE GROUP, LLC
d/b/a Western Plains Medical Complex

By:_____
Name:_____
Its:_____

DLP CONEMAUGH MINERS MEDICAL CENTER, LLC

By:_____
Name:_____
Its:_____

DLP CONEMAUGH MEMORIAL MEDICAL CENTER, LLC

By:_____
Name:_____
Its:_____

SOUTHWESTERN MEDICAL CENTER, LLC

By:_____
Name:_____
Its:_____

4850-8732-8417

DLP CONEMAUGH MEYERSDALE MEDICAL CENTER, LLC

By:_____
Name:_____
Its:_____

RCHP-OTTUMWA, LLC
d/b/a Ottumwa Regional Health Center

By:_____
Name:_____
Its:_____

PALESTINE PRINCIPAL HEALTHCARE LIMITED PARTNERSHIP
d/b/a Palestine Regional Medical Center

By:_____
Name:_____
Its:_____

PALESTINE-PRINCIPAL G.P., INC.

By:_____
Name:_____
Its:_____

RIVERTON MEMORIAL HOSPITAL, LLC
d/b/a SageWest Health Care - Riverton Campus and SageWest Health Care - Lander Campus

By:_____
Name:_____
Its:_____

4850-8732-8417

NASON MEDICAL CENTER, LLC

By:_____
Name:_____
Its:_____

4850-8732-8417

Exhibit A-1

Legal Description of Dodge City Owned Land

4850-8732-8417
4850-8732-8417

Exhibit A-2

Legal Description of Hastings Owned Land

4850-8732-8417

Exhibit A-3

Legal Description of Johnstown Owned Land

4850-8732-8417

Exhibit A-4

Legal Description of Lander Leased Land

4850-8732-8417
4850-8732-8417

Exhibit A-5

Intentionally Omitted

4850-8732-8417
4850-8732-8417

Exhibit A-6

Legal Description of Lawton Owned Land

4850-8732-8417
4850-8732-8417

Exhibit A-7

Legal Description of Meyersdale Owned Land

4850-8732-8417
4850-8732-8417

Exhibit A-8

Legal Description of Ottumwa Owned Land

4850-8732-8417
4850-8732-8417

Exhibit A-9

Legal Description of Palestine Owned Land

4850-8732-8417

Exhibit A-10

Legal Description of Riverton Owned Land

4850-8732-8417
4850-8732-8417

Exhibit A-11

Legal Description of Roaring Springs Owned Land

4850-8732-8417
4850-8732-8417

Exhibit B-1

Permitted Exceptions – Dodge City Owned Land

4850-8732-8417
4850-8732-8417

Exhibit B-2

Permitted Exceptions – Hastings Owned Land

4850-8732-8417
4850-8732-8417

Exhibit B-3

Permitted Exceptions – Johnstown Owned Land

4850-8732-8417
4850-8732-8417

Exhibit B-4

Permitted Exceptions – Lander Leased Land

4850-8732-8417
4850-8732-8417

Exhibit B-5

Intentionally Omitted

4850-8732-8417

Exhibit B-6

Permitted Exceptions – Lawton Owned Land

4850-8732-8417
4850-8732-8417

Exhibit B-7

Permitted Exceptions – Meyersdale Owned Land

4850-8732-8417
4850-8732-8417

Exhibit B-8

Permitted Exceptions – Ottumwa Owned Land

4850-8732-8417
4850-8732-8417

Exhibit B-9

Permitted Exceptions – Palestine Owned Land

4850-8732-8417
4850-8732-8417

Exhibit B-10

Permitted Exceptions - Riverton Owned Land

4850-8732-8417
4850-8732-8417

Exhibit B-11

Permitted Exceptions – Roaring Springs Owned Land

4850-8732-8417
4850-8732-8417

Exhibit C-1

Facilities Located on Dodge City Owned Leased Land

Facility/Practice Name	Address

4850-8732-8417
4850-8732-8417

Exhibit C-2

Facilities Located on Hastings Owned Land

Facility/Practice Name	Address

4850-8732-8417
4850-8732-8417

Exhibit C-3

Facilities Located on Johnstown Owned Land

Facility/Practice Name	Address

4850-8732-8417

Exhibit C-4

Facilities Located on Lander Leased Land

Facility/Practice Name	Address

4850-8732-8417

Exhibit C-5

Intentionally Omitted

4850-8732-8417
4850-8732-8417

Exhibit C-6

Facilities Located on Lawton Owned Land

Facility/Practice Name	Address

4850-8732-8417
4850-8732-8417

Exhibit C-7

Facilities Located on Meyersdale Owned Land

Facility/Practice Name	Address

4850-8732-8417
4850-8732-8417

Exhibit C-8

Facilities Located on Ottumwa Owned Land

Facility/Practice Name	Address

4850-8732-8417

Exhibit C-9

Facilities Located on Palestine Owned Land

Facility/Practice Name	Address

4850-8732-8417

Exhibit C-10

Facilities Located on Riverton Owned Land

Facility/Practice Name	Address

4850-8732-8417

Exhibit C-11

Facilities Located on Roaring Springs Owned Land

Facility/Practice Name	Address

4850-8732-8417

Exhibit D

Lessee Representations and Warranties

Each Facility Lessee hereby represents and warrants to Lessor, jointly and severally, that:

(a) it has full legal right, power and authority to enter into this Lease, to incur the obligations provided for herein, and to execute and deliver the same to Lessor;

(b) this Lease has been duly executed and delivered by such Facility Lessee and constitutes such Facility Lessee's valid and legally binding obligation, enforceable against it in accordance with its terms, subject to bankruptcy, insolvency, reorganization, and similar laws affecting the enforcement of creditor's rights or contractual obligations generally and, as to enforcement, to general principles of equity, regardless of whether applied in a proceeding at law or in equity;

(c) no approval or consent of any foreign, federal, state, county, local or other governmental or regulatory body, and no approval or consent of any other person is required in connection with the execution and delivery by such Facility Lessee of this Lease or the consummation and performance by such Facility Lessee of the transactions contemplated hereby, except such approvals or consents as shall have been obtained on or prior to the Effective Date;

(d) the execution and delivery of this Lease and the obligations created hereby have been duly authorized by all necessary proceedings on the part of such Facility Lessee, and will not conflict with or result in the breach or violation of any of the terms or conditions of, or constitute (or with notice or lapse of time or both would constitute) a default under the governing documents of such Facility Lessee, any instrument, contract or other agreement to which it is a party or by or to which such Facility Lessee or any of its assets or properties are bound or subject; or any statute or any regulation, order, judgment or decree of any court or governmental or regulatory body;

(e) it is not a party to, or to it's knowledge, threatened with any litigation or judicial, administrative, or arbitration proceeding which, if decided adversely to it, would restrain, prohibit, or materially delay, void, or invalidate the transactions contemplated under this Lease or any other Obligation Document;

(f) Lessees and Guarantors (i) were Solvent prior to entering into the Purchase Agreement and this Lease, (ii) were or will be Solvent immediately after giving effect to the transactions contemplated in this Lease and the Purchase Agreement (including, without limitation, the LifePoint Upper Tier Restructuring Transaction (and related LifePoint Upper Tier Distributions)), and (iii) are now Solvent;

(g) no transfer of property is being made or has been made and no obligation is being incurred in connection with the transactions contemplated in this Lease or the Purchase Agreement with the intent to hinder, delay, or defraud either present or future creditors of any Lessee or Guarantor;

4850-8732-8417

(h) any and all actions taken, or to be taken, by the Lessees and Guarantors in connection with the LifePoint Upper Tier Restructuring Transaction (and related LifePoint Upper Tier Distributions): (i) have been, are, and will be, properly authorized and approved in accordance with the applicable Organizational Documents of each of them prior to undertaking such LifePoint Upper Tier Restructuring Transaction (and related LifePoint Upper Tier Distributions), and (ii) after giving effect to the transactions contemplated in this Lease and the Purchase Agreement (including, without limitation, the LifePoint Upper Tier Restructuring Transaction (and related LifePoint Upper Tier Distribution)), has complied with, is in compliance with, and will comply with all applicable laws (including, without limitation, all applicable Legal Requirements and all applicable laws relating to the paying, making, or declaring dividends or distributions); and

(i) none of the Lessees or Guarantors are involved in any proceeding by or against it as a debtor before any Governmental Body under Title 11 of the United States Bankruptcy Code or any other insolvency or debtors' relief act, whether state, federal, or foreign, or for the appointment of a trustee, received, liquidator, assignee, sequestrator, or other similar official for any part of any of the property or assets of any Lessee or Guarantor.

4850-8732-8417

Exhibit E

Existing Subleases

[TO BE POPULATED BY LESSEE AT CLOSING]

4850-8732-8417
4850-8732-8417

Exhibit F

Intentionally Omitted

4850-8732-8417

Exhibit G

Form of Subordination of Management Agreement

4850-8732-8417
4850-8732-8417

SUBORDINATION OF MANAGEMENT AGREEMENT

THIS SUBORDINATION OF MANAGEMENT AGREEMENT (this "Agreement") is made this ___ day of _____, 2020, by and among [_____], a [_____] ("Manager"); **LIMA HOLDCO, LLC**, a Delaware limited liability company ("Lima Holdco"); the entities listed on ***ANNEX A*** hereto under the heading "Lessees" (hereinafter be referred to, individually, as a "Lessee" and, collectively, as the "Lessees") (Lima Holdco and Lessees shall hereinafter be referred to, individually, as an "Obligor" and, collectively, as the "Obligors"); and the entities listed on ***ANNEX A*** hereto under the heading "Lessors" (hereinafter be referred to, individually, as a "Lessor" and, collectively, as the "Lessors") (Manager, Obligors, and Lessors shall hereinafter be referred to, individually, as a "Party" and, collectively, as the "Parties").[1]

W I T N E S S E T H:

WHEREAS, Lessors and Lessees have entered into that certain Master Lease Agreement, dated of even date herewith (as the same may be amended, modified and restated from time to time, the "Master Lease"), whereby Lessors are leasing (or, as applicable, subleasing) to Lessees, and Lessees are leasing (or, as applicable, subleasing) from Lessors, certain real property consisting of multiple parcels of land, the improvements now or hereafter located thereon (including any improvements consisting of multiple hospital facilities), the fixtures now or hereafter attached thereto and all easements, licenses, rights-of-way, appurtenances and other matters and items relating thereto, all as more particularly described in the Master Lease (collectively, the "Leased Property");

WHEREAS, LifePoint Health, [Inc.] and Lima Holdco has each entered into those certain Guaranty Agreements, dated of even date herewith, in favor of the Lessors (collectively, as the same may be amended, modified and restated from time to time, the "Guaranty"), pursuant to which Lima Holdco guarantees the payment and performance of all of the respective obligations and liabilities of the Lessees under the Master Lease;

WHEREAS, pursuant to that certain [Management Services Agreement, dated as of _____, 20___], by and among Manager and certain of the Lessees (the "Management Agreement Counterparties"), a copy of which is attached hereto as ***EXHIBIT A*** (as the same may be amended, modified or restated from time to time, the "Management Agreement"), Manager provides management services to such Management Agreement Counterparties with respect to the operation of each of the hospital facilities (each a "Facility" and collectively the "Facilities") located, respectively, on any of the Leased Property;

WHEREAS, Manager and the Obligors acknowledge that, as a result of the above described transactions, Manager and the Obligors will derive direct and indirect benefits in the form of economies of scale, access to capital and other important strategic operational benefits and, accordingly, Manager and the Obligors have concluded that it is in their best interest to enter into this Agreement; and

---

[1] To be entered into with respect to each Management Agreement.

WHEREAS, Lessors have required the execution and delivery of this Agreement as a condition precedent to the transactions and agreements contemplated in the Master Lease and the other Obligation Documents (as defined below).

NOW, THEREFORE, in consideration of the premises, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto do hereby agree as follows:

1. **Defined Terms**. Capitalized terms used herein and not expressly defined herein shall have the respective meanings ascribed to them in this Section 1.

"Affiliate" means, with respect to any Person (i) any Person that, directly or indirectly, controls or is controlled by or is under common control with such Person, (ii) any other Person that owns, beneficially, directly or indirectly, 10% or more of the outstanding capital stock, shares or equity interests of such Person, or (iii) any officer, director, employee, shareholder, partner, member, manager or trustee of such Person or any Person controlling, controlled by or under common control with such Person (excluding trustees and persons serving in similar capacities who are not otherwise an Affiliate of such Person). For the purposes of this definition, "control" (including the correlative meanings of the terms "controlled by" and "under common control with"), as used with respect to any Person, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, through the ownership of voting securities or otherwise.

"Business Day" means each Monday, Tuesday, Wednesday, Thursday and Friday that is not a day on which money centers in the City of New York, New York are authorized or obligated by law or executive order to close.

"Major Event of Default" means the occurrence of any of the following events: (a) the occurrence of a "Major Event of Default" under and as defined in the Master Lease; (b) the occurrence of a "Major Event of Default" under and as defined in any of the other Obligation Documents; or (c) the failure of any of the Obligors to punctually and properly perform in all material respects (without duplication of any materiality qualifier herein) any covenant or obligation contained herein if the same shall remain uncured within a period of thirty (30) days after receipt by Obligors of written notice thereof from the Lessors, unless such failure cannot with due diligence be cured within a period of thirty (30) days (in the Lessors' reasonable discretion), in which case such failure shall not be deemed to continue so long as Obligors commence to cure such failure within the thirty (30) day period and proceed with due diligence to complete the curing thereof within sixty (60) days after receipt by Obligors of the Lessors' notice of default (or such longer period as is reasonably required in the determination of the Lessors to effect such cure if Obligors are diligently proceeding to do so); provided, however, in no event shall the Lessors be required to give more than two (2) notices and cure period for Obligors' failure to observe or perform the same (or repetitive) covenant or condition in any consecutive twelve (12) month period.

"MPT Documents" means, collectively, Master Lease and the other Obligation Documents

"Obligation Documents" has the meaning set forth in the Master Lease.

"Person" means an individual, a corporation, a limited liability company, a general or limited partnership, an unincorporated association, a joint venture, a governmental entity or another entity or group.

2. **Management Agreement**. Manager and Obligors hereby jointly and severally represent and warrant to the Lessors as follows: (a) attached hereto as ***EXHIBIT A*** is a true, correct and complete copy of the Management Agreement; (b) the Management Agreement is the only "Management Agreement" (as defined in the Master Lease) between Obligors and Manager, and any of their respective Affiliates with respect to the Leased Property; (c) the Management Agreement remains unmodified and in full force and effect as of the date hereof, without default thereunder by either Manager or any Obligor; and (d) Manager has been paid all amounts due for all services, if any, furnished as of this date with respect to the Leased Property, except for amounts due and payable with respect to services, if any, furnished during the calendar month in which this Agreement is made. The Management Agreement Counterparties represent and warrant to the Lessors that, other than this Agreement, neither the Management Agreement Counterparties nor Manager has entered into any subordination agreement with respect to the Management Agreement. Manager further acknowledges that the Lessees are leasing the Leased Property from the applicable Lessors pursuant to the Master Lease, which are secured by liens encumbering certain assets, including, but not limited to, the Management Agreement Counterparties' rights and interests under the Management Agreement.

3. **Subordination of Management Fees**. Manager acknowledges and agrees that the liens created by the MPT Documents, and the Lessors' right to payment thereunder, shall be superior to and have priority over the right of the Manager to receive payment under the Management Agreement. In furtherance of the foregoing, Manager fully and completely subordinates to the liens created by the MPT Documents, and to the Lessors' right to payment thereunder, any right to payment of Manager arising out of or in any way connected with its services performed under the Management Agreement. Manager further agrees that neither Manager nor its Affiliates: (a) shall demand, collect or accept from any of the Management Agreement Counterparties' or their Affiliates any payment or collateral on account of any amounts due or to become due under the Management Agreement (the "Subordinated Amounts") or any part thereof or realize upon or enforce any collateral securing such Subordinated Amounts, nor commence any action or proceeding against any of the Management Agreement Counterparties or their Affiliates in any court or other tribunal to recover all or any part of such Subordinated Amounts, except with respect to any payment to Manager permitted under Section 5 hereof; (b) shall have given or shall hereafter give any subordination or enter into any subordination agreement in respect of the Subordinated Amounts or transfer or assign any of the Subordinated Amounts to any Person other than the Lessors or their Affiliates; (c) will commence or join with any of the other creditors of the Management Agreement Counterparties or their Affiliates in commencing any bankruptcy, reorganization, receivership or insolvency proceeding against any of the Management Agreement Counterparties or their Affiliates; or (d) shall take or permit any action prejudicial to or inconsistent with the Lessors' priority position over Manager and its Affiliates that is created by this Agreement.

4. **Rights of Lessors Following a Major Event of Default**. Notwithstanding anything to the contrary in the Management Agreement, during the continuation of a Major Event of Default,

unless waived in writing by the Lessors, the Lessors shall have the right, upon written notice to Manager:

(a) to require Manager to continue performance under and in accordance with the Management Agreement, on behalf of the Lessors, with respect to any one or more of the Facilities as the Lessors may elect, for so long as the Lessors may elect, in consideration of the compensation due and payable under the Management Agreement with respect to such period of time; or

(b) to require the Management Agreement Counterparties to immediately remove any one or more of the Facilities (including all if so elected by the Lessors) from coverage under the Management Agreement, which shall terminate the management of such Facility or Facilities and, within five (5) days after receipt of such written notice, execute and deliver to the Lessors an amendment to the Management Agreement evidencing such removal.

Upon the removal of any one or more of the Facilities from coverage under the Management Agreement, as provided in subsection (ii) above (each, a "Removed Facility"), no termination fee or other compensation shall be due to Manager with respect to such Removed Facility; *provided, however*, that subject to the subordination provisions of this Agreement, nothing in this Agreement shall limit the Management Agreement Counterparties' obligation to pay to Manager the fees due under the Management Agreement for services rendered through the date of such removal.

5. **Permitted Receipt of Subordinated Amounts**. Notwithstanding anything to the contrary in this Agreement, so long as no Major Event Default has occurred and is continuing, the Management Agreement Counterparties may pay, and Manager may receive, the Subordinated Amounts (so long as such payment does not give rise to a Major Event of Default); *provided, that*: (a) nothing herein shall limit the accrual of the Subordinated Amounts during the existence of a Major Event of Default for Manager's services during such period and (b) if such Major Event of Default is cured or waived in writing by the Lessors, subject to the proviso below, any such accrued amounts shall be paid as provided under the Management Agreement; *provided, however*, that in no event shall any such accrued amount be payable to Manager if, as a result of a Major Event of Default, (i) the Master Lease is terminated (or Lessees' right of possession is terminated thereunder), or (ii) the Management Agreement is terminated (except to the extent provided therein), and in no event shall any such amounts continue to accrue with respect to a Removed Facility after the removal of such Removed Facility.

6. **Payment of Subordinated Amounts Following Certain Events**. Notwithstanding anything to the contrary in the Management Agreement, (a) during the continuation of a Major Event of Default, if Manager receives payment of or security for any Subordinated Amounts from any Obligor; or (b) after the date of removal of any one or more Removed Facilities, if Manager receives payment of or security for any Subordinated Amounts from any Obligor relating to such Removed Facilities, in either such case, Manager shall forthwith deliver such payment or security to the Lessors in precisely the form received (except for Manager's endorsement when necessary) for application in accordance with the MPT Documents. Until delivered such payment or security shall be held in trust by Manager as the property of the Lessors. In the event of the failure of Manager to endorse any instrument for the payment of

money so received, each Lessor is hereby appointed attorney-in-fact, which is coupled with an interest, for Manager with full power to make such endorsement and with full power of substitution.

7. **Remedies Upon Termination**. Upon any termination of the Management Agreement with respect to one or more Removed Facilities and the portion or portions of the Leased Property relating thereto, Manager may pursue those remedies set forth in the Management Agreement with regard to the Management Agreement Counterparties, so long as all such rights and remedies in respect of the Subordinated Amounts are subordinate to Lessors' rights and remedies under this Agreement and pursuant to the MPT Documents. Upon any such termination of the Management Agreement with respect to a Removed Facility, except as otherwise provided in Section 4, Manager shall have no right of specific performance and no lien or charge upon such Removed Facility, the portion or portions of the Leased Property relating thereto, or income from or relating to such Removed Facility or the portion or portions of the Leased Property relating thereto, with respect to the Subordinated Amounts, until all liabilities and obligations under the MPT Documents have been fully paid and satisfied (other than contingent indemnification obligations for which no claim has been asserted that expressly survive the termination of this Agreement).

8. **Bankruptcy; Liquidation**. In the event of any distribution, division or application, partial or complete, voluntary or involuntary, by operation of law or otherwise, of all or any part of the assets of the Obligors or the proceeds thereof to creditors of the Obligors, by reason of the liquidation, dissolution or other winding up of the Obligors or the business of the Obligors or, in the event of any sale, receivership, insolvency or bankruptcy case or proceeding by or against the Obligors for any relief under any bankruptcy or insolvency law or laws relating to the relief of debtors, readjustments of indebtedness, liquidations, reorganizations, compositions, or extensions, then, and in any such event, any payment or distribution of any kind or character, either in cash, securities or other property, which shall be payable or deliverable to Manager solely with respect to the Subordinated Amounts (and not any other amount payable to the Manager pursuant to the Management Agreement or otherwise) shall be paid or delivered directly to Lessors for application against any obligations or liabilities of Obligors under the MPT Documents, whether due or not due, until all such obligations shall have been fully paid and satisfied.

9. **Grant of Security Interest**. As an additional inducement to Lessors to enter into the MPT Documents and this Agreement, Manager hereby grants to the Lessors a security interest in all of Manager's fees, accounts receivable, and other amounts, due or to become due, arising from or related to the Management Agreement. The Lessors shall have the right at any time to file a UCC-1 financing statement without Manager's signature where authorized by law, but the failure of Lessors to do so shall not impair the validity or enforceability of this Agreement. Upon Lessors' request, and at Manager's expense, Manager shall promptly execute any and all documents (including all bank/lender required documents) and take all other actions as Lessors reasonably deem necessary to perfect its security interest as provided herein. Notwithstanding any provision of this Section to the contrary, Manager shall be entitled to receive and apply, without restriction, any Subordinated Amounts earned and received pursuant to the Management Agreement as permitted under Section 5 hereof.

10. **Receipt of Security Instruments**. Manager acknowledges receipt of a copy of the security instruments being delivered by Obligors to the Lessors in connection with the MPT Documents. Furthermore, Manager acknowledges that all rents or other funds that may hereafter be held by Manager, as agent for Obligors, are subject to the liens and security interests granted to the Lessors pursuant to the MPT Documents, and shall remit such funds to or as directed by the Lessors pursuant to the MPT Documents.

11. **Amendment of Management Agreement; Prepayment and Accrual of Fees**. Subject to the proviso set forth in Section 39.9 of the Master Lease, Manager and Obligors (a) shall not terminate or materially amend or modify the Management Agreement unless (i) they have obtained the prior written consent of the Lessors, which consent shall not be unreasonably withheld, conditioned or delayed, or (ii) such amendment or modification would not adversely affect the rights of the Lessors, in the reasonable determination of Lessors, (b) shall not make or accept any prepayment or advance payment of fees or other obligations due under the Management Agreement, and (c) neither shall accrue any fees, expenses and other amounts due under the Management Agreement in excess of one (1) month, unless, they have obtained the prior written consent of the Lessors, which consent shall not be unreasonably withheld, conditioned or delayed.

12. **Notice of Defaults**. Notwithstanding anything to the contrary in the Management Agreement, in the event the Management Agreement Counterparties default in the payment of any amounts due to Manager under the Management Agreement, Manager shall provide prompt written notice of such default to the Lessors, whereupon, the Lessors shall have the right, but not the obligation, within fifteen (15) days after receipt of such notice, to cure such default by paying directly to Manager any amounts due or outstanding under the Management Agreement so as to put the Management Agreement Counterparties in good standing thereunder.

13. **Representations and Warranties of Manager and Obligors**. Manager, individually and as to itself only, and each Obligor, jointly and severally, hereby represent and warrant to the Lessors as of the date hereof that (a) each of them has full legal right, power and authority to enter into this Agreement, to incur the obligations provided for herein, and to execute and deliver the same to the Lessors; (b) this Agreement has been duly executed and delivered by each of them and constitutes their valid and legally binding obligation, enforceable against them in accordance with its terms, subject to bankruptcy, insolvency, reorganization, and similar laws affecting the enforcement of creditor's rights or contractual obligations generally and, as to enforcement, to general principles of equity, regardless of whether applied in a proceeding at law or in equity; (c) no approval or consent of any foreign, federal, state, county, local or other governmental or regulatory body, and no approval or consent of any other Person is required in connection with the execution and delivery by any of them of this Agreement or the consummation and performance by any of them of the transactions contemplated hereby, except such approvals or consents as shall have been obtained on or prior to the date hereof; (d) the execution and delivery of this Agreement and the obligations created hereby have been duly authorized by all necessary proceedings on the part of each of them and will not conflict with or result in the material breach or violation of any of the terms or conditions of, or constitute (or with notice or lapse of time or both would constitute) a default under the governing documents of any of them, any material instrument, contract or other agreement to which any of them is a party or by or to which any of them or their respective assets or properties are bound or subject, or any

statute or any regulation, order, judgment or decree of any court or governmental or regulatory body; (e) ***Schedule 13(e)*** attached hereto sets forth, as of the date hereof, the ownership of Manager and, except as set forth therein, no other Person has, and none of them have offered to any Person, any written option to acquire same; (f) none of them is a party to or, to their knowledge, threatened with any litigation or judicial, administrative or arbitration proceeding which, if decided adversely to any of them, would restrain, prohibit or materially delay the transactions contemplated hereby; (g) the Management Agreement is the only "Management Agreement" (as defined in the Master Lease) between any of the Management Agreement Counterparties and Manager, with respect to the management of the Leased Property; (h) other than this Agreement, none of the Management Agreement Counterparties, nor Manager, has entered into any subordination agreement with respect to the Management Agreement; and (i) the Management Agreement remains unmodified and in full force and effect as of the date hereof, without default thereunder by any Obligor or Manager under the Management Agreement.

14. **Accounting of Services**. Manager and the Management Agreement Counterparties shall render to the Lessors from time to time upon the Lessors' reasonable request therefor an accounting of all amounts paid by any Obligor to Manager, which accounting shall include copies of all related invoices and receipts.

15. **Absolute and Unconditional Obligations**. Manager will perform its obligations under this Agreement regardless of any law now or hereafter in effect in any jurisdiction or venue affecting any of the terms of any of the MPT Documents or the rights of the Lessors with respect thereto. The obligations of Manager under this Agreement are independent of the MPT Documents, and a separate action or actions may be brought and prosecuted against Manager to enforce this Agreement, irrespective of whether any action is brought against any Obligor or their respective Affiliates or whether any Obligor or their respective Affiliates is joined in any such action or actions. The obligations of Manager under this Agreement shall be absolute and unconditional irrespective of:

(a) any lack of validity or enforceability of any of the MPT Documents;

(b) the validity of any lien granted to the Lessors or their Affiliates in any of the assets of the Management Agreement Counterparties;

(c) any change in the time, manner or place of payment or performance of, or in any other term of, any of the MPT Documents, or any other amendment thereof, or waiver of any provision thereof, including, without limitation, any increase in any indebtedness owed from the Obligors to the Lessors or their Affiliates resulting from the extension of additional credit to the Obligors or otherwise;

(d) any taking, exchange, release or non perfection of any lien granted to Lessors or their Affiliates in any of the assets of the Obligors;

(e) any manner of application of the assets of the Obligors, or proceeds thereof, to all or any of the indebtedness of the Obligors to the Lessors or their Affiliates, or any manner of sale or other disposition of any of such assets for all or any of such indebtedness of the Obligors to the Lessors or their Affiliates;

(f) any change, restructuring or termination of the organizational structure or existence of the Obligors; or

(g) any other circumstance which might otherwise constitute a defense available to, or a discharge of, the Obligors.

16. **Waiver of Notice**. The Obligors and Manager hereby waive promptness, diligence, notice of acceptance and any other notice with respect to this Agreement, the MPT Documents, and any requirement that the Lessors perfect or insure any lien or any collateral or exhaust any right or take any action against the Obligors, their respective Affiliates, Manager, or any other person or any collateral securing the indebtedness of the Obligors to the Lessors or their Affiliates.

17. **No Waiver**. Any provision of this Agreement or Exhibits hereto may be amended or waived only in a writing signed by the parties hereto. No waiver of any provision hereunder or any breach or default thereof shall extend to or affect in any way any other provision or prior or subsequent breach or default.

18. **Necessary Action**. Each party shall perform any further acts and execute and deliver any documents that may be reasonably necessary to carry out the provisions of this Agreement.

19. **Notices**. All notices, demands and other communications to be given or delivered under or by reason of the provisions of this Agreement shall be in writing and shall be deemed to have been given (a) when personally delivered, (b) when transmitted via telecopy (or other facsimile device) to the number set out below if the sender on the same day sends a confirming copy of such notice by a recognized overnight delivery service (charges prepaid), (c) the day following the day (except if not a Business Day then the next Business Day) on which the same has been delivered prepaid to a reputable national overnight air courier service or (d) the third Business Day following the day on which the same is sent by certified or registered mail, postage prepaid. Notices, demands and communications, in each case to the respective parties, shall be sent to the applicable address set forth below, unless another address has been previously specified in writing:

IF TO MANAGER:

[_____]
[_____]
[_____]
Attn: [_____]
Fax: [(___) [_____]

WITH A COPY TO:

[_____]
[_____]
[_____]
Attn: [_____]
Fax: [(___) [_____]

IF TO ANY OBLIGOR:

c/o LifePoint Health, [Inc.]
330 Seven Springs Way
Brentwood, TN 37027

	Attention: General Counsel Facsimile: (615) 920-8948
WITH A COPY TO:	Sidley Austin LLP 787 Seventh Avenue New York, NY 10019 Attn: [redacted] Fax: [redacted]
WITH A COPY TO:	Waller Lansden Dortch & Davis, LLP 511 Union Street, Suite 2700 Nashville, TN 37219 Attn: [redacted] Facsimile: [redacted]
IF TO ANY LESSOR:	c/o MPT Operating Partnership, L.P. 1000 Urban Center Drive, Suite 501 Birmingham, Alabama 35242 Attention: Legal Department Facsimile: (205) 969-3756
WITH A COPY TO:	Baker, Donelson, Bearman, Caldwell & Berkowitz, PC 420 20th Street North 1400 Wells Fargo Tower Birmingham, Alabama 35203 Attention: [redacted] Facsimile: [redacted]

or to such other address with respect to a party as such party notifies the other in writing as above provided.

20. **Severability**. Whenever possible, each provision of this Agreement shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Agreement, unless the severance of such provision would be in opposition to the parties' intent with respect to such provision.

21. **Entire Agreement**. This Agreement and the documents referred to herein contain the complete agreement between the parties hereto and supersede any prior understandings, agreements or representations by or between the parties, written or oral, which may have related to the subject matter hereof in any way.

22. **Governing Law; Jurisdiction and Venue; Waiver of Jury Trial**.

(a) This Agreement shall be governed by and construed in accordance with the laws of the State of Delaware applicable to contracts executed and performed in such State, without giving effect to conflicts of law principles.

(b) THE PARTIES HERETO CONSENT TO PERSONAL JURISDICTION IN THE STATE OF DELAWARE. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, THE PARTIES AGREE THAT ANY ACTION OR PROCEEDING ARISING FROM OR RELATED TO THIS AGREEMENT SHALL BE BROUGHT AND TRIED EXCLUSIVELY IN THE STATE OR FEDERAL COURTS OF DELAWARE. EACH OF THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY OBJECTION TO THE LAYING OF VENUE OF ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. THE PARTIES EXPRESSLY ACKNOWLEDGE THAT DELAWARE IS A FAIR, JUST AND REASONABLE FORUM AND AGREE NOT TO SEEK REMOVAL OR TRANSFER OF ANY ACTION FILED BY THE OTHER PARTIES IN SAID COURTS. FURTHER, THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY CLAIM THAT SUCH SUIT, ACTION OR PROCEEDING HAS BEEN BROUGHT IN AN INCONVENIENT FORUM. SERVICE OF ANY PROCESS, SUMMONS, NOTICE OR DOCUMENT BY CERTIFIED MAIL ADDRESSED TO A PARTY AT THE ADDRESS DESIGNATED PURSUANT TO SECTION 19 SHALL BE EFFECTIVE SERVICE OF PROCESS AGAINST SUCH PARTY FOR ANY ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. A FINAL JUDGMENT IN ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT MAY BE ENFORCED IN ANY OTHER COURT TO WHOSE JURISDICTION ANY OF THE PARTIES IS OR MAY BE SUBJECT.

(c) TO THE MAXIMUM EXTENT PERMITTED BY LAW, THE PARTIES HEREBY KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVE THE RIGHT TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION BASED HEREON, ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT, OR ANY COURSE OF CONDUCT, COURSE OF DEALING, STATEMENT (WHETHER VERBAL OR WRITTEN) OR ACTION OF ANY PARTY OR ANY EXERCISE OF ANY PARTY OF THEIR RESPECTIVE RIGHTS HEREUNDER OR IN ANY WAY RELATING TO THIS AGREEMENT OR THE COLLATERAL (INCLUDING ANY CLAIM OR DEFENSE ASSERTING THAT THIS AGREEMENT WAS FRAUDULENTLY INDUCED OR IS OTHERWISE VOID OR VOIDABLE). THIS WAIVER IS A MATERIAL INDUCEMENT FOR THE LESSORS TO ENTER INTO THIS AGREEMENT AND THE OTHER OBLIGATION DOCUMENTS.

23. **No-Third Party Beneficiaries**. Nothing expressed or referred to in this Agreement will be construed to give any Person other than the parties to this Agreement any legal or equitable right, remedy, or claim under or with respect to this Agreement or any provision of this Agreement.

24. **Binding Effect; Assignment**. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns, except that neither this Agreement nor any of the rights, interests or obligations hereunder may be assigned or delegated by Manager or any Obligor without the prior written consent of the Lessors. Any Lessor may at any time and without the consent of Manager or the Obligors assign all of its rights and obligations hereunder to any other Person.

25. **Delivery by Electronic Transmission**. This Agreement and any signed agreement entered into in connection herewith or contemplated hereby, and any amendments hereto or thereto, to the extent signed and delivered by means of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail, shall be treated in all manner and respects as an original contract and shall be considered to have the same binding legal effects as if it were the original signed version thereof delivered in person. At the request of any party hereto or to any such contract, each other party hereto or thereto shall re-execute original forms thereof and deliver them to all other parties. No party hereto or to any such contract shall raise the use of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail to deliver a signature or the fact that any signature or contract was transmitted or communicated through the use of facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail as a defense to the formation of a contract and each such party forever waives any such defense.

26. **Counterparts**. This Agreement may be executed in multiple counterparts, any one of which need not contain the signature of more than one party, but all such counterparts taken together shall constitute one and the same instrument.

27. **Joint Drafting**. The parties hereto and their respective counsel have participated in the drafting and redrafting of this Agreement and the general rules of construction which would construe any provisions of this Agreement in favor of or to the advantage of one party as opposed to the other as a result of one party drafting this Agreement as opposed to the other or in resolving any conflict or ambiguity in favor of one party as opposed to the other on the basis of which party drafted this Agreement are hereby expressly waived by all parties to this Agreement.

28. **Representatives**.

(a) The Obligors hereby appoint Lima Holdco as their duly authorized agent and representative (the "Obligor Representative") to take all actions and enforce all rights of the Obligors under this Agreement, including, without limitation, (i) giving and receiving any notice or instruction permitted or required under this Agreement; (ii) interpreting all of the terms and provisions of this Agreement; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with the other parties hereto under this Agreement; (v) conducting negotiations and dealing with the Lessors under this Agreement; and (vi) taking any other actions on behalf of the Obligors relating to the Obligors' rights, claims, duties and obligations under this Agreement. In the performance of the Lessors' duties and obligations hereunder, the Lessors shall be authorized and permitted to correspond and transact with the Obligor Representative on behalf of all the Obligors and shall be entitled to rely upon any document or instrument executed and delivered by the Obligor Representative.

(b) The Lessors hereby appoint MPT of Johnstown-Lima, LLC as their duly authorized agent and representative (the "MPT Representative") to take all actions and enforce all rights of the Lessors under this Agreement, including, without limitation, (i) giving and receiving any notice or instruction permitted or required under this Agreement; (ii) interpreting all of the terms and provisions of this Agreement; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with the other parties hereto under this Agreement; (v) conducting negotiations and dealing with the Obligors under this Agreement; and (vi) taking any other actions on behalf of

the Lessors relating to the Lessors' rights, claims, duties and obligations under this Agreement. In the performance of the Obligors duties and obligations hereunder, the Obligors shall be authorized and permitted to correspond and transact with the MPT Representative on behalf of all the Lessors and shall be entitled to rely upon any document or instrument executed and delivered by the MPT Representative.

[*Signatures Appear on Following Pages*]

IN WITNESS WHEREOF, this Agreement is executed and delivered as of the day and year first above written.

MANAGER:

[_____]

By:_____
Name:_____
Title:_____

[Signatures Continue on Following Pages]

OBLIGORS:

LIMA HOLDCO, LLC

By:_____
Name:_____
Title:_____

DODGE CITY HEALTHCARE GROUP, LLC
d/b/a Western Plains Medical Complex

By:_____
Name:_____
Title:_____

DLP CONEMAUGH MINERS MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

DLP CONEMAUGH MEMORIAL MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

SOUTHWESTERN MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

DLP CONEMAUGH MEYERSDALE MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

RCHP-OTTUMWA, LLC
d/b/a Ottumwa Regional Health Center

By:_____
Name:_____
Title:_____

PALESTINE PRINCIPAL HEALTHCARE LIMITED PARTNERSHIP
d/b/a Palestine Regional Medical Center

By:_____
Name:_____
Title:_____

PALESTINE-PRINCIPAL G.P., INC.

By:_____
Name:_____
Title:_____

RIVERTON MEMORIAL HOSPITAL, LLC
d/b/a SageWest Health Care - Riverton Campus and SageWest Health Care - Lander Campus

By:_____
Name:_____
Title:_____

NASON MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

LESSORS:

MPT OF DODGE CITY-LIMA, LLC
MPT OF HASTINGS-LIMA, LLC
MPT OF JOHNSTOWN-LIMA, LLC
MPT OF LANDER-LIMA, LLC
MPT OF LAWTON-LIMA, LLC
MPT OF MEYERSDALE-LIMA, LLC
MPT OF OTTUMWA-LIMA, LLC
MPT OF PALESTINE-LIMA, LLC
MPT OF RIVERTON-LIMA, LLC
MPT OF ROARING SPRINGS-LIMA, LLC

By: MPT Operating Partnership, L.P.
Its: Sole Member of each above-referenced entity

By:_____
Name:_____
Title:_____

ANNEX A
Lessees and Lessors

LESSEES

1. DODGE CITY HEALTHCARE GROUP, LLC
2. DLP CONEMAUGH MINERS MEDICAL CENTER, LLC
3. DLP CONEMAUGH MEMORIAL MEDICAL CENTER, LLC
4. SOUTHWESTERN MEDICAL CENTER, LLC
5. DLP CONEMAUGH MEYERSDALE MEDICAL CENTER, LLC
6. RCHP-OTTUMWA, LLC
7. PALESTINE PRINCIPAL HEALTHCARE LIMITED PARTNERSHIP
8. PALESTINE-PRINCIPAL G.P., INC.
9. RIVERTON MEMORIAL HOSPITAL, LLC
10. NASON MEDICAL CENTER, LLC

LESSORS

1. MPT OF DODGE CITY-LIMA, LLC
2. MPT OF HASTINGS-LIMA, LLC
3. MPT OF JOHNSTOWN-LIMA, LLC
4. MPT OF LANDER-LIMA, LLC
5. MPT OF LAWTON-LIMA, LLC
6. MPT OF MEYERSDALE-LIMA, LLC
7. MPT OF OTTUMWA-LIMA, LLC
8. MPT OF PALESTINE-LIMA, LLC
9. MPT OF RIVERTON-LIMA, LLC
10. MPT OF ROARING SPRINGS-LIMA, LLC

EXHIBIT A

Management Agreement

[See attached.]

Schedule 13(e)

Ownership of Manager

Exhibit H

Excluded Real Estate

4850-8732-8417
4850-8732-8417

	Facility	Survey/Tax Parcel/Hastings Bldg No.	Property Name[3]	Owner	Address	City	State
1.	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	DLP Conemaugh Memorial Medical Center, LLC	1125 Milford Street	Johnstown	PA
2.	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	DLP Conemaugh Memorial Medical Center, LLC	1133 Milford Street Johnstown, PA	Johnstown	PA
3.	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	DLP Conemaugh Memorial Medical Center, LLC	1121 Milford Street	Johnstown	PA
4.	Conemaugh Memorial Medical Center	78-009.-204.000 (same as Hospital)	GME housing	DLP Conemaugh Memorial Medical Center, LLC	138 Skelly Street	Johnstown	PA
5.	Conemaugh Memorial Medical Center	78-009.-204.000 (same as Hospital)	Physician on-call housing (green house)	DLP Conemaugh Memorial Medical Center, LLC	134 Skelly Street	Johnstown	PA
6.	Conemaugh Memorial Medical Center	78-010.-302.000	GME Housing - Duplex	DLP Conemaugh Memorial Medical Center, LLC	20 Rose Street	Johnstown	PA
7.	Conemaugh Memorial Medical Center	78-010.-303.000	GME Housing - Duplex	DLP Conemaugh Memorial Medical Center, LLC	18 Rose Street	Johnstown	PA
8.	Conemaugh Memorial Medical Center	78-010A.111-000	GME Housing	DLP Conemaugh Memorial Medical Center, LLC	R. 16 Osborne Street (actually on Otto Court)	Johnstown	PA

[3] **Note**: Excludes leased properties unless under hospital lease.

4850-8732-8417

9.	Conemaugh Memorial Medical Center	78.009.-504.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	1113 Barnett Street	Johnstown	PA
10.	Conemaugh Memorial Medical Center	78.009.-505.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	1115 Barnett Street	Johnstown	PA
11.	Conemaugh Memorial Medical Center	78-008.-209.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	Franklin St.	Johnstown	PA
12.	Conemaugh Memorial Medical Center	75.002.-204.000 per Assessor: 075-000647	Unused Parking lot	DLP Conemaugh Memorial Medical Center, LLC	522 Sherman Street	Johnstown	PA
13.	Conemaugh Memorial Medical Center	72.002.-115.000	Locust Plaza	DLP Conemaugh Memorial Medical Center, LLC	315 Locust Street	Johnstown	PA
14.	Conemaugh Memorial Medical Center	75.001.-100.000	Vacant MRI Building and land surrounding UPMC Conemaugh Cancer Center	DLP Conemaugh Memorial Medical Center, LLC	331- 337 Somerset St (331: MRI, 337: Cancer Ctr)	Johnstown	PA
15.	Conemaugh Memorial Medical Center	83.002.-106.000	Part of unused "I" Parking lot	DLP Conemaugh Memorial Medical Center, LLC	Walnut Street/River Avenue	Johnstown	PA
16.	Conemaugh Memorial Medical Center	62.008.-109.003	Vacant Medical Office Building	DLP Conemaugh Memorial Medical Center, LLC	318 Goucher Street	Johnstown	PA

4850-8732-8417

17.	Conemaugh Memorial Medical Center	50.037.-427.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	Rear Hostetler Road	Johnstown	PA
18.	Conemaugh Memorial Medical Center	46.002.-114.000	Office Building (LHC-Home Health)	DLP Conemaugh Memorial Medical Center, LLC	813 Jefferson	Portage	PA
19.	Conemaugh Memorial Medical Center	522-027-071-00	MOB and adjacent Parking Lot	DLP Conemaugh Memorial Medical Center, LLC	1609 & 1611 W Pitt St	Jennerstown	PA
20.	Conemaugh Memorial Medical Center	E.09-E.04-103	Medical Office Building	DLP Conemaugh Memorial Medical Center, LLC	140 South Anderson St	Bedford	PA
21.	Palestine Regional Medical Center	TX40707 6910-00007-00118 R0064347	Memorial Mother Frances	Palestine Principal Healthcare Ltd Partnership	100 W. Brazos/duplex with below	Palestine	TX
22.	Palestine Regional Medical Center	TX40708 6910-00007-00118 R0064347 (same as above)	Memorial Mother Frances	Palestine Principal Healthcare Ltd Partnership	1004 S Magnolia/shares tax parcel with 100 W. Brazos	Palestine	TX
23.	Palestine Regional Medical Center	TX40710 6910-12000-00400 R0034954	Vacant - Clinic	Palestine Principal Healthcare Ltd Partnership	804 S. Sycamore	Palestine	TX

4850-8732-8417

Schedule 1-A

1. MPT OF DODGE CITY-LIMA, LLC
2. MPT OF HASTINGS-LIMA, LLC
3. MPT OF JOHNSTOWN-LIMA, LLC
4. MPT OF LANDER-LIMA, LLC
5. MPT OF LAWTON-LIMA, LLC
6. MPT OF MEYERSDALE-LIMA, LLC
7. MPT OF OTTUMWA-LIMA, LLC
8. MPT OF PALESTINE-LIMA, LLC
9. MPT OF RIVERTON-LIMA, LLC
10. MPT OF ROARING SPRINGS-LIMA, LLC

each a Delaware limited liability company, collectively, jointly and severally, as Lessor.

4850-8732-8417

Schedule 1-B

1. DLP CONEMAUGH MEMORIAL MEDICAL CENTER, LLC
2. DLP CONEMAUGH MEYERSDALE MEDICAL CENTER, LLC
3. DLP CONEMAUGH MINERS MEDICAL CENTER, LLC
4. NASON MEDICAL CENTER, LLC
5. RCHP-OTTUMWA, LLC (D/B/A OTTUMWA REGIONAL HEALTH CENTER)
6. PALESTINE PRINCIPAL HEALTHCARE LTD. PARTNERSHIP (D/B/A PALESTINE REGIONAL MEDICAL CENTER)
7. PALESTINE-PRINCIPAL G.P., INC.
8. RIVERTON MEMORIAL HOSPITAL, LLC (D/B/A SAGEWEST HEALTH CARE-RIVERTON CAMPUS AND SAGEWEST HEALTH CARE-LANDER CAMPUS)
9. SOUTHWESTERN MEDICAL CENTER, LLC
10. DODGE CITY HEALTHCARE GROUP, LLC

collectively, jointly and severally, as Lessee.

4850-8732-8417

Schedule 3.1(a)

Lease Rate and Lease Bases

The "**Lease Rate**" shall be a per annum rate equal to Seven and One-Quarter Percent (7.25%), subject to the Escalator as set forth in Section 3.1(b).

The "**Lease Base**" for each of the Properties are as follows:

Property	Lease Base
1. Dodge City Property	$58,607,076
2. Hastings Property	$10,675,241
3. Johnstown Property	$294,956,923
4. Lander Property	$47,641,423
5. Lawton Property	$73,153,622
6. Meyersdale Property	$5,337,621
7. Ottumwa Property	$57,028,731
8. Palestine Property	$106,088,647
9. Riverton Property	$33,837,665
10. Roaring Springs Property	$12,673,051

and, in each case, plus all costs and expenses not included in such sum which are incurred or paid in connection with the purchase and lease of each of the Properties, including, but not limited to legal, appraisal, title, survey, environmental, seismic, engineering and other fees and expenses paid in connection with the inspection of the Properties and each Facility, and paid to advisors and brokers (except to the extent such items are paid by the Lessees), and shall include the costs and Capital Additions funded by Lessor (and Lessor's Affiliates) as provided in Section 10.4 of this Lease with respect to each Property. Notwithstanding any provision hereof, no item shall be included in the Lease Base for purposes of this Lease to the extent that such item is paid separately by Lessee or is subject to a separate loan repayment obligation of Lessee.

Schedule 9.2

The Total "Number Of Beds" Available for Active Use at Each Facility

[TO BE UPDATED BY LESSEE AT CLOSING]

Facility	Total # of Beds
1. Dodge City Facility	99
2. Hastings Facility	30
3. Johnstown Facility	537
4. Lander Facility	76
5. Lawton Facility	199
6. Meyersdale Facility	20
7. Ottumwa Facility	217
8. Palestine Facility	156
9. Riverton Facility	70
10. Roaring Springs Facility	45

4850-8732-8417

Schedule 9.3

Required Repairs

[None.][4]

[4] To be updated at closing if necessary.

4850-8732-8417
4850-8732-8417

Schedule 10.5

Required Ongoing Capital Projects

1. With respect to the Johnstown Property, the "Conemaugh Ebensburg Outpatient Center" project, with an estimated project cost of approximately Twenty Million Seven Hundred Thousand and No/100 ($20,700,000.00), with an outside completion date of March 31, 2019.

2. With respect to the Johnstown Property, the "Conemaugh Somerset Outpatient" project, with an estimated project cost of approximately Nine Million Two Hundred Thousand and No/100 ($9,200,000.00), with an outside completion date of April 30, 2020.

Schedule 39.25

State Specific Provisions

1. **Iowa Property**. None.

2. **Kansas Property**. None.

3. **Oklahoma Property**. None.

4. **Pennsylvania Property**. With respect to the Pennsylvania Properties, without limiting any other provision of this Lease, the following additional provisions shall apply:

(a) Mechanics Liens. No work performed by Lessee to Pennsylvania Properties pursuant to this Lease, whether in the nature of erection, construction, alteration, or repair, shall be deemed to be for the immediate use and benefit of Lessor so that no mechanic's or other lien shall be allowed against the estate of Lessor by reason of any consent given by Lessor to Lessee to improve such Property. Lessee shall do all things necessary to prevent the filing of any mechanic's liens or other liens against the Property or any part thereof by reason of work, labor, services, or materials supplied or claimed to have been supplied to Lessee. Nothing contained in this Lease shall be construed as consent on the part of Lessor to subject the estate of Lessor to liability under the Mechanic's Lien Law of the Commonwealth of Pennsylvania.

(b) Certain Waivers of Notices. If Lessor commences an action to recover possession of the Property upon the expiration or earlier termination of this Lease, Lessee waives in favor of Lessor all rights to notice under the Pennsylvania Landlord and Tenant Act (including a notice to quit the Property required under 68 P.S. §250.501).

5. **Texas Property**. With respect to the Texas Property, without limiting any other provision of this Lease, the following additional provisions shall apply:

(a) Texas Deceptive Trade Practices Consumer Protection Act. Lessor and Lessee each acknowledge, on its own behalf and on the behalf of its successors and assigns, that the Texas Deceptive Trade Practices Consumer Protection Act, Subchapter E of Chapter 17 of the Texas Business and Commerce Code ("**DTPA**"), is not applicable to this Lease. Accordingly, the rights and remedies of Lessor and Lessee with respect to all acts or practices of the other, past, present, or future, in connection with this Lease shall be governed by legal principles other than the DTPA. Lessor and Lessee each hereby waives its rights under the DTPA, a law that gives consumers special rights and protections. After consultation with an attorney of its own selection, Lessor and Lessee, respectively, voluntarily consent to this waiver.

(b) Waiver Under Texas Property Code Section 93.012. LESSOR AND LESSEE ARE KNOWLEDGEABLE AND EXPERIENCED IN COMMERCIAL LEASING TRANSACTIONS AND AGREE THAT THE PROVISIONS OF THIS LEASE FOR DETERMINING ALL CHARGES, AMOUNTS, AND ADDITIONAL RENT PAYABLE BY LESSEE ARE COMMERCIALLY REASONABLE AND VALID EVEN THOUGH SUCH METHODS MAY NOT STATE A PRECISE MATHEMATICAL FORMULA FOR DETERMINING SUCH

4850-8732-8417

CHARGES. ACCORDINGLY, LESSEE VOLUNTARILY AND KNOWINGLY WAIVES ALL RIGHTS AND BENEFITS OF A LESSEE UNDER SECTION 93.012 OF THE TEXAS PROPERTY CODE, AS SUCH SECTION NOW EXISTS.

(c) Lien Waiver. Lessee hereby waives all lien rights under Section 91.004 of the Texas Property Code (as currently enacted or hereafter modified), as well as any successor statute granting Lessee a lien in Lessor's property.

6. **Wyoming Property**. None.

4850-8732-8417

Exhibit D

Form of Guaranty

See attached.

GUARANTY
(LIMA HOLDCO)

THIS GUARANTY (this "Guaranty") is made and entered into as of this ___ day of _____, 20____, by and among **LIMA HOLDCO, LLC**, a Delaware limited liability company (the "Guarantor"), for the benefit of the undersigned entities listed on the signature page hereto under the heading "MPT Parties" (hereinafter referred to, individually, as an "MPT Party" and, collectively, as the "MPT Parties" or the "Beneficiary"). The Guarantor and the MPT Parties are herein sometimes referred to individually as a "Party" and collectively, as the "Parties."

W I T N E S S E T H:

WHEREAS, certain of the MPT Parties (each a "Lessor" and collectively the "Lessors"), have entered into that certain Master Lease Agreement, dated of even date herewith (as the same may be amended, modified and restated from time to time, the "Master Lease"), with certain Affiliates (as hereinafter defined) of the Guarantor (each a "Lessee" and collectively the "Lessees"), whereby Lessors are leasing (or, as applicable, subleasing) to Lessees, and Lessees are leasing (or, as applicable, subleasing) from Lessors, certain real property consisting of multiple parcels of land, the improvements now or hereafter located thereon (including improvements consisting of multiple hospital facilities), the fixtures now or hereafter attached thereto and all easements, licenses, rights-of-way, appurtenances and other matters and items relating thereto, all as more particularly described in the Master Lease (collectively, the "Master Leased Property");

WHEREAS, the Guarantor is an Affiliate (as herein defined) of the Lessees (together with the Guarantor, hereinafter be referred to, individually, as an "Obligor" and, collectively, as the "Obligors";

WHEREAS, the Guarantor acknowledges that, as a result of the above described transactions, the Guarantor will derive direct and indirect benefits in the form of economies of scale, access to capital and other important strategic operational benefits and, accordingly, the Guarantor has concluded that it is in its best interest to enter into this Guaranty; and

WHEREAS, the Guarantor desires to guarantee unconditionally the Obligations (as herein defined) upon the terms and conditions hereinafter set forth.

NOW, THEREFORE, in consideration of the premises, representations, warranties, mutual covenants and agreements set forth herein, and for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Guarantor covenants and agrees as follows:

1. **Defined Terms**. Capitalized terms used herein and not expressly defined herein shall have the respective meanings ascribed to them in this Section 1.

"Affiliate" means, with respect to any Person (i) any Person that, directly or indirectly, controls or is controlled by or is under common control with such Person, (ii) any other Person that owns, beneficially, directly or indirectly, 10% or more of the outstanding capital stock, shares or equity interests of such Person, or (iii) any officer, director, employee, shareholder, partner, member, manager or trustee of such Person or any Person controlling, controlled by or under common control with such Person (excluding trustees and persons serving in similar capacities who

are not otherwise an Affiliate of such Person). For the purposes of this definition, "control" (including the correlative meanings of the terms "controlled by" and "under common control with"), as used with respect to any Person, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, through the ownership of voting securities or otherwise.

"Business Day" means each Monday, Tuesday, Wednesday, Thursday and Friday that is not a day on which money centers in the City of New York, New York are authorized or obligated by law or executive order to close.

"Environmental Indemnification Agreement" means that certain Environmental Indemnification Agreement, dated of even date herewith, among Lima Holdco, Lessees, and Lessors, on the other hand, as the same may be amended, modified and restated from time to time.

"Obligations" means the respective obligations, duties and liabilities (as applicable) of the Obligors and each of their respective Affiliates under or pursuant to (a) the Master Lease, (b) the Environmental Indemnification Agreement, (c) each of the other Obligation Documents, and (d) any and all amendments, restatements, supplements, renewals, and extensions of the liabilities or obligations described or referred to in subsections (a), (b), and (c) above.

"Obligation Documents" shall mean the Master Lease, the Environmental Indemnification Agreement, and all other "Obligation Documents" under and as defined in the Master Lease, in each case, as the same may be modified, amended, or restated from time to time.

2. **Guaranty.** The Guarantor absolutely, unconditionally and irrevocably guarantees to and for the benefit of Beneficiary, the full and prompt payment when due and performance of the Obligations (other than those with respect to which it is already a direct obligor). Upon the occurrence of an Event of Default hereunder, the Guarantor shall, within ten (10) days after receipt of written notice from any MPT Party perform or cause the Obligors, as applicable, to perform such obligations, as if they constituted the direct and primary obligations of the Guarantor. Beneficiary may, in its sole discretion, seek satisfaction of such Obligations from any or all of the Obligors and/or the Guarantor. The obligations and liabilities of the Guarantor under this Guaranty are continuing, absolute and unconditional, shall not be subject to any counterclaim, recoupment, set-off, reduction or defense based upon any claim that the Guarantor may have against any of the Obligors, MPT Parties or their respective Affiliates, officers, directors, members, shareholders, employees, agents and representatives, and shall remain in full force and effect until all of the Obligations guaranteed hereby have been paid and performed in full (other than contingent indemnification obligations for which no claim has been made), without regard to, and without being released, discharged, impaired, modified or in any way affected by, the occurrence from time to time of the following events, circumstances or conditions, whether or not the Guarantor shall have knowledge or notice thereof or shall have consented thereto:

(a) the failure or refusal to give notice to the Guarantor;

(b) in each case, except as expressly applicable to the Guarantor, the compromise, settlement, release or termination with any Obligor of any or all of the obligations, covenants or agreements of such Obligor under any of the Obligation Documents, or the amendment, modification, restatement, or forgiveness of any of the Obligation Documents;

(c) any consent, extension or indulgence under or in respect of any exercise or non-exercise of any right, remedy, power or privilege under or with respect to any of the Obligations guaranteed hereby;

(d) the assignment of any of the Obligation Documents by any MPT Party or Obligor or the subletting of any portion of the Property to the extent permitted by the Obligation Documents; or

(e) the voluntary or involuntary liquidation or dissolution of, sale or other disposition of all or substantially all of the assets of, or the marshalling of assets and liabilities, receivership, insolvency, bankruptcy, assignment for the benefit of creditors, reorganization, arrangement, composition or readjustment of, or other similar proceeding affecting, the Beneficiary, the Guarantor, any of the Obligors, or any of their respective assets, or any action taken by any trustee or receiver or by any court in any such proceeding, or the disaffirmance, rejection or postponement in any such proceeding, of any of the Beneficiary's, the Guarantor's, any Obligor's, or any other party's covenants, obligations, undertakings or agreements.

3. **Representations and Warranties of Guarantor**. The Guarantor hereby represents and warrants to Beneficiary as of the date hereof that (a) the Guarantor has full legal right, power and authority to enter into this Guaranty, to incur the obligations provided for herein, and to execute and deliver the same to Beneficiary; (b) this Guaranty has been duly executed and delivered by the Guarantor and constitutes the Guarantor's valid and legally binding obligation, enforceable against the Guarantor in accordance with its terms, subject to bankruptcy, insolvency, reorganization, and similar laws affecting the enforcement of creditor's rights or contractual obligations generally and, as to enforcement, to general principles of equity, regardless of whether applied in a proceeding at law or in equity; (c) no approval or consent of any foreign, federal, state, county, local or other governmental or regulatory body, and no approval or consent of any other person is required in connection with the execution and delivery by the Guarantor of this Guaranty or the consummation and performance by the Guarantor of the transactions contemplated hereby, except such approvals or consents as shall have been obtained on or prior to the date hereof; (d) the execution and delivery of this Guaranty and the obligations created hereby have been duly authorized by all necessary proceedings on the part of the Guarantor, and will not conflict with or result in the material breach or violation of any of the terms or conditions of, or constitute (or with notice or lapse of time or both would constitute) a default under the governing documents of the Guarantor, any material instrument, contract or other agreement to which the Guarantor is a party or by or to which the Guarantor or the Guarantor's assets or properties are bound or subject; or any statute or any regulation, order, judgment or decree of any court or governmental or regulatory body; and (e) the Guarantor is not party to or, to the knowledge of the Guarantor, threatened with any litigation or judicial, administrative or arbitration proceeding which, if decided adversely to the Guarantor, would restrain, prohibit or materially delay the transactions contemplated hereby.

4. **Events of Default**. An occurrence of any of the following shall constitute an "Event of Default" hereunder:

(a) There shall occur an "Event of Default" under and within the meaning of the Master Lease.

(b) There shall occur an "Event of Default" under and within the meaning of any of the other Obligation Documents.

(c) The failure of the Guarantor to punctually and properly perform in all material respects (without duplication of any materiality qualifier herein) any covenant or obligation contained herein if the same shall remain uncured within a period of thirty (30) days after receipt by Guarantor of written notice thereof from the MPT Parties, unless such failure cannot with due diligence be cured within a period of thirty (30) days (in the MPT Parties' reasonable discretion), in which case such failure shall not be deemed to continue so long as the Guarantor commences to cure such failure within the thirty (30) day period and proceed with due diligence to complete the curing thereof within sixty (60) days after receipt by the Guarantor of the MPT Parties' notice of default (or such longer period as is reasonably required in the reasonable determination of the MPT Parties to effect such cure if the Guarantor is diligently proceeding to do so); *provided, however*, in no event shall the MPT Parties be required to give more than two (2) notices and cure period for Guarantor's failure to observe or perform the same (or repetitive) covenant or condition in any consecutive twelve (12) month period.

5. **Remedies**. Upon the occurrence of an Event of Default, the Beneficiary shall have any and all rights and remedies available in law or equity to enforce any failure by the Guarantor to fulfill its obligations hereunder. No remedy herein conferred upon or reserved to the Beneficiary hereunder is intended to be exclusive of any other available remedy or remedies, but each and every such remedy shall be cumulative and shall be in addition to every such remedy now or hereafter existing at law or in equity.

6. **Waiver of Acceptance, Etc**.

(a) The Guarantor waives diligence, presentment, protest, demand for payment and notice of default or nonpayment to or upon any Obligor with respect to the Obligations guaranteed hereunder. Without limiting the other provisions of this Section 6, this Guaranty shall be construed as a continuing, absolute and unconditional guarantee of performance and payment without regard to the validity, regularity or enforceability of any obligations or any other collateral security thereof (if any) or other guarantee thereof (if any) or any other circumstance whatsoever (with or without notice to or knowledge of the Guarantor) which constitutes, or might be construed to constitute, an equitable or legal discharge of the obligations of the Guarantor under this Guaranty, in bankruptcy or in any other instance, and the obligations and liabilities of the Guarantor hereunder shall not be conditioned or contingent upon the pursuit by Beneficiary or any other person at any time of any right or remedy against any Obligor or against any other person (if any) which may be or become liable in respect of all or any part of the obligations or against any collateral security therefor or guarantee thereof or right of offset with respect thereto (if any). This Guaranty is not merely a guarantee of collection and the obligations of the Guarantor hereunder are primary and this Guaranty constitutes a guarantee of payment.

(b) The Guarantor waives any and all rights or defenses arising by reason of: (i) any "one action" or "anti-deficiency" law or any other law which may prevent the Beneficiaries from bringing any action, including a claim for deficiency, against the Guarantor, before or after the Beneficiaries commencement or completion of any foreclosure or similar action or actions, either judicially or by exercise of a power of sale; (ii) any election of remedies by the Beneficiaries which destroys or otherwise adversely affects the Guarantor's subrogation rights or any the Guarantor's

rights to proceed against any Person for reimbursement, including without limitation, any loss of rights the Guarantor may suffer by reason of any law limiting, qualifying, or discharging the Obligations, if any, (iii) any disability or other defense of any other Person, other than payment in full in legal tender, of the Obligations; (iv) any right to claim discharge of the Obligations on the basis of unjustified impairment of any collateral for the Obligations; (v) any statute of limitations; (vi) any defenses given to guarantors, sureties, and/or co-makers at law or in equity other than actual payment and performance of the Obligations; or (vii) any action by the Beneficiaries to enforce their respective rights and remedies under the Master Lease and the other Obligation Documents. If payment on the Obligations is made by any third party, and thereafter the Beneficiaries are forced to remit the amount of that payment under any federal or state bankruptcy law or law for the relief of debtors, the Obligations shall be considered unpaid for the purpose of enforcement of this Guaranty and the other Obligation Documents against the Guarantor.

7. **Subrogation**. Until all of the Obligations guaranteed hereunder have been satisfied and discharged in full (other than contingent indemnification obligations for which no claim has been made), (a) the Guarantor shall not exercise its right of subrogation and (b) the Guarantor waives any right to enforce any remedy which Beneficiary now has or may hereafter have against any Obligor or any other guarantor or any other party to any of the Obligations Documents, and any benefit of, and any right to participate in, any security or other assets now or hereafter held by Beneficiary with respect to any of the Obligation Documents or any other document entered into in connection therewith.

8. **Severability**. Whenever possible, each provision of this Guaranty shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Guaranty is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Guaranty, unless the severance of such provision would be in opposition to the parties' intent with respect to such provision.

9. **No Waiver**. Any provision of this Guaranty or Exhibits hereto may be amended or waived only in a writing signed by the parties hereto. No waiver of any provision hereunder or any breach or default thereof shall extend to or affect in any way any other provision or prior or subsequent breach or default.

10. **Patriot Act Compliance**. Guarantors hereby represents and warrants to Beneficiary as follows:

(a) the Guarantor has complied in all material respects with the International Money Laundering Abatement and Anti-Terrorist Financing Act of 2001, which comprises Title III of the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001 (the "Patriot Act") and the regulations promulgated thereunder, and the rules and regulations administered by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"), to the extent the same are applicable to the Guarantor; and

(b) the Guarantor is not included on the List of Specially Designated Nationals and Blocked Persons maintained by the OFAC, nor is the Guarantor a resident in, or organized or chartered under the laws of, (i) a jurisdiction that has been designated by the U.S. Secretary of the Treasury under Section 311 or 312 of the Patriot Act as warranting special measures due to money

laundering concerns or (ii) any foreign country that has been designated as non-cooperative with international anti-money laundering principles or procedures by an intergovernmental group or organization, such as the Financial Action Task Force on Money Laundering, of which the United States is a member and with which designation the United States representative to the group or organization continues to concur.

11. **Tolling of Statute of Limitations**. Any act or circumstance that shall toll any statute of limitations applicable to the Obligations guaranteed hereby shall also toll the statute of limitations applicable to the liability of the Guarantor for the Obligations guaranteed by this Guaranty.

12. **Notices**. All notices, demands and other communications to be given or delivered under or by reason of the provisions of this Guaranty shall be in writing and shall be deemed to have been given (a) when personally delivered, (b) when transmitted via telecopy (or other facsimile device) to the number set out below if the sender on the same day sends a confirming copy of such notice by a recognized overnight delivery service (charges prepaid), (c) the day following the day (except if not a Business Day then the next Business Day) on which the same has been delivered prepaid to a reputable national overnight air courier service or (d) the third Business Day following the day on which the same is sent by certified or registered mail, postage prepaid. Notices, demands and communications, in each case to the respective parties, shall be sent to the applicable address set forth below, unless another address has been previously specified in writing:

IF TO GUARANTOR:
c/o LifePoint Health[, Inc.]
330 Seven Springs Way
Brentwood, TN 37027
Attention: General Counsel
Facsimile: (615) 920-8948

WITH A COPY TO:
Sidley Austin LLP
787 Seventh Avenue
New York, NY 10019
[redacted]

WITH A COPY TO:
Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219
[redacted]

IF TO BENEFICIARY:
c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242
Attn: Legal Department
[redacted]

WITH A COPY TO:
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
420 20th Street North
1400 Wells Fargo Tower

Birmingham, Alabama 35203
[redacted]

or to such other address with respect to a party as such party notifies the other in writing as above provided.

13. **Governing Law; Jurisdiction and Venue; Waiver of Jury Trial**.

(a) This Agreement shall be governed by and construed in accordance with the laws of the State of Delaware applicable to contracts executed and performed in such State, without giving effect to conflicts of law principles.

(b) THE PARTIES HERETO CONSENT TO PERSONAL JURISDICTION IN THE STATE OF DELAWARE. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, THE MPT PARTIES AND THE GUARANTOR AGREE THAT ANY ACTION OR PROCEEDING ARISING FROM OR RELATED TO THIS AGREEMENT SHALL BE BROUGHT AND TRIED EXCLUSIVELY IN THE STATE OR FEDERAL COURTS OF DELAWARE. EACH OF THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY OBJECTION TO THE LAYING OF VENUE OF ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. THE PARTIES EXPRESSLY ACKNOWLEDGE THAT DELAWARE IS A FAIR, JUST AND REASONABLE FORUM AND AGREE NOT TO SEEK REMOVAL OR TRANSFER OF ANY ACTION FILED BY THE OTHER PARTIES IN SAID COURTS. FURTHER, THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY CLAIM THAT SUCH SUIT, ACTION OR PROCEEDING HAS BEEN BROUGHT IN AN INCONVENIENT FORUM. SERVICE OF ANY PROCESS, SUMMONS, NOTICE OR DOCUMENT BY CERTIFIED MAIL ADDRESSED TO A PARTY AT THE ADDRESS DESIGNATED PURSUANT TO SECTION 12 SHALL BE EFFECTIVE SERVICE OF PROCESS AGAINST SUCH PARTY FOR ANY ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. A FINAL JUDGMENT IN ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT MAY BE ENFORCED IN ANY OTHER COURT TO WHOSE JURISDICTION ANY OF THE PARTIES IS OR MAY BE SUBJECT.

(c) TO THE MAXIMUM EXTENT PERMITTED BY LAW, THE PARTIES HEREBY KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVE THE RIGHT TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION BASED HEREON, ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT, OR ANY COURSE OF CONDUCT, COURSE OF DEALING, STATEMENT (WHETHER VERBAL OR WRITTEN) OR ACTION OF ANY PARTY OR ANY EXERCISE OF ANY PARTY OF THEIR RESPECTIVE RIGHTS HEREUNDER OR IN ANY WAY RELATING TO THIS AGREEMENT OR THE COLLATERAL (INCLUDING ANY CLAIM OR DEFENSE ASSERTING THAT THIS AGREEMENT WAS FRAUDULENTLY INDUCED OR IS OTHERWISE VOID OR VOIDABLE). THIS WAIVER IS A MATERIAL INDUCEMENT FOR THE MPT PARTIES TO ENTER INTO THIS AGREEMENT AND THE OTHER OBLIGATION DOCUMENTS.

14. **Delivery by Electronic Transmission**. This Guaranty and any signed agreement entered into in connection herewith or contemplated hereby, and any amendments hereto or thereto, to the extent signed and delivered by means of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar

attachment to electronic mail, shall be treated in all manner and respects as an original contract and shall be considered to have the same binding legal effects as if it were the original signed version thereof delivered in person. At the request of any party hereto or to any such contract, each other party hereto or thereto shall re-execute original forms thereof and deliver them to all other parties. No party hereto or to any such contract shall raise the use of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail to deliver a signature or the fact that any signature or contract was transmitted or communicated through the use of facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail as a defense to the formation of a contract and each such party forever waives any such defense.

15. **Expenses**. The Beneficiary shall be entitled to recover all reasonable and documented out-of-pocket costs associated with enforcing the provisions of this Guaranty in the event of a breach hereof by the Guarantor, including, without limitation, courts costs and reasonable and documented out-of-pocket attorneys' fees.

16. **Entire Agreement; Modification**. This Guaranty and the documents referred to herein contain the complete agreement between the parties hereto and supersede any prior understandings, agreements or representations by or between the parties, written or oral, which may have related to the subject matter hereof in any way.

17. **Binding Effect; Assignment**. This Guaranty shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns, except that neither this Guaranty nor any of the rights, interests or obligations hereunder may be assigned or delegated by the Guarantor without the prior written consent of the MPT Parties. Beneficiary may at any time and without the consent of the Guarantor assign all of its rights and obligations hereunder.

18. **No Third Party Beneficiaries**. Nothing expressed or referred to in this Guaranty will be construed to give any Person other than the parties to this Guaranty any legal or equitable right, remedy, or claim under or with respect to this Guaranty or any provision of this Guaranty.

19. **Counterparts**. This Guaranty may be executed in multiple counterparts, any one of which need not contain the signature of more than one party, but all such counterparts taken together shall constitute one and the same instrument.

20. **Necessary Action**. Each party shall perform any further acts and execute and deliver any documents that may be reasonably necessary to carry out the provisions of this Guaranty.

21. **Joint Drafting**. The parties hereto and their respective counsel have participated in the drafting and redrafting of this Guaranty and the general rules of construction which would construe any provisions of this Guaranty in favor of or to the advantage of one party as opposed to the other as a result of one party drafting this Guaranty as opposed to the other or in resolving any conflict or ambiguity in favor of one party as opposed to the other on the basis of which party drafted this Guaranty are hereby expressly waived by all parties to this Guaranty.

22. **Intentionally Omitted**.

23. **Representatives**. The MPT Parties hereby appoint MPT of Johnstown-Lima, LLC as their duly authorized agent and representative (the "MPT Representative") to take all actions and enforce

all rights of the MPT Parties under this Guaranty, including, without limitation, (i) giving and receiving any notice or instruction permitted or required under this Guaranty; (ii) interpreting all of the terms and provisions of this Guaranty; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with the Guarantors under this Guaranty; (v) conducting negotiations and dealing with the Guarantor under this Guaranty; and (vi) taking any other actions on behalf of the MPT Parties relating to the MPT Parties' rights, claims, duties and obligations under this Guaranty. In the performance of the Guarantor's duties and obligations hereunder, the Guarantor shall be authorized and permitted to correspond and transact with the MPT Representative on behalf of all the MPT Parties and shall be entitled to rely upon any document or instrument executed and delivered by the MPT Representative.

[*Signatures appear on following 2 pages.*]

IN WITNESS WHEREOF, the Guarantor has executed and delivered this Guaranty as of the date first above written.

GUARANTOR:

LIMA HOLDCO, LLC

By:_____
Name:_____
Title:_____

MPT PARTIES/BENEFICIARY:

MPT OF DODGE CITY-LIMA, LLC
MPT OF HASTINGS-LIMA, LLC
MPT OF JOHNSTOWN-LIMA, LLC
MPT OF LANDER-LIMA, LLC
MPT OF LAWTON-LIMA, LLC
MPT OF MEYERSDALE-LIMA, LLC
MPT OF OTTUMWA-LIMA, LLC
MPT OF PALESTINE-LIMA, LLC
MPT OF RIVERTON-LIMA, LLC
MPT OF ROARING SPRINGS-LIMA, LLC

By: MPT Operating Partnership, L.P.
Title: Sole Member of each above-referenced entity

By:_____
Name:_____
Title:_____

Exhibit E

Form of LifePoint Lease Guaranty

See attached.

GUARANTY
(LIFEPOINT)

THIS GUARANTY (this "Guaranty") is made and entered into as of this ___ day of _____, 20____, by and among **LIFEPOINT HEALTH, [INC.]**, a Delaware [corporation] (the "Guarantor"), for the benefit of the undersigned entities listed on the signature page hereto under the heading "MPT Parties" (hereinafter referred to, individually, as an "MPT Party" and, collectively, as the "MPT Parties" or the "Beneficiary"). The Guarantor and the MPT Parties are herein sometimes referred to individually as a "Party" and collectively, as the "Parties."

W I T N E S S E T H:

WHEREAS, certain of the MPT Parties (each a "Lessor" and collectively the "Lessors"), have entered into that certain Master Lease Agreement, dated of even date herewith (as the same may be amended, modified and restated from time to time, the "Master Lease"), with certain Affiliates (as hereinafter defined) of the Guarantor (each a "Lessee" and collectively the "Lessees"), whereby Lessors are leasing (or, as applicable, subleasing) to Lessees, and Lessees are leasing (or, as applicable, subleasing) from Lessors, certain real property consisting of multiple parcels of land, the improvements now or hereafter located thereon (including improvements consisting of multiple hospital facilities), the fixtures now or hereafter attached thereto and all easements, licenses, rights-of-way, appurtenances and other matters and items relating thereto, all as more particularly described in the Master Lease (collectively, the "Master Leased Property");

WHEREAS, the Guarantor is an Affiliate (as herein defined) of the Lessees (together with the Guarantor, hereinafter be referred to, individually, as an "Obligor" and, collectively, as the "Obligors";

WHEREAS, the Guarantor acknowledges that, as a result of the above described transactions, the Guarantor will derive direct and indirect benefits in the form of economies of scale, access to capital and other important strategic operational benefits and, accordingly, the Guarantor has concluded that it is in its best interest to enter into this Guaranty; and

WHEREAS, the Guarantor desires to guarantee unconditionally the Obligations (as herein defined) upon the terms and conditions hereinafter set forth.

NOW, THEREFORE, in consideration of the premises, representations, warranties, mutual covenants and agreements set forth herein, and for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Guarantor covenants and agrees as follows:

1. **Defined Terms**. Capitalized terms used herein and not expressly defined herein shall have the respective meanings ascribed to them in this Section 1.

"Affiliate" means, with respect to any Person (i) any Person that, directly or indirectly, controls or is controlled by or is under common control with such Person, (ii) any other Person that owns, beneficially, directly or indirectly, 10% or more of the outstanding capital stock, shares or equity interests of such Person, or (iii) any officer, director, employee, shareholder, partner, member, manager or trustee of such Person or any Person controlling, controlled by or under common control with such Person (excluding trustees and persons serving in similar capacities who

are not otherwise an Affiliate of such Person). For the purposes of this definition, "control" (including the correlative meanings of the terms "controlled by" and "under common control with"), as used with respect to any Person, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, through the ownership of voting securities or otherwise.

"Business Day" means each Monday, Tuesday, Wednesday, Thursday and Friday that is not a day on which money centers in the City of New York, New York are authorized or obligated by law or executive order to close.

"Environmental Indemnification Agreement" means that certain Environmental Indemnification Agreement, dated of even date herewith, among Lima Holdco, LLC, a Delaware limited liability company ("Lima HoldCo"), Lessees, and Lessors, on the other hand, as the same may be amended, modified and restated from time to time.

"Obligations" means the respective obligations, duties and liabilities (as applicable) of the Obligors and each of their respective Affiliates under or pursuant to (a) the Master Lease, (b) the Environmental Indemnification Agreement, (c) each of the other Obligation Documents, and (d) any and all amendments, restatements, supplements, renewals, and extensions of the liabilities or obligations described or referred to in subsections (a), (b), and (c) above.

"Obligation Documents" shall mean the Master Lease, the Environmental Indemnification Agreement, and all other "Obligation Documents" under and as defined in the Master Lease, in each case, as the same may be modified, amended, or restated from time to time.

"Purchase Agreement" has the meaning set forth in the Master Lease.

2. **Guaranty.** The Guarantor absolutely, unconditionally and irrevocably guarantees to and for the benefit of Beneficiary, the full and prompt payment when due and performance of the Obligations (other than those with respect to which it is already a direct obligor). Upon the occurrence of an Event of Default hereunder, the Guarantor shall, within ten (10) days after receipt of written notice from any MPT Party perform or cause the Obligors, as applicable, to perform such obligations, as if they constituted the direct and primary obligations of the Guarantor. Beneficiary may, in its sole discretion, seek satisfaction of such Obligations from any or all of the Obligors and/or the Guarantor. The obligations and liabilities of the Guarantor under this Guaranty are continuing, absolute and unconditional, shall not be subject to any counterclaim, recoupment, set-off, reduction or defense based upon any claim that the Guarantor may have against any of the Obligors, MPT Parties or their respective Affiliates, officers, directors, members, shareholders, employees, agents and representatives, and shall remain in full force and effect until all of the Obligations guaranteed hereby have been paid and performed in full (other than contingent indemnification obligations for which no claim has been made), without regard to, and without being released, discharged, impaired, modified or in any way affected by, the occurrence from time to time of the following events, circumstances or conditions, whether or not the Guarantor shall have knowledge or notice thereof or shall have consented thereto:

(a) the failure or refusal to give notice to the Guarantor;

(b) in each case, except as expressly applicable to the Guarantor, the compromise, settlement, release or termination with any Obligor of any or all of the obligations, covenants or agreements of such Obligor under any of the Obligation Documents, or the amendment, modification, restatement, or forgiveness of any of the Obligation Documents;

(c) any consent, extension or indulgence under or in respect of any exercise or non-exercise of any right, remedy, power or privilege under or with respect to any of the Obligations guaranteed hereby;

(d) the assignment of any of the Obligation Documents by any MPT Party or Obligor or the subletting of any portion of the Property to the extent permitted by the Obligation Documents; or

(e) the voluntary or involuntary liquidation or dissolution of, sale or other disposition of all or substantially all of the assets of, or the marshalling of assets and liabilities, receivership, insolvency, bankruptcy, assignment for the benefit of creditors, reorganization, arrangement, composition or readjustment of, or other similar proceeding affecting, the Beneficiary, the Guarantor, any of the Obligors, or any of their respective assets, or any action taken by any trustee or receiver or by any court in any such proceeding, or the disaffirmance, rejection or postponement in any such proceeding, of any of the Beneficiary's, the Guarantor's, any Obligor's, or any other party's covenants, obligations, undertakings or agreements.

3. **Representations and Warranties of Guarantor**. The Guarantor hereby represents and warrants to Beneficiary as of the date hereof that (a) the Guarantor has full legal right, power and authority to enter into this Guaranty, to incur the obligations provided for herein, and to execute and deliver the same to Beneficiary; (b) this Guaranty has been duly executed and delivered by the Guarantor and constitutes the Guarantor's valid and legally binding obligation, enforceable against the Guarantor in accordance with its terms, subject to bankruptcy, insolvency, reorganization, and similar laws affecting the enforcement of creditor's rights or contractual obligations generally and, as to enforcement, to general principles of equity, regardless of whether applied in a proceeding at law or in equity; (c) no approval or consent of any foreign, federal, state, county, local or other governmental or regulatory body, and no approval or consent of any other person is required in connection with the execution and delivery by the Guarantor of this Guaranty or the consummation and performance by the Guarantor of the transactions contemplated hereby, except such approvals or consents as shall have been obtained on or prior to the date hereof; (d) the execution and delivery of this Guaranty and the obligations created hereby have been duly authorized by all necessary proceedings on the part of the Guarantor, and will not conflict with or result in the material breach or violation of any of the terms or conditions of, or constitute (or with notice or lapse of time or both would constitute) a default under the governing documents of the Guarantor, any material instrument, contract or other agreement to which the Guarantor is a party or by or to which the Guarantor or the Guarantor's assets or properties are bound or subject; or any statute or any regulation, order, judgment or decree of any court or governmental or regulatory body; and (e) the Guarantor is not party to or, to the knowledge of the Guarantor, threatened with any litigation or judicial, administrative or arbitration proceeding which, if decided adversely to the Guarantor, would restrain, prohibit or materially delay the transactions contemplated hereby.

4. **Events of Default**. An occurrence of any of the following shall constitute an "Event of Default" hereunder:

(a) There shall occur an "Event of Default" under and within the meaning of the Master Lease.

(b) There shall occur an "Event of Default" under and within the meaning of any of the other Obligation Documents.

(c) The failure of the Guarantor to punctually and properly perform in all material respects (without duplication of any materiality qualifier herein) any covenant or obligation contained herein if the same shall remain uncured within a period of thirty (30) days after receipt by Guarantor of written notice thereof from the MPT Parties, unless such failure cannot with due diligence be cured within a period of thirty (30) days (in the MPT Parties' reasonable discretion), in which case such failure shall not be deemed to continue so long as the Guarantor commences to cure such failure within the thirty (30) day period and proceed with due diligence to complete the curing thereof within sixty (60) days after receipt by the Guarantor of the MPT Parties' notice of default (or such longer period as is reasonably required in the reasonable determination of the MPT Parties to effect such cure if the Guarantor is diligently proceeding to do so); *provided, however*, in no event shall the MPT Parties be required to give more than two (2) notices and cure period for Guarantor's failure to observe or perform the same (or repetitive) covenant or condition in any consecutive twelve (12) month period.

5. **Remedies**. Upon the occurrence of an Event of Default, the Beneficiary shall have any and all rights and remedies available in law or equity to enforce any failure by the Guarantor to fulfill its obligations hereunder. No remedy herein conferred upon or reserved to the Beneficiary hereunder is intended to be exclusive of any other available remedy or remedies, but each and every such remedy shall be cumulative and shall be in addition to every such remedy now or hereafter existing at law or in equity.

6. **Waiver of Acceptance, Etc**.

(a) The Guarantor waives diligence, presentment, protest, demand for payment and notice of default or nonpayment to or upon any Obligor with respect to the Obligations guaranteed hereunder. Without limiting the other provisions of this Section 6, this Guaranty shall be construed as a continuing, absolute and unconditional guarantee of performance and payment without regard to the validity, regularity or enforceability of any obligations or any other collateral security thereof (if any) or other guarantee thereof (if any) or any other circumstance whatsoever (with or without notice to or knowledge of the Guarantor) which constitutes, or might be construed to constitute, an equitable or legal discharge of the obligations of the Guarantor under this Guaranty, in bankruptcy or in any other instance, and the obligations and liabilities of the Guarantor hereunder shall not be conditioned or contingent upon the pursuit by Beneficiary or any other person at any time of any right or remedy against any Obligor or against any other person (if any) which may be or become liable in respect of all or any part of the obligations or against any collateral security therefor or guarantee thereof or right of offset with respect thereto (if any). This Guaranty is not merely a guarantee of collection and the obligations of the Guarantor hereunder are primary and this Guaranty constitutes a guarantee of payment.

(b) The Guarantor waives any and all rights or defenses arising by reason of: (i) any "one action" or "anti-deficiency" law or any other law which may prevent the Beneficiaries from

bringing any action, including a claim for deficiency, against the Guarantor, before or after the Beneficiaries commencement or completion of any foreclosure or similar action or actions, either judicially or by exercise of a power of sale; (ii) any election of remedies by the Beneficiaries which destroys or otherwise adversely affects the Guarantor's subrogation rights or any the Guarantor's rights to proceed against any Person for reimbursement, including without limitation, any loss of rights the Guarantor may suffer by reason of any law limiting, qualifying, or discharging the Obligations, if any, (iii) any disability or other defense of any other Person, other than payment in full in legal tender, of the Obligations; (iv) any right to claim discharge of the Obligations on the basis of unjustified impairment of any collateral for the Obligations; (v) any statute of limitations; (vi) any defenses given to guarantors, sureties, and/or co-makers at law or in equity other than actual payment and performance of the Obligations; or (vii) any action by the Beneficiaries to enforce their respective rights and remedies under the Master Lease and the other Obligation Documents. If payment on the Obligations is made by any third party, and thereafter the Beneficiaries are forced to remit the amount of that payment under any federal or state bankruptcy law or law for the relief of debtors, the Obligations shall be considered unpaid for the purpose of enforcement of this Guaranty and the other Obligation Documents against the Guarantor.

7. **Subrogation**. Until all of the Obligations guaranteed hereunder have been satisfied and discharged in full (other than contingent indemnification obligations for which no claim has been made), (a) the Guarantor shall not exercise its right of subrogation and (b) the Guarantor waives any right to enforce any remedy which Beneficiary now has or may hereafter have against any Obligor or any other guarantor or any other party to any of the Obligations Documents, and any benefit of, and any right to participate in, any security or other assets now or hereafter held by Beneficiary with respect to any of the Obligation Documents or any other document entered into in connection therewith.

8. **Severability**. Whenever possible, each provision of this Guaranty shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Guaranty is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Guaranty, unless the severance of such provision would be in opposition to the parties' intent with respect to such provision.

9. **No Waiver**. Any provision of this Guaranty or Exhibits hereto may be amended or waived only in a writing signed by the parties hereto. No waiver of any provision hereunder or any breach or default thereof shall extend to or affect in any way any other provision or prior or subsequent breach or default.

10. **Patriot Act Compliance**. Guarantors hereby represents and warrants to Beneficiary as follows:

(a) the Guarantor has complied in all material respects with the International Money Laundering Abatement and Anti-Terrorist Financing Act of 2001, which comprises Title III of the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001 (the "Patriot Act") and the regulations promulgated thereunder, and the rules and regulations administered by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"), to the extent the same are applicable to the Guarantor; and

(b) the Guarantor is not included on the List of Specially Designated Nationals and Blocked Persons maintained by the OFAC, nor is the Guarantor a resident in, or organized or chartered under the laws of, (i) a jurisdiction that has been designated by the U.S. Secretary of the Treasury under Section 311 or 312 of the Patriot Act as warranting special measures due to money laundering concerns or (ii) any foreign country that has been designated as non-cooperative with international anti-money laundering principles or procedures by an intergovernmental group or organization, such as the Financial Action Task Force on Money Laundering, of which the United States is a member and with which designation the United States representative to the group or organization continues to concur.

11. **Tolling of Statute of Limitations**. Any act or circumstance that shall toll any statute of limitations applicable to the Obligations guaranteed hereby shall also toll the statute of limitations applicable to the liability of the Guarantor for the Obligations guaranteed by this Guaranty.

12. **Notices**. All notices, demands and other communications to be given or delivered under or by reason of the provisions of this Guaranty shall be in writing and shall be deemed to have been given (a) when personally delivered, (b) when transmitted via telecopy (or other facsimile device) to the number set out below if the sender on the same day sends a confirming copy of such notice by a recognized overnight delivery service (charges prepaid), (c) the day following the day (except if not a Business Day then the next Business Day) on which the same has been delivered prepaid to a reputable national overnight air courier service or (d) the third Business Day following the day on which the same is sent by certified or registered mail, postage prepaid. Notices, demands and communications, in each case to the respective parties, shall be sent to the applicable address set forth below, unless another address has been previously specified in writing:

IF TO GUARANTOR:
330 Seven Springs Way
Brentwood, TN 37027
Attention: General Counsel
Facsimile: (615) 920-8948

WITH A COPY TO:
Sidley Austin LLP
787 Seventh Avenue
New York, NY 10019
[redacted]

WITH A COPY TO:
Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219
[redacted]

IF TO BENEFICIARY:
c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242
[redacted]

WITH A COPY TO: Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
420 20th Street North
1400 Wells Fargo Tower
Birmingham, Alabama 35203
[redacted]

or to such other address with respect to a party as such party notifies the other in writing as above provided.

13. **Governing Law; Jurisdiction and Venue; Waiver of Jury Trial**.

(a) This Agreement shall be governed by and construed in accordance with the laws of the State of Delaware applicable to contracts executed and performed in such State, without giving effect to conflicts of law principles.

(b) THE PARTIES HERETO CONSENT TO PERSONAL JURISDICTION IN THE STATE OF DELAWARE. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, THE MPT PARTIES AND THE GUARANTOR AGREE THAT ANY ACTION OR PROCEEDING ARISING FROM OR RELATED TO THIS AGREEMENT SHALL BE BROUGHT AND TRIED EXCLUSIVELY IN THE STATE OR FEDERAL COURTS OF DELAWARE. EACH OF THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY OBJECTION TO THE LAYING OF VENUE OF ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. THE PARTIES EXPRESSLY ACKNOWLEDGE THAT DELAWARE IS A FAIR, JUST AND REASONABLE FORUM AND AGREE NOT TO SEEK REMOVAL OR TRANSFER OF ANY ACTION FILED BY THE OTHER PARTIES IN SAID COURTS. FURTHER, THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY CLAIM THAT SUCH SUIT, ACTION OR PROCEEDING HAS BEEN BROUGHT IN AN INCONVENIENT FORUM. SERVICE OF ANY PROCESS, SUMMONS, NOTICE OR DOCUMENT BY CERTIFIED MAIL ADDRESSED TO A PARTY AT THE ADDRESS DESIGNATED PURSUANT TO SECTION 12 SHALL BE EFFECTIVE SERVICE OF PROCESS AGAINST SUCH PARTY FOR ANY ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. A FINAL JUDGMENT IN ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT MAY BE ENFORCED IN ANY OTHER COURT TO WHOSE JURISDICTION ANY OF THE PARTIES IS OR MAY BE SUBJECT.

(c) TO THE MAXIMUM EXTENT PERMITTED BY LAW, THE PARTIES HEREBY KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVE THE RIGHT TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION BASED HEREON, ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT, OR ANY COURSE OF CONDUCT, COURSE OF DEALING, STATEMENT (WHETHER VERBAL OR WRITTEN) OR ACTION OF ANY PARTY OR ANY EXERCISE OF ANY PARTY OF THEIR RESPECTIVE RIGHTS HEREUNDER OR IN ANY WAY RELATING TO THIS AGREEMENT OR THE COLLATERAL (INCLUDING ANY CLAIM OR DEFENSE ASSERTING THAT THIS AGREEMENT WAS FRAUDULENTLY INDUCED OR IS OTHERWISE VOID OR VOIDABLE). THIS WAIVER IS A MATERIAL INDUCEMENT FOR THE MPT PARTIES TO ENTER INTO THIS AGREEMENT AND THE OTHER OBLIGATION DOCUMENTS.

14. **Delivery by Electronic Transmission**. This Guaranty and any signed agreement entered into in connection herewith or contemplated hereby, and any amendments hereto or thereto, to the extent signed and delivered by means of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail, shall be treated in all manner and respects as an original contract and shall be considered to have the same binding legal effects as if it were the original signed version thereof delivered in person. At the request of any party hereto or to any such contract, each other party hereto or thereto shall re-execute original forms thereof and deliver them to all other parties. No party hereto or to any such contract shall raise the use of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail to deliver a signature or the fact that any signature or contract was transmitted or communicated through the use of facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail as a defense to the formation of a contract and each such party forever waives any such defense.

15. **Expenses**. The Beneficiary shall be entitled to recover all reasonable and documented out-of-pocket costs associated with enforcing the provisions of this Guaranty in the event of a breach hereof by the Guarantor, including, without limitation, courts costs and reasonable and documented out-of-pocket attorneys' fees.

16. **Entire Agreement; Modification**. This Guaranty and the documents referred to herein contain the complete agreement between the parties hereto and supersede any prior understandings, agreements or representations by or between the parties, written or oral, which may have related to the subject matter hereof in any way.

17. **Binding Effect; Assignment**. This Guaranty shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns, except that neither this Guaranty nor any of the rights, interests or obligations hereunder may be assigned or delegated by the Guarantor without the prior written consent of the MPT Parties. Beneficiary may at any time and without the consent of the Guarantor assign all of its rights and obligations hereunder.

18. **No Third Party Beneficiaries**. Nothing expressed or referred to in this Guaranty will be construed to give any Person other than the parties to this Guaranty any legal or equitable right, remedy, or claim under or with respect to this Guaranty or any provision of this Guaranty.

19. **Counterparts**. This Guaranty may be executed in multiple counterparts, any one of which need not contain the signature of more than one party, but all such counterparts taken together shall constitute one and the same instrument.

20. **Necessary Action**. Each party shall perform any further acts and execute and deliver any documents that may be reasonably necessary to carry out the provisions of this Guaranty.

21. **Joint Drafting**. The parties hereto and their respective counsel have participated in the drafting and redrafting of this Guaranty and the general rules of construction which would construe any provisions of this Guaranty in favor of or to the advantage of one party as opposed to the other as a result of one party drafting this Guaranty as opposed to the other or in resolving any conflict or ambiguity in favor of one party as opposed to the other on the basis of which party drafted this Guaranty are hereby expressly waived by all parties to this Guaranty.

22. **Termination**. Notwithstanding anything to the contrary, this Guaranty shall terminate and be of no further force or effect on the earlier of (A) if the Outside Closing Date (as defined in the Purchase Agreement) has occurred, the date that Lima HoldCo holds a direct or indirect ownership interest in each Lessee and (B) if the Outside Closing Date has not occurred, the date that Lima HoldCo holds a direct or indirect ownership interest in each Lima Seller (as defined in the Purchase Agreement) and from and after such date, Guarantor shall have no further obligations hereunder. Upon request of the Guarantor, the MPT Parties will provide the Guarantor with written evidence of such termination.

23. **Representatives**. The MPT Parties hereby appoint MPT of Johnstown-Lima, LLC as their duly authorized agent and representative (the "MPT Representative") to take all actions and enforce all rights of the MPT Parties under this Guaranty, including, without limitation, (i) giving and receiving any notice or instruction permitted or required under this Guaranty; (ii) interpreting all of the terms and provisions of this Guaranty; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with the Guarantors under this Guaranty; (v) conducting negotiations and dealing with the Guarantor under this Guaranty; and (vi) taking any other actions on behalf of the MPT Parties relating to the MPT Parties' rights, claims, duties and obligations under this Guaranty. In the performance of the Guarantor's duties and obligations hereunder, the Guarantor shall be authorized and permitted to correspond and transact with the MPT Representative on behalf of all the MPT Parties and shall be entitled to rely upon any document or instrument executed and delivered by the MPT Representative.

[*Signatures appear on following 2 pages.*]

IN WITNESS WHEREOF, the Guarantor has executed and delivered this Guaranty as of the date first above written.

GUARANTOR:

LIFEPOINT HEALTH, [INC.]

By:_____
Name:_____
Title:_____

MPT PARTIES/BENEFICIARY:

MPT OF DODGE CITY-LIMA, LLC
MPT OF HASTINGS-LIMA, LLC
MPT OF JOHNSTOWN-LIMA, LLC
MPT OF LANDER-LIMA, LLC
MPT OF LAWTON-LIMA, LLC
MPT OF MEYERSDALE-LIMA, LLC
MPT OF OTTUMWA-LIMA, LLC
MPT OF PALESTINE-LIMA, LLC
MPT OF RIVERTON-LIMA, LLC
MPT OF ROARING SPRINGS-LIMA, LLC

By: MPT Operating Partnership, L.P.
Title: Sole Member of each above-referenced entity

By:_____
Name:_____
Title:_____

Exhibit F

Form of Assignment and Assumption of Lease Agreement

See attached.

TO BE RECORDED IN [_____] COUNTY, [___].

[Facility Name/Description]
(Leasehold Parcel)
[_____] County, [_____]

THIS DOCUMENT PREPARED BY AND AFTER RECORDING RETURN TO:
Baker Donelson Bearman Caldwell & Berkowitz PC
420 20th Street North
Suite 1400 Wells Fargo Tower
Birmingham, Alabama 35203
Attention: Lynn Reynolds

ASSIGNMENT AND ASSUMPTION OF LEASE AGREEMENT[1]

THIS ASSIGNMENT AND ASSUMPTION OF LEASE (this "**Assignment and Assumption**") is made as of _____, 20__, by and between [_____], a [_____], with an address of c/o LifePoint Health, [Inc.], 330 Seven Springs Way, Brentwood, TN 37027, Attention: General Counsel (the "**Assignor**"), and **MPT OF [_____]-LIMA, LLC**, a Delaware limited liability company with an address of 1000 Urban Center Drive, Suite 501, Birmingham, Alabama 35242 ("**Assignee**").

WITNESSETH:

A. The Assignor, as lessee, and [_____], as lessor (the "**Lessor**"), are parties to that certain [Lease Agreement, dated _____, ____] (the "**Assumed Lease**"), whereby the Lessor leased to the Assignor certain property located in the City of [_____], [_____] County, [_____], more particularly described on ***EXHIBIT A*** attached hereto and made a part hereof by reference and incorporation (the "**Assumed Leased Property**").

B. Notice of the Assumed Lease has been provided by the recordation of a [Memorandum of Lease Agreement] recorded at Book [____], Page [____], in the Office of the [County Clerk] of [_____] County, [_____].

[1] NTD: Form subject to revision on a property-by-property basis following local counsel review.

C. Assignor, and certain of its affiliates, and Assignee, and certain of its Affiliates, are parties to that certain Real Property Asset Purchase Agreement, dated as of _____, 2019 (as amended, modified, or restated from time to time, the "**Purchase Agreement**"), pursuant to which Purchase Agreement, Assignor is required to assign to Assignee all of the right, title and interest of Assignor in and to the Assumed Lease and the Assumed Leased Property.

D. [The Lessor has consented to this Assignment and Assumption and the Lessor's written consent is attached hereto as ***EXHIBIT B*** and made a part hereof by reference and incorporation.]

AGREEMENT

N O W, T H E R E F O R E, in consideration of the mutual covenants herein set forth, the parties agree as follows:

1. Assignor hereby assigns and transfers to Assignee all of Assignor's right, title and interest in and to the Assumed Lease and the Assumed Leased Property, and Assignee hereby accepts from Assignor all such right, title and interest, regardless of whether such obligations first arise or accrue before, on or after the date hereof; subject, however, to the terms, conditions and provisions set forth in this Assignment and Assumption and the Purchase Agreement.

2. This Assignment and Assumption shall be governed by and construed in accordance with the laws of the State of [_____] and may not be modified or amended in any manner other than by a written agreement signed by the party to be charged therewith.

3. If any term or provision of this Assignment and Assumption or the application thereof to any persons or circumstances shall, to any extent, be invalid or unenforceable, the remainder of this Assignment and Assumption or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable shall not be affected thereby, and each term and provision of this Assignment and Assumption shall be valid and enforced to the fullest extent permitted by law.

4. This Assignment and Assumption may be executed in counterparts, each of which shall be an original and all of which counterparts taken together shall constitute one and the same agreement. Any signatures transmitted electronically or by facsimile shall be deemed originals.

5. This Assignment shall be binding upon, and inure to the benefit of, all of the parties hereto, their successors and assigns.

[Intentionally Left Blank]

[Signatures appear on following 2 pages]

IN WITNESS WHEREOF, the undersigned have executed this Assignment and Assumption as of the date first set forth hereinabove.

ASSIGNOR:

[_____]

By:_____
Name: _____
Title: _____

[NOTARY TO BE UPDATED BY LOCAL COUNSEL]

STATE OF _____)
) SS.
COUNTY OF _____)

On _____, 20___, before me, the undersigned, a Notary Public in and for said County and State personally appeared [_____] known to me to be the identical person who executed the within and foregoing instrument, and who acknowledged himself to be the _____ of [_____], a [_____], and acknowledged to me that as such officer, being authorized to do so, executed the within instrument on behalf of said limited partnership, as the sole member of said limited liability company, for the purposes therein contained.

IN TESTIMONY WHEREOF, I have hereunto set my hand and official seal on this _____, 2015.

_____
Notary Public in and for said County and State
My Commission Expires:_____

(SEAL)

ASSIGNEE:

MPT OF [_____]-LIMA, LLC,
a Delaware limited liability company

By: MPT Operating Partnership, L.P.,
a Delaware limited liability company
Its: Sole Member

By:_____
Name: _____
Title: _____

[NOTARY TO BE UPDATED BY LOCAL COUNSEL]

STATE OF _____)
) SS.
COUNTY OF _____)

On _____, 20___, before me, the undersigned, a Notary Public in and for said County and State personally appeared [_____] known to me to be the identical person who executed the within and foregoing instrument, and who acknowledged himself to be the _____ of MPT Operating Partnership, L.P., a Delaware limited partnership, as the Sole Member of **MPT OF [_____]-LIMA, LLC**, a Delaware limited liability company, and acknowledged to me that as such officer, being authorized to do so, executed the within instrument on behalf of said limited partnership, as the sole member of said limited liability company, for the purposes therein contained.

WITNESS my hand and official seal.

_____
Notary Public in and for said County and State

My commission expires:_____

(SEAL)

EXHIBIT A

Legal Description

EXHIBIT B

Consent of Lessor to Assignment and Sublease

Dated: _____, 20___

MPT of [_____]-Lima, LLC
c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242
Attn: Legal Department

[_____, a _____] (the "**Lessor**"), is the owner of that certain property located in the City of [_____], [_____] County, [_____] (the "**Leased Property**"), and which Leased Property Lessor leases to [_____, a _____] ("**Tenant**"), pursuant to the terms and conditions of that certain [Lease Agreement], dated _____, 20___, by and between the Lessor and the Tenant (as amended, modified or restated from time to time, the "**Assumed Lease**").

The undersigned authorized agent of Lessor, intending Lessor to be legally bound hereby, and for other good and valuable consideration, hereby agrees as follows:

1. Lessor hereby acknowledges and consents to: (a) that certain Assignment and Assumption of Lease Agreement, dated of even date herewith (the "**Assignment and Assumption**"), pursuant to which Tenant assigns to MPT OF [_____]-Lima, LLC, a Delaware limited liability company (together with its successors and assigns, collectively, "**MPT**"), and MPT assumes from the Tenant, all of Tenant's right, title, and interest in and to the Assumed Lease and Leased Property, and (b) that certain Master Lease Agreement by and among Tenant, MPT, and certain of their affiliates, (as the same may be modified, amended or restated from time to time, the "**Primary Lease**"), pursuant to which MPT will sublease the Leased Property back to the Tenant.

2. The Lessor further acknowledges and consents to the right of MPT to exercise its rights and remedies under the Primary Lease with respect to the Tenant and the Leased Property, and the right of MPT's assignee or designee to assume (following written notice to Lessor) all rights, interests, duties and obligations under the Assumed Lease as permitted in the Primary Lease and applicable law, so long as all of the terms, covenants, conditions, and obligations required to be performed and fulfilled under the Assumed Lease are performed and fulfilled. PURSUANT TO THE PRIMARY LEASE, TENANT SHALL REMAIN LIABLE FOR ANY AND ALL COVENANTS, DUTIES AND OBLIGATIONS OF TENANT UNDER THE ASSUMED LEASE.

3. All notices, demands, consents or requests which are either required or desired to be given or furnished to Tenant pursuant to the Assumed Lease or otherwise to any party hereto,

shall be sent in the manner as set forth in the Assumed Lease (or by Federal Express or other recognized overnight couriers) to the following address, as applicable:

IF TO TENANT: [_____]
c/o LifePoint Health, [Inc.]
330 Seven Springs Way
Brentwood, TN 37027
Attn: General Counsel
[redacted]

With a copy to : MPT of [_____]-Lima, LLC
c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242
Attn: Legal Department
[redacted]

IF TO MPT: MPT of [_____]-Lima, LLC
c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242
Attn: Legal Department
[redacted]

IF TO LESSOR: _____
_____
_____
Attn: _____
Phone: (___) _____
Fax: (___) _____

4. Lessor acknowledges that this instrument shall be binding upon and shall inure to the benefit of MPT and Tenant and each of their respective successors and assigns. Lessor further acknowledges and covenants that Lessor has the full right to execute this instrument without the necessity of obtaining consents from any lender or any other entity or individual.

4. This instrument is executed and delivered by Lessor with the understanding that it will be relied upon by MPT and Tenant in connection with the above referenced agreements.

5. This instrument may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Executed signature pages to this instrument may be delivered by facsimile transmission and any such signature page shall be deemed an original.

[*Signature Appears on Following Page*]

This Consent of Lessor to Assignment and Sublease is executed and delivered by the undersigned on this _____ day of _____, 20____.

LESSOR:

[_____]

By: _____
Name: _____
Its: _____

Exhibit G

Form of Assignment and Assumption of MOB Ground Lease Agreement

See attached.

TO BE RECORDED IN [_____] COUNTY, [___].

[Facility Name/Description]
(Leasehold Parcel)
[_____] County, [_____]

THIS DOCUMENT PREPARED BY AND AFTER RECORDING RETURN TO:
Baker Donelson Bearman Caldwell & Berkowitz PC
420 20th Street North
Suite 1400 Wells Fargo Tower
Birmingham, Alabama 35203
Attention: Lynn Reynolds

ASSIGNMENT AND ASSUMPTION OF LEASE AGREEMENT[1]

THIS ASSIGNMENT AND ASSUMPTION OF LEASE (this "**Assignment and Assumption**") is made as of _____, 20___, by and between [_____], a [_____], with an address of c/o LifePoint Health, [Inc.], 330 Seven Springs Way, Brentwood, TN 37027, Attention: General Counsel (the "**Assignor**"), and **MPT OF [_____]-LIMA, LLC**, a Delaware limited liability company with an address of 1000 Urban Center Drive, Suite 501, Birmingham, Alabama 35242 ("**Assignee**").

WITNESSETH:

A. The Assignor, as lessor, and [_____], as lessee (the "**Lessee**"), are parties to that certain [Ground Lease Agreement, dated _____, ____] (the "**Assumed Lease**"), whereby the Assignor leased to the Lessee certain property located in the City of [_____], [_____] County, [_____], more particularly described on ***EXHIBIT A*** attached hereto and made a part hereof by reference and incorporation.

B. Notice of the Assumed Lease has been provided by the recordation of a [Memorandum of Ground Lease Agreement] recorded at Book [____], Page [____], in the Office of the [County Clerk] of [_____] County, [_____].

[1] NTD: Form subject to revision on a property-by-property basis following local counsel review.

C. Assignor, and certain of its affiliates, and Assignee, and certain of its Affiliates, are parties to that certain Real Property Asset Purchase Agreement, dated as of _____, 2019 (as amended, modified, or restated from time to time, the "**Purchase Agreement**"), pursuant to which Purchase Agreement, Assignor is required to assign to Assignee all of the right, title and interest of Assignor in and to the Assumed Lease.

AGREEMENT

N O W, T H E R E F O R E, in consideration of the mutual covenants herein set forth, the parties agree as follows:

1. Assignor hereby assigns and transfers to Assignee all of Assignor's right, title and interest in and to the Assumed Lease, and Assignee hereby accepts from Assignor all such right, title and interest, regardless of whether such obligations first arise or accrue before, on or after the date hereof; subject, however, to the terms, conditions and provisions set forth in this Assignment and Assumption and the Purchase Agreement.

2. This Assignment and Assumption shall be governed by and construed in accordance with the laws of the State of [_____] and may not be modified or amended in any manner other than by a written agreement signed by the party to be charged therewith.

3. If any term or provision of this Assignment and Assumption or the application thereof to any persons or circumstances shall, to any extent, be invalid or unenforceable, the remainder of this Assignment and Assumption or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable shall not be affected thereby, and each term and provision of this Assignment and Assumption shall be valid and enforced to the fullest extent permitted by law.

4. This Assignment and Assumption may be executed in counterparts, each of which shall be an original and all of which counterparts taken together shall constitute one and the same agreement. Any signatures transmitted electronically or by facsimile shall be deemed originals.

5. This Assignment shall be binding upon, and inure to the benefit of, all of the parties hereto, their successors and assigns.

[Intentionally Left Blank]

[Signatures appear on following 2 pages]

IN WITNESS WHEREOF, the undersigned have executed this Assignment and Assumption as of the date first set forth hereinabove.

ASSIGNOR:

[_____]

By:_____
Name: _____
Title: _____

[NOTARY TO BE UPDATED BY LOCAL COUNSEL]

STATE OF _____)
) SS.
COUNTY OF _____)

On _____, 20___, before me, the undersigned, a Notary Public in and for said County and State personally appeared [_____] known to me to be the identical person who executed the within and foregoing instrument, and who acknowledged himself to be the _____ of [_____], a [_____], and acknowledged to me that as such officer, being authorized to do so, executed the within instrument on behalf of said limited partnership, as the sole member of said limited liability company, for the purposes therein contained.

IN TESTIMONY WHEREOF, I have hereunto set my hand and official seal on this _____, 2015.

_____
Notary Public in and for said County and State
My Commission Expires:_____

(SEAL)

ASSIGNEE:

MPT OF [_____]-LIMA, LLC,
a Delaware limited liability company

By: MPT Operating Partnership, L.P.,
a Delaware limited liability company
Its: Sole Member

By:_____
Name: _____
Title: _____

[NOTARY TO BE UPDATED BY LOCAL COUNSEL]

STATE OF _____)
) SS.
COUNTY OF _____)

On _____, 20___, before me, the undersigned, a Notary Public in and for said County and State personally appeared [_____] known to me to be the identical person who executed the within and foregoing instrument, and who acknowledged himself to be the _____ of MPT Operating Partnership, L.P., a Delaware limited partnership, as the Sole Member of **MPT OF [_____]-LIMA, LLC**, a Delaware limited liability company, and acknowledged to me that as such officer, being authorized to do so, executed the within instrument on behalf of said limited partnership, as the sole member of said limited liability company, for the purposes therein contained.

WITNESS my hand and official seal.

_____
Notary Public in and for said County and State

My commission expires:_____

(SEAL)

EXHIBIT A

Legal Description

Exhibit H

Form Assignment of Rents and Leases

See attached.

This Instrument Prepared By
And After Recording Return To:
BAKER, DONELSON, BEARMAN, CALDWELL
& BERKOWITZ, a Professional Corporation
1400 Wells Fargo Tower
420 North 20th Street
Birmingham, Alabama 35203
Attn: Lynn Reynolds, Esq.

ASSIGNMENT OF RENTS AND LEASES[1]

STATE OF [_____]

KNOW ALL MEN BY THESE PRESENTS:

COUNTY OF [_____]

THIS ASSIGNMENT OF RENTS AND LEASES (this "Assignment") is entered into as of _____, 20___, by and among **[_____, a _____]** (the "Assignor"), having an address at c/o LifePoint Health[, Inc.], 330 Seven Springs Way, Brentwood, TN 37027, Attn: General Counsel, and the undersigned entities listed on the signature pages hereof under the heading "Assignees" (together with the successors and assigns of each, each an "Assignee" and collectively, the "Assignees"), each having their principal place of business at c/o MPT Operating Partnership, L.P., 1000 Urban Center Drive, Suite 501, Birmingham, Alabama 35242, Attn: Legal Department.

W I T N E S S E T H:

ARTICLE I
Definitions

As used herein, the following capitalized terms used herein shall have the following meanings:

"Affiliate" means, with respect to any Person (i) any Person that, directly or indirectly, controls or is controlled by or is under common control with such Person, (ii) any other Person that owns, beneficially, directly or indirectly, 10% or more of the outstanding capital stock, shares or equity interests of such Person, or (iii) any officer, director, employee, shareholder, partner, member, manager or trustee of such Person or any Person controlling, controlled by or under common control with such Person (excluding trustees and persons serving in similar capacities who are not otherwise an Affiliate of such Person). For the purposes of this definition, "control"

---

[1] NTD: Form subject to revision on a property-by-property basis following local counsel review.

(including the correlative meanings of the terms "controlled by" and "under common control with"), as used with respect to any Person, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, through the ownership of voting securities or otherwise.

"Assignor's Personal Property" shall mean, all of Assignor's consumable inventory and supplies, machinery, equipment, furniture, furnishings, trailers, movable walls or partitions, computers, trade fixtures, and other tangible or intangible personal property (including all such items not permanently affixed to the applicable Property), currently owned and acquired after the execution of this Assignment, and necessary, used, or useful in the operation of the applicable Facility, but excluding any items included within the definition of Fixtures.

"Bankruptcy Claims" shall mean all of Assignor's claims and rights to the payment of damages arising from any rejection by a Tenant of any Tenant Lease under the Bankruptcy Code.

"Bankruptcy Code" shall mean 11 U.S.C. § 101 et seq. (as the same may be amended from time to time).

"Business Day" shall mean each Monday, Tuesday, Wednesday, Thursday and Friday that is not a day on which commercial banks in the City of New York, New York are authorized or obligated by law or executive order to close.

"Engineering Documents" shall mean all site plans, surveys, soil and substrata studies, architectural drawings, plans and specifications, engineering plans and studies, floor plans, landscape plans, and other plans and studies that relate to all or any portion of the Land, the Improvements or the Personal Property.

"Environmental Indemnification Agreement" means that certain Environmental Indemnification Agreement, dated of even date herewith, among Lima Holdco, Assignor and certain of their Affiliates, on the one hand, and certain of the Assignees, on the other hand, as the same may be amended, modified and restated from time to time.

"Event of Default" shall mean any happening or occurrence described in Article VI hereof.

"Facility" shall mean those certain healthcare facilities located on the Land.

"Fixtures" shall mean, all equipment, machinery, fixtures, and other items of real property, including all components thereof, now and hereafter located in, on or used in connection with, and that are, in each case, permanently affixed to the Land or affixed or incorporated into the buildings and structure on the Land, Improvements, including, without limitation, all affixed furnaces, boilers, heaters, electrical equipment, heating, plumbing, lighting, ventilating, refrigerating, incineration, air and water pollution control, waste disposal, air-cooling and air-conditioning systems and apparatus, sprinkler systems and fire and theft protection equipment, and built-in oxygen and similar vacuum systems, all of which, to the greatest extent permitted by law, are hereby deemed by the parties to constitute real estate, together with all replacements, modifications, alterations and additions thereto.

"Guaranty" means collectively, (i) the Lima Guaranty and (ii) the LifePoint Guaranty.

"Improvements" shall mean all buildings, structures, Fixtures and other improvements of every kind, alleyways and connecting tunnels, sidewalks, utility pipes, conduits and lines (on-site and off-site), parking areas and roadways appurtenant to such buildings and structures presently or hereafter situated on the Land, including, without limitation, any such items constituting Capital Additions, and all hereditaments, easements, rights of way and other appurtenances related thereto.

"Intangible Property" shall mean all permits, licenses, approvals, entitlements and other governmental and quasi-governmental authorizations, including, without limitation, certificates of occupancy or need required in connection with the ownership, planning, development, construction, use, operation or maintenance of all or any portion of the Property, and other intangible property or any interest therein now or hereafter owned or held by Assignor in connection with the Land or Improvements, or any business or businesses now or hereafter conducted by Assignor or any Tenant thereon or with the use thereof, including all leases, contract rights, agreements, trademarks, trade names, water rights and reservations, zoning rights, business licenses and warranties (including those relating to construction or fabrication) related to the Land or Improvements, or any part thereof; excluding, however, Assignor's general corporate trademarks, service marks, logos or insignia or books and records.

"Land" shall mean all those certain lots, tracts or parcels of land described on ***Exhibit A*** attached hereto and incorporated herein by reference, any other parcel of land acquired or leased and made subject to this Assignment, for all purposes, together with all covenants, licenses, privileges and benefits thereto belonging, and any easements, rights-of-way, rights of ingress or egress or other interests in, on, or to any land, highway, street, road or avenue, open or proposed, in, on, across, in front of, abutting or adjoining such real property including, without limitation, any strips and gores adjacent to or lying between such real property and any adjacent real property.

"License" shall mean the limited license as defined in Section 3.1 hereof.

"LifePoint" means LifePoint Health, [Inc.] or its successor in interest.

"LifePoint Guaranty" means that certain Guaranty, dated as of the date hereof, executed and delivered by LifePoint in favor of Assignee, as may be modified, amended, restated and/or supplemented from time to time; provided that, the LifePoint Guaranty shall automatically terminate on the date that Lima HoldCo holds a direct or indirect ownership interest in each Facility Lessee.

"Lima Guaranty" shall mean that certain Guaranty, dated as of the date hereof, executed and delivered by Lima HoldCo in favor of Assignee, as may be modified, amended, restated and/or supplemented from time to time.

"Lima Holdco" shall mean Lima HoldCo, LLC, a Delaware limited liability company.

"Master Lease" shall mean that certain Master Lease Agreement, dated as of the date hereof, among the Assignor and certain of its Affiliates, as lessors, and certain of the Assignees, as lessees, as the same has been or may hereafter be modified, amended or restated from time to time.

"Material Tenant Lease" means any Tenant Lease providing for greater than One Hundred Thousand Dollars ($100,000) in rent payments per year.

"Obligations" means the respective obligations, duties and liabilities (as applicable) of Assignor and each of its Affiliates under or pursuant to (a) the Master Lease, (b) the Guaranty, (c) the Environmental Indemnification Agreement, (d) each of the other Obligation Documents, and (e) any and all renewals, increases, and substitutions, amendments and extensions of the liabilities or obligations described or referred to in subsections (a), (b), (c), and (d) above.

"Obligation Documents" shall mean the Master Lease, the Environmental Indemnification Agreement, the Guaranty, and all other "Obligation Documents" under and as defined in the Master Lease, in each case, as the same may be modified, amended, or restated from time to time.

"Person" shall mean an individual, a corporation, a limited liability company, a general or limited partnership, an unincorporated association, a joint venture, a governmental entity or another entity or group.

"Personal Property" shall mean all Intangible Property, Warranties, Engineering Documents, all furnishings, equipment, tools, machinery, fixtures, appliances and all other tangible personal property now or hereafter located on or about the Land or the Improvements, other than the Fixtures.

"Property" shall mean the Improvements, the Land, the Personal Property and the Rents (hereinafter defined), together with:

(a) all rights, privileges, tenements, hereditaments, rights-of-way, easements, appendages and appurtenances in anywise appertaining thereof, and all right, title and interest, if any, of Assignor in and to any streets, ways, alleys, strips or gores of land adjoining the Land or any part thereof;

(b) all betterments, improvements, additions, alterations, appurtenances, substitutions, replacements and revisions thereof and thereto and all reversions and remainders therein;

(c) all of Assignor's right, title and interest in and to any awards, remunerations, reimbursements, settlements or compensation heretofore made or hereafter to be made by any governmental authority pertaining to the Land, the Improvements, the Fixtures or the Personal Property, including, but not limited to, those for any vacation of, or change in grade in, any streets affecting the Land or the Improvements and those for municipal utility district or other utility costs incurred or deposits made in connection with the Land; and

(d) any and all security and collateral of any nature whatsoever, now or hereafter given for the repayment of or the performance and discharge of the Obligations.

As used in this Assignment, the term "Property" shall be expressly defined as meaning all or, where the context permits or requires, any portion of the above and all or, whether the context permits or requires, any interest therein.

"Rents" shall mean, with respect to the Land and the Improvements, the immediate, absolute and continuing right to collect and receive all of the rents, income, receipts, revenues, proceeds, security, guaranties, and other types of deposits, issues and profits now due or which may become due or to which Assignor may now or shall hereafter (whether upon any applicable period of redemption or otherwise) become entitled or may demand or claim, arising or issuing from or out of the Tenant Leases, or any part thereof, including, without limiting the generality of the foregoing, minimum rents, additional rents, percentage rents, parking maintenance charges or fees, tax and insurance contributions, proceeds of sale of electricity, gas, chilled and heated water and other utilities and services, deficiency rents and liquidated damages following default, premiums payable by any Tenant upon the exercise of a cancellation privilege provided for in a Tenant Lease and all proceeds payable under any policy of insurance covering loss of rents resulting from untenability caused by destruction or damage to the Property, together with any and all rights and claims of any kind which the Assignor may have against any Tenant under a Tenant Lease or any subtenants or occupants of the Property.

"Tenant" shall mean the lessee, sublessee, tenant, subtenant, or licensee under a Tenant Lease.

"Tenant Leases" shall mean, with respect to the Land and the Improvements, all leases, subleases, licenses and other rental agreements (written or oral, now or hereafter in effect), as any of the same may be amended, modified and/or restated from time to time, which grant a possessory interest in and to, or the right to use, occupy and enjoy all or any portion of the Land and the Improvements, including, without limitation, those certain Tenant Leases (if any) described on ***Schedule A*** attached hereto and incorporated herein by reference for all purposes, as the same may be amended, modified and/or restated from time to time, together with all the right, power and authority of the Assignor to enforce, alter, modify or change the terms of such leases and agreements or to surrender, cancel or terminate such leases and agreements, together with any and all guarantees, letters of credit and other credit support, modifications, extensions and renewals thereof, as the same may be amended, modified and/or restated from time to time (whether before or after the filing by or against the Assignor of any petition of relief under the Bankruptcy Code) and all other related security and other deposits.

"Warranties" shall mean, all warranties, representations and guaranties with respect to the Property, whether express or implied, which Assignor now holds or under which Assignor is the beneficiary, including, without limitation, all of the representations, warranties and guaranties given and/or assigned to the Assignor under the Tenant Leases.

Any capitalized terms used in this Assignment but not defined herein shall have the meanings ascribed to such terms in the Master Lease.

ARTICLE II
Assignment

Assignor, in consideration of the sum of TEN AND NO/100 DOLLARS ($10.00), and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, does hereby absolutely and unconditionally GRANT, BARGAIN, SELL, CONVEY, ASSIGN, TRANSFER, SET OVER and DELIVER to Assignees the Tenant Leases, the Rents, the Warranties

and the Bankruptcy Claims TO HAVE AND TO HOLD UNTO ASSIGNEES forever, and Assignor does hereby bind itself, its successors and assigns to WARRANT and FOREVER DEFEND the title to the Tenant Leases, the Rents, the Warranties and the Bankruptcy Claims unto Assignees against every Person whomsoever lawfully claiming or to claim the same or any part thereof, by, through or under Assignor but not otherwise. This Assignment is an absolute, unconditional and presently effective assignment to Assignees, subject to Section 3.1 below, to secure the performance of the Obligations.

ARTICLE III
Limited License, Continuation and Termination of Assignment

3.1 **Limited License**. Provided that there exists no Event of Default, Assignor shall have all rights under the Tenant Leases, under a limited license (the "License"), to observe, perform and discharge the obligations, terms, covenants, conditions and warranties of the Tenant Leases, including the right to (A) collect upon, but not prior to accrual, all of the Rents arising from or out of the Tenant Leases, or any renewals or extensions thereof, or from or out of the Property or any part thereof and (B) exercise all other rights as landlord under the applicable Tenant Leases, subject to the limitations set forth in Article XXIII of the Master Lease. Assignor may use the Rents in any manner not inconsistent with the Obligation Documents. Upon the sale and conveyance by Assignees or their Affiliates, successors or assigns of the fee title to the Land and the Improvements, all right, title, interest and power granted under the License granted herein with respect to such Property shall be automatically continued subject to the terms and conditions of the Master Lease and the other Obligation Documents, including this Assignment. Upon the occurrence of and during the continuation of an Event of Default, without any further action by Assignees, Assignor shall hold all Rents paid to Assignor thereafter in trust for the use and benefit of the Assignees and the Assignees shall have the right, power and authority, whether or not Assignees take possession of the Property, to demand, collect, receive, sue for and recover in their own names any and all Rents and Bankruptcy Claims and to apply the sum(s) collected, first to the payment, satisfaction and discharge of expenses incident to the collection of the same, and the balance to the payment of the Obligations; provided, however, that Assignees shall not be deemed to have taken possession of such Property and shall not be deemed to have accepted or assumed any duties or obligations under the Tenant Leases except, in any such case, the exercise of their option to do so, evidenced by their written demand and overt act for such purpose in accordance with Article VII. It shall not be necessary for Assignees to institute any type of legal proceedings or take any other action whatsoever to enforce the assignment provisions set forth herein. If such Event of Default is cured or waived in accordance with the applicable Obligation Documents, the revocable license shall be reinstated.

3.2 **Continuation and Termination of Assignment**. Upon final payment in full and discharge in full of the Obligations (other than contingent indemnification obligations for which no claim has been made), this Assignment shall become and be void and of no force or effect; provided, however, that the affidavit, certificate, letter or statement of any officer of any Assignee certifying in writing that any part of the Obligations remain unpaid and undischarged shall be and constitute conclusive evidence of the validity, effectiveness or continuing force of this Assignment, and any Person may, and is hereby authorized to, rely thereon. Written demand by any Assignee delivered to any Tenant for payment of the Rents during the continuation of any Event of Default

claimed by Assignees shall, with respect to each such Tenant, be sufficient evidence of each such Tenant's obligation and authority to make all future payments of the Rents to Assignees without the necessity for further consent by Assignor.

ARTICLE IV
Representations and Warranties

Assignor hereby unconditionally represents and warrants to Assignees as follows:

4.1 **In General**. (a) Assignor has full legal right, power and authority to execute and deliver this Assignment; (b) this Assignment has been duly executed and delivered by Assignor and constitutes its valid and legally binding obligation, enforceable against it in accordance with its terms, subject to bankruptcy, insolvency, reorganization, and similar laws affecting the enforcement of creditor's rights or contractual obligations generally and, as to enforcement, to general principles of equity, regardless of whether applied in a proceeding at law or in equity; (c) no approval or consent of any foreign, federal, state, county, local or other governmental or regulatory body, and no approval or consent of any other person is required in connection with the execution and delivery by Assignor of this Assignment or the consummation and performance by Assignor of the transactions contemplated hereby; and (d) the execution and delivery of this Assignment and the obligations created hereby have been duly authorized by all necessary proceedings on the part of Assignor, and will not conflict with or result in the breach or violation of any of the terms or conditions of, or constitute (or with notice or lapse of time or both would constitute) a default under the governing documents of Assignor, any instrument, contract or other agreement to which Assignor is a party or by or to which it or its assets or properties are bound or subject; or any statute or any regulation, order, judgment or decree of any court or governmental or regulatory body.

4.2 **Ownership of Tenant Leases and the Rents**. Assignor may lease or license portions of the Property, which sublease(s) or licenses shall be subject to and in accordance with the terms and conditions of the Master Lease. Subject to the terms of the Master Lease, Assignor has all requisite right, power and authority to assign such Tenant Leases and the Rents, and no other person, firm or corporation has any right, title or interest therein.

4.3 **No Default**. Assignor has duly and punctually materially performed, all and singular, the terms, covenants, conditions and warranties of the Tenant Leases on Assignor's part to be kept, observed and performed; and, to Assignor's knowledge, the Tenants thereunder are not in material default of any of the terms or provisions of the respective Tenant Leases.

4.4 **No Modification of the Tenant Leases or Anticipation or Hypothecation of the Rents**. (a) The Tenant Leases are valid and remain in full force and effect; (b) Assignor has not previously sold, assigned, transferred, or pledged the Tenant Leases or the Rents, or any part thereof, whether now due or hereafter to become due, except for the sales, assignments, transfers, mortgages and pledges for which Assignor has heretofore or contemporaneously herewith obtained a full release, (c) the Rents now due, or to become due, for any periods subsequent to the date hereof have not been collected and that payment thereof has not been anticipated, waived or released, discounted, setoff or otherwise discharged or compromised; and (d) Assignor has not received any funds or deposits from any Tenant for which credit has not already been made on account of the accrued Rents.

ARTICLE V
Affirmative Covenants

Assignor hereby unconditionally covenants and agrees with Assignees as follows:

5.1 **Performance**. Assignor shall observe, perform and discharge, duly and punctually, all and singular, the obligations, terms, covenants, conditions and warranties of the Obligation Documents and of the Tenant Leases (as applicable) (except upon Assignees' execution of their remedies under Article III by written demand or other overt act, among other things, to perform and discharge such duties or obligations under the Tenant Leases). Assignor shall promptly deliver to Assignees any notices received with respect to any Material Tenant Leases alleging any material failure on the part of Assignor to observe, perform and discharge the same.

5.2 **Notification to Tenants**. Upon Assignees' written request, Assignor shall notify and direct, in writing, each and every present or future Tenant or occupant of the Property or any part thereof that any security deposit or other deposits heretofore delivered to Assignor has been retained by Assignor or assigned and delivered to Assignees, as the case may be.

5.3 **Enforcement**. Assignor shall enforce or secure in the name of Assignees the performance of each and every material obligation, term, covenant, condition and agreement in the Tenant Leases by any Tenant to be performed, and Assignor shall appear in and defend any action or proceeding arising under, occurring out of or in any manner connected with the Tenant Leases or the obligations, duties or liabilities of Assignor and any Tenant thereunder, and upon request by Assignees, Assignor will do so in the names and on behalf of Assignees, but at the expense of Assignor, and Assignor shall pay all reasonable costs and expenses of Assignees, including reasonable attorneys' fees and disbursements, in any action or proceeding in which Assignees may appear.

5.4 **Anticipation or Hypothecation of the Rents**. Assignor hereby covenants and agrees (a) to give to Assignees duplicate notice of each notice of default sent to each Tenant and copies of all material notices and communications received from any Tenant promptly upon delivery or receipt thereof; (b) to obtain and furnish to Assignees, upon request, itemized statements, in such detail as shall be reasonably satisfactory to Assignees, of the total rent and other charges paid or payable by each Tenant; (c) to comply in all material respects with the terms and provisions of each Tenant Lease; (d) not to assign, transfer, pledge, mortgage or otherwise encumber any Tenant Lease; (e) not to assign, transfer, pledge, mortgage or otherwise encumber any Rents; (f) except as otherwise expressly provided in any Tenant Lease, not to hereafter collect, accept from any Tenant, or permit any Tenant under any Material Tenant Lease to pay any Rents for more than one (1) month in advance (whether in cash or by evidence of indebtedness); and (g) not to enter into any Tenant Lease or terminate, amend, modify, surrender, extend or renew any Tenant Lease for a time period extending beyond the term of the Master Lease, without prior written approval of Assignees, which approval shall not be unreasonably withheld, conditioned, or delayed.

5.5 **Delivery of the Tenant Leases; Further Acts and Assurance**. Until the Obligations secured hereby have been paid in full and discharged (other than contingent indemnification obligations for which no claim has been made), Assignor shall enter into only

leases or licenses of the Property that are permitted pursuant to the terms and conditions of Master Lease, and the other Obligation Documents, and shall upon the request of Assignees deliver executed copies of all existing and all other and future Tenant Leases when executed upon all or any part of the Property and will transfer and assign such other and future Tenant Leases upon the same terms and conditions as herein contained, and Assignor hereby covenants and agrees to make, execute and deliver to Assignees, upon demand and at any time or times, any and all assignments and other documents and instruments which Assignees may reasonably deem advisable to carry out the true purpose and intent of this Assignment.

ARTICLE VI
Events of Default

The term "Event of Default," as used herein, shall mean the occurrence or happening, at any time and from time to time, of any one or more of the following:

6.1 **Event of Default under Master Lease**. The occurrence of any "Event of Default" under and as defined in the Master Lease.

6.2 **Event of Default under the Other Obligation Documents**. The occurrence of an "Event of Default" under and as defined in any of the other Obligation Documents.

6.3 **Performance of Obligations**. If Assignor shall fail, refuse or neglect to perform and discharge fully and timely in all material respects (without duplication of any materiality qualifier herein) any of its obligations hereunder, and, in the case of a monetary failure, such failure, refusal or neglect is not cured within a period of five (5) days after written notice from Assignees and, in the case of a non-monetary failure, such failure, refusal or neglect is not cured by Assignor within a period of thirty (30) days after receipt by Assignor of written notice thereof from the Assignees, unless such failure cannot with due diligence be cured within a period of thirty (30) days (in the Assignees' reasonable discretion), in which case such failure shall not be deemed to continue so long as Assignor commences to cure such failure within the thirty (30) day period and proceeds with due diligence to complete the curing thereof within sixty (60) days after receipt by Assignor of Assignees' notice of default (or such longer period as is reasonably required in the determination of the Assignees to effect such cure if Assignor is diligently proceeding to do so); *provided, however*, in no event shall Assignees be required to give more than two (2) notices and cure period for Assignor's failure to observe or perform the same (or repetitive) covenant or condition in any consecutive twelve (12) month period.

ARTICLE VII
Remedies

7.1 **Remedies**. Upon and during the continuation of an Event of Default, Assignees, at their option, shall have the complete right, power and authority hereunder, then or thereafter, to exercise and enforce any or all of the following rights and remedies, all of which shall be cumulative, shall be in addition to all other rights and remedies of Assignees and may be exercised concurrently or independently from time to time as Assignees shall elect:

(a) To revoke the License with respect to the Property and then and thereafter, without taking possession of such Property, to the extent permitted by law, in the Assignee's

own names, to demand, collect, receive, sue for, attach and levy the Rents and give proper receipts, releases and acquittances therefor, after deducting all necessary and proper costs and expenses of operation and collection, as determined by Assignees, including reasonable attorneys' fees, and apply the net proceeds thereof, together with any funds of Assignor deposited with Assignees, in reduction or repayment of the Obligations in such order of priority as Assignees may, in their sole discretion, determine;

(b) To declare the Master Lease in default and, at its option, exercise all of the rights and remedies contained in the Master Lease or any other Obligation Documents;

(c) Without regard to the adequacy of the security or solvency of Assignor, with or without any action or proceeding through any Person or by any agent or by a receiver to be appointed by a court of competent jurisdiction, and irrespective of Assignor's possession, then or thereafter to enter upon, take possession of, manage and operate the Property or any part thereof; make, modify, enforce, cancel or accept surrender of a Tenant Lease now in effect or hereafter in effect on the Property or any part thereof; remove and evict any Tenant (subject to the provisions of any non-disturbance and attornment agreement entered into by and between any Assignee and any Tenant); increase or decrease the Rents under a Tenant Lease; decorate, clean and repair, and otherwise do any act or incur any cost or expense which Assignees may deem reasonably necessary to protect the status and value of the Property as fully and to the same extent as Assignor could do if in possession thereof; and in such event, to apply the Rents so collected to the operation and management of the Property, but in such order or priority as Assignees shall deem proper, and including the payment of reasonable management, brokerage and attorneys' fees and disbursements, and payment of the Obligations and to the establishment and maintenance, without interest, of a reserve for replacements; and

(d) Without exception for any remedies exercised by or available to Assignees, the immediate right, at Assignees' option, without further notice to Assignor and without the execution by Assignor of any further instrument, to (i) assume Assignor's rights, duties and obligations under the Tenant Leases and/or (ii) designate a replacement landlord or sub-landlord under any of the Tenant Leases, which replacement landlord or sub-landlord shall be selected in Assignees' sole discretion.

7.2 **Exculpation of Assignees**. The acceptance by Assignees of this Assignment, with all of the rights, powers, privileges and authority created hereby, shall not, prior to entry upon and taking possession of the Property by Assignees, be deemed or construed to constitute Assignees a "mortgagee in possession," nor thereafter or at any time or in any event obligate Assignees to appear in or defend any action or proceeding relating to the Tenant Leases, the Rents or the Property or to take any action hereunder or to expend any money or incur any expenses or perform or discharge any obligation, duty or liability under a Tenant Lease or to assume any obligation or responsibility for any security deposits or other deposits delivered to Assignor by a Tenant and not assigned and delivered to Assignees, nor shall Assignees be liable in any way for any injury or damage to persons or property sustained by any Person in or about the Property except to the extent caused by any Assignee's gross negligence or willful misconduct.

7.3 **No Waiver or Election of Remedies**.

(a) Neither the collection of the Rents and application as provided for in this Assignment, nor the entry upon and taking possession of the Property by Assignees, nor Assignees' right to assume, perform or enforce the Tenant Leases shall be deemed to cure or waive any Event of Default or waive, modify or affect any notice of default under the Master Lease or any Obligation Document or invalidate any act done pursuant to any such notice. The enforcement of any such rights or remedies by Assignees, once exercised, shall continue for so long as Assignees shall elect, notwithstanding that the collection and application of the Rents may have cured the original Event of Default. If Assignees shall thereafter elect to discontinue the exercise of any such rights or remedies hereunder, such rights or remedies may be reasserted at any time and from time to time following any subsequent Event of Default.

(b) The delay, omission or failure of Assignees to assert any of the terms, covenants or conditions of this Assignment for any period of time or at any time or times shall not be construed or deemed to be a waiver of any such right, and nothing herein contained nor anything done or omitted to be done by Assignees pursuant to this Assignment shall be deemed to be an election of remedies or a waiver by Assignees of any of their rights and remedies under any other Obligation Document or under the law. The right of the Assignees to collect and enforce the payment and performance of the Obligations and to enforce any security therefor may be exercised by the Assignees either prior to or simultaneously with or subsequent to any action taken hereunder. To the extent permitted by law, Assignees shall not be required to seek the appointment of a receiver or to institute any proceeding of any kind, possessory or otherwise, to secure or enjoy the full benefits of this Assignment.

7.4 **Appointment of Attorney-in-Fact**.

(a) Subject to the provisions of Section 7.4(c) hereof, Assignor hereby constitutes and appoints each Assignee the true and lawful attorney-in-fact, coupled with an interest, of Assignor and in the name, place and stead of Assignor to demand, sue for, attach, levy, recover and receive any premium or penalty payable upon the exercise by a Tenant under a Tenant Lease of a privilege of cancellation originally provided in such Tenant Lease and to give proper receipts, releases and acquittances therefor and, after deducting expenses of collection, to apply the net proceeds as a credit upon any portion of the Obligations selected by Assignees, notwithstanding the fact that such portion of the Obligations may not then be due and payable or that such portion of the Obligations is otherwise adequately secured; and Assignor does hereby authorize and direct any such Tenant to deliver such payment to Assignees in accordance with this Assignment, and Assignor hereby ratifies and confirms all that Assignees, as attorney-in-fact, shall do or cause to be done by virtue of the powers granted hereby. The foregoing appointment is irrevocable and continuing, and such rights, powers and privileges shall be exclusive in Assignees, their successors and assigns, so long as any part of the Obligations secured hereby remain unpaid and undischarged (other than contingent indemnification obligations for which no claim has been made).

(b) Subject to the provisions of Section 7.4(c) hereof, Assignor hereby constitutes and appoints each Assignee the true and lawful attorney-in-fact, coupled with an interest, of Assignor and in the name, place and stead of Assignor to subject and subordinate

at a time and from time to time a Tenant Lease or any part thereof to the lien and security interest of any mortgage, deed of trust or security agreement on, or to any ground lease of, the Property, or to request or require such subordination, where such reservation, option or authority was reserved to Assignor under a Tenant Lease, or in any case where Assignor otherwise would have the right, power or privilege so to do. The foregoing appointment is irrevocable and continuing, and such rights, powers and privileges shall be exclusive in Assignees, their successors and assigns, so long as any part of the Obligations secured hereby remain unpaid and undischarged, and Assignor hereby warrants that it has not at any time prior to the date hereof exercised a right, and Assignor hereby covenants not to exercise any such right, to subordinate a Tenant Lease to the lien of any mortgage, deed of trust or security agreement or to any ground lease.

(c) Assignees will exercise the rights set forth in Sections 7.4(a) and 7.4(b) hereof only during the continuation of an Event of Default.

7.5 **Assignor's Indemnities**. Assignor hereby agrees to indemnify and hold Assignees free and harmless from and against any and all liability, loss, costs, damage or expense which any Assignee may incur under or by reason of this Assignment, or for any action taken by any Assignee hereunder other than an Assignee's acts of gross negligence or willful misconduct, or by reason or in defense of any and all claims and demands whatsoever which may be asserted against any Assignee arising out of the Tenant Leases, including specifically, but without limitation, any claim by a Tenant of credit for the Rents paid to and received by Assignor, but not delivered to Assignees. In the event Assignees incur any such liability, loss, costs, damage or expense, the amount thereof, including reasonable attorneys' fees, with interest thereon at the highest rate of interest permitted by applicable state or federal law, shall be payable by Assignor to Assignees immediately, without demand, and shall be secured hereby and by all other security for the payment and performance of the Obligations.

ARTICLE VIII
Miscellaneous

8.1 **Bankruptcy**.

(a) Upon and during the continuation of an Event of Default hereunder, Assignees shall have the right to proceed in their own names or in the name of Assignor in respect of any claim, suit, action or proceeding relating to the rejection of any Tenant Lease, including, without limitation, the right to file and prosecute, to the exclusion of Assignor, any proofs of claim, complaints, motions, applications, notices and other documents, in any case in respect of the lessee under such Tenant Lease under the Bankruptcy Code.

(b) If there shall be filed by or against Assignor a petition under the Bankruptcy Code, and Assignor, as lessor under any Tenant Lease, shall determine to reject such Tenant Lease pursuant to Section 365(a) of the Bankruptcy Code, then Assignor shall give Assignees not less than ten (10) days' prior written notice of the date on which it shall apply to the bankruptcy court for authority to reject the Tenant Lease. Assignees shall have the right, but not the obligation, to serve upon Assignor within such ten (10) day period a notice stating that (i) Assignees demand that Assignor assume and assign the Tenant Lease to

Assignees pursuant to Section 365 of the Bankruptcy Code and (ii) Assignees covenant to cure or provide adequate assurance of future performance under the Tenant Lease. If Assignees serve upon Assignor the notice described in the preceding sentence, Assignor shall not seek to reject the Tenant Lease and shall comply with the demand provided for in clause (i) of the preceding sentence within thirty (30) days after the notice shall have been given, subject to the performance by Assignees of the covenant provided for in clause (ii) of the preceding sentence.

8.2 **Performance at Assignor's Expense**. The cost and expense of performing or complying with any and all of the Obligations shall be borne solely by Assignor, and no portion of such cost and expense shall be, in any way and to any extent, credited against any installment on or portion of the Obligations.

8.3 **Survival of Obligations**. Each and all of the Obligations shall survive the execution and delivery of the Obligation Documents and the consummation of the transactions called for therein, and shall continue in full force and effect until the Obligations shall have been paid, performed and discharged in full (other than contingent indemnification obligations for which no claim has been made).

8.4 **Necessary Action**. Each party shall perform any further acts and execute and deliver any documents that may be reasonably necessary to carry out the provisions of this Assignment.

8.5 **Recording and Filing**. Assignor will cause this Assignment and all amendments and supplements thereto and substitutions therefor to be recorded, filed, re-recorded and re-filed in such manner and in such places as Assignees shall reasonably request, and will pay all such recording, filing, re-recording and re-filing taxes, fees and other charges.

8.6 **Notices**. All notices, demands and other communications to be given or delivered under or by reason of the provisions of this Assignment shall be in writing and shall be deemed to have been given (a) when personally delivered, (b) when transmitted via telecopy (or other facsimile device) to the number set out below if the sender on the same day sends a confirming copy of such notice by a recognized overnight delivery service (charges prepaid), (c) the day following the day (except if not a Business Day then the next Business Day) on which the same has been delivered prepaid to a reputable national overnight air courier service or (d) the third Business Day following the day on which the same is sent by certified or registered mail, postage prepaid. Notices, demands and communications, in each case to the respective parties, shall be sent to the applicable address set forth below, unless another address has been previously specified in writing:

If to Assignor:
c/o LifePoint Health[, Inc.]
330 Seven Springs Way
Brentwood, TN 37027
Attention: General Counsel
Facsimile: (615) 920-8948

with a copy to:
Sidley Austin LLP
787 Seventh Avenue
New York, NY 10019

[redacted]

with a copy to: Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219
[redacted]

If to an Assignee: c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242
[redacted]

With a copy to: Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
420 20th Street North
1400 Wells Fargo Tower
Birmingham, Alabama 35203
[redacted]

or to such other address with respect to a party as such party notifies the other in writing as above provided.

8.7 **Assignment.** This Assignment is not assignable by Assignor without the prior written consent of Assignees. Any Assignee may at any time and without the consent of any Assignor assign all of its rights and obligations hereunder to any other Person.

8.8 **Binding Effect**. This Assignment shall bind and inure to the benefit of the parties and their successors and assigns; provided, however, that this Assignment shall not inure to the benefit of any assignee pursuant to an assignment which violates the terms of this Assignment.

8.9 **No Waiver**. Any provision of this Assignment or Exhibits hereto may be amended or waived only in a writing signed by the parties hereto. No waiver of any provision hereunder or any breach or default thereof shall extend to or affect in any way any other provision or prior or subsequent breach or default.

8.10 **Severability**. The parties agree that each provision of this Assignment shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Assignment or any application of this Assignment (as to any party or otherwise) is held to be prohibited by or invalid under applicable law, such provision or application shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Assignment or any other applications of this Assignment.

8.11 **Entire Agreement; Modification**. This Assignment, together with all exhibits, schedules and the other documents referred to herein, embody and constitute the entire understanding between the parties with respect to the subject matter hereof in any way. The parties

have not relied upon, and shall not be entitled to rely upon, any prior or contemporaneous agreements, understandings, representations or statements (oral or written) other than this Assignment in effecting the transactions contemplated herein or otherwise. Neither this Assignment, any exhibit or schedule attached hereto, nor any provision hereof or thereof may be modified or amended except by an instrument in writing signed by all of the parties hereto.

8.12 **Counterparts**. This Assignment may be executed in any number of counterparts, each of which shall be an original and all of which taken together shall constitute one and the same instrument.

8.13 **Governing Law**. THIS ASSIGNMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF [_____] (THE "APPLICABLE LAW") APPLICABLE TO CONTRACTS EXECUTED AND PERFORMED IN SUCH STATE, WITHOUT GIVING EFFECT TO CONFLICTS OF LAW PRINCIPLES.

8.14 **Jurisdiction And Venue**. ASSIGNEES AND ASSIGNOR CONSENT TO PERSONAL JURISDICTION IN THE STATE OF DELAWARE. ASSIGNEES AND ASSIGNOR AGREE THAT ANY ACTION OR PROCEEDING ARISING FROM OR RELATED TO THIS ASSIGNMENT SHALL BE BROUGHT AND TRIED EXCLUSIVELY IN THE STATE OR FEDERAL COURTS OF THE STATE OF DELAWARE. EACH OF THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY OBJECTION TO THE LAYING OF VENUE OF ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. ASSIGNEES AND ASSIGNOR EXPRESSLY ACKNOWLEDGE THAT THE FOREGOING CONSENT TO JURISDICTION AND VENUE IS JUST AND REASONABLE AND ASSIGNEES AND ASSIGNOR AGREE NOT TO SEEK REMOVAL OR TRANSFER OF ANY ACTION FILED BY ASSIGNEES OR ASSIGNOR IN SAID COURTS. FURTHER, ASSIGNEES AND ASSIGNOR IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY CLAIM THAT SUCH SUIT, ACTION OR PROCEEDING HAS BEEN BROUGHT IN AN INCONVENIENT FORUM. SERVICE OF ANY PROCESS, SUMMONS, NOTICE OR DOCUMENT BY CERTIFIED MAIL ADDRESSED TO A PARTY AT THE ADDRESS DESIGNATED PURSUANT TO SECTION 8.6 HEREOF SHALL BE EFFECTIVE SERVICE OF PROCESS AGAINST SUCH PARTY FOR ANY ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. A FINAL JUDGMENT IN ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT MAY BE ENFORCED IN ANY OTHER COURT TO WHOSE JURISDICTION ANY OF THE PARTIES IS OR MAY BE SUBJECT.

8.15 **Waiver of Jury Trial**. EACH OF THE PARTIES HERETO HEREBY KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVES THE RIGHT ANY SUCH PARTY MAY HAVE TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION BASED HEREON, OR ARISING OUT OF, UNDER, OR IN CONNECTION WITH THIS ASSIGNMENT AND ANY AGREEMENT CONTEMPLATED TO BE EXECUTED IN CONNECTION HEREWITH, OR ANY COURSE OF CONDUCT, COURSE OF DEALING, STATEMENTS (WHETHER VERBAL OR WRITTEN) OR ACTIONS OF ANY PARTY IN CONNECTION WITH THIS ASSIGNMENT OR SUCH AGREEMENTS.

8.16 **Usury**. If the Applicable Law is ever revised, repealed or judicially interpreted so as to render usurious any amount called for under any of the Obligation Documents, or if Assignees' exercise of the option to accelerate the maturity of the Obligations or if any prepayment by Assignor results in Assignor having paid any interest in excess of that permitted by law, then it is Assignor's and Assignees' express intent that all excess amounts theretofore collected by Assignees be credited on the principal balance of the Obligations (or, if the Obligations have been paid in full, refunded to Assignor), and the provisions of the Obligation Documents immediately be deemed reformed and the amounts thereafter collectible hereunder and thereunder reduced, so as to comply with the then applicable law, but so as to permit the recovery of the fullest amount otherwise called for hereunder or thereunder. All sums paid or agreed to be paid to Assignees for the use, forbearance or detention of the Obligations shall, to the extent permitted by applicable law, be amortized, prorated, allocated and spread throughout the full term of the Obligations until payment in full so that the rate or amount of interest on account of such Obligations does not exceed the usury ceiling from time to time in effect and applicable to the Obligations so long as debt is outstanding thereunder.

8.17 **Headings**. The Article, Section and Subsection entitlements hereof are inserted for convenience of reference only and shall in no way alter, modify or define, or be used in construing, the test of such Articles, Sections or Subsections.

8.18 **Joint Drafting**. The parties hereto and their respective counsel have participated in the drafting and redrafting of this Assignment and the general rules of construction which would construe any provisions of this Assignment in favor of or to the advantage of one party as opposed to the other as a result of one party drafting this Assignment as opposed to the other or in resolving any conflict or ambiguity in favor of one party as opposed to the other on the basis of which party drafted this Assignment are hereby expressly waived by all parties to this Assignment.

8.19 **Joint and Several Obligations**. Each Assignor (if there is more than one hereunder) shall be jointly and severally liable for all of the liabilities and obligations of the Assignor under this Assignment. Additionally, each Assignor acknowledges and agrees that all of the representations, warranties, covenants, obligations, conditions, agreements and other terms contained in this Assignment shall be applicable to and shall be binding upon and enforceable against any one or more of the Assignor.

[Signatures appear on following pages.]

IN WITNESS WHEREOF, the parties hereto have caused this Assignment of Rents and Leases to be executed by the duly authorized persons effective as of the date first above written.

ASSIGNOR:

[_____]

By: _____
Name:_____
Title:_____

SIGNED, SEALED AND DELIVERED IN
THE PRESENCE OF:

_____
Witness Number 1
Printed Name:_____

_____
Witness Number 2
Printed Name:_____

[NOTARY TO BE UPDATED BY LOCAL COUNSEL]

STATE OF [_____]
[_____] COUNTY

The foregoing instrument was acknowledged before me on this _____ day of _____, 20___, by _____, as the _____ of _____, on behalf of said corporation.

Witness my hand and official seal this the _____ day of _____, 20___.

(NOTARY SEAL)

_____
Notary Public in and for
the State of _____
My commission expires:_____

ASSIGNEES:

MPT OF DODGE CITY-LIMA, LLC
MPT OF HASTINGS-LIMA, LLC
MPT OF JOHNSTOWN-LIMA, LLC
MPT OF LANDER-LIMA, LLC
MPT OF LAWTON-LIMA, LLC
MPT OF MEYERSDALE-LIMA, LLC
MPT OF OTTUMWA-LIMA, LLC
MPT OF PALESTINE-LIMA, LLC
MPT OF RIVERTON-LIMA, LLC
MPT OF ROARING SPRINGS-LIMA, LLC

By: MPT Operating Partnership, L.P.,
a Delaware limited partnership.
Its: Sole Member of each above-referenced entity

By:_____
Name:_____
Title:_____

SIGNED, SEALED AND DELIVERED IN
THE PRESENCE OF:

_____
Witness Number 1
Printed Name:_____

_____
Witness Number 2
Printed Name:_____

[NOTARY TO BE UPDATED BY LOCAL COUNSEL]

STATE OF ALABAMA §
JEFFERSON COUNTY §

I, the undersigned, a notary public, do hereby certify that _____, as the _____ of MPT Operating Partnership, L.P., a Delaware limited partnership, as the Sole Member of each of MPT OF DODGE CITY-LIMA, LLC, MPT OF HASTINGS-LIMA, LLC, MPT OF JOHNSTOWN-LIMA, LLC, MPT OF LANDER-LIMA, LLC, MPT OF LAWTON-LIMA, LLC, MPT OF MEYERSDALE-LIMA, LLC, MPT OF OTTUMWA-LIMA, LLC, MPT OF PALESTINE-LIMA, LLC, MPT OF RIVERTON-LIMA, LLC, and MPT OF ROARING SPRINGS-LIMA, LLC, each a Delaware limited liability company, personally appeared before me this day and acknowledged the due execution of the foregoing instrument on behalf of said limited partnership, as the Sole Member of each such limited liability company.

Witness my hand and official seal this the _____ day of _____, 20___.

(NOTARY SEAL)

_____
Notary Public in and for
the State of Alabama
My commission expires:_____

Exhibit A

Legal Description

Schedule A

Tenant Leases

#	Landlord Name	Tenant Name	Address of Premises	Lease Agreement	Effective Date
1.					
2.					
3.					

Exhibit I

Form Bill of Sale and Assignment

See attached.

[TRANSFEROR NAME]
[CITY, STATE]

BILL OF SALE AND ASSIGNMENT

KNOW ALL MEN BY THESE PRESENTS that [_____], a [_____] ("**Transferor**"), for good and valuable consideration from **MPT OF [_____]-LIMA, LLC**, a Delaware limited liability company ("**Transferee**"), in hand paid (receipt, sufficiency and legal adequacy of which are hereby acknowledged), acting pursuant to that certain Real Property Asset Purchase Agreement, dated _____, 2019, by and among the Transferee, the Transferor, and certain of their respective Affiliates (as defined therein) (as amended, modified, or supplemented, the "**Purchase Agreement**"), does hereby bargain, sell, convey, assign, transfer and deliver unto Transferee, its successors and assigns, all of the right, title and interest of Transferor in and to all of the assets described below (collectively, the "**Assets**") (any capitalized terms used herein but not expressly defined herein shall have the meaning ascribed thereto in the Purchase Agreement):

(a) to the extent assignable, all rights in all intangible property relating exclusively to that certain parcel of land located in [CITY, COUNTY, STATE], and all related improvements thereon, as more particularly described on ***Exhibit A*** attached hereto (such parcel of land, together with all easements, rights of way and other appurtenances related thereto, and all improvements relating to such parcel, being herein referred to as the "**Real Property**"), including, but not limited to, zoning rights, licenses and indemnification or similar rights and all warranties, representations and guaranties affecting or inuring to the benefit of the Real Property or the owner thereof (including, without limitation, any indemnification or similar rights and warranties, representations and guaranties related to the Real Property);

(b) to the extent assignable, all right, title and interest in and to site plans, surveys, soil and substrata studies, architectural drawings, plans and specifications, inspection reports, engineering and environmental plans and studies, title reports, floor plans, landscape plans and other plans relating to the Real Property; and

(c) all right, title and interest of the Transferor in and to all causes of action, claims and rights in litigation (or which could result in litigation against any party) pertaining or relating to the Real Property.

Notwithstanding the foregoing, Assets herein conveyed shall not include any Excluded Assets (as defined in the Purchase Agreement).

This conveyance is being made subject to the terms of the Purchase Agreement, including, but not limited to the representations, warranties, covenants, agreements and indemnities of and by the Transferor relating to the Assets and such terms are incorporated herein by this reference. Nothing contained herein supersedes, alters, modifies, limits, qualifies or reduces any of the obligations, agreements, covenants, warranties or representations of and by

Transferor set forth in the Purchase Agreement. If any conflict exists between the terms of this Bill of Sale and the terms of the Purchase Agreement, the terms of the Purchase Agreement shall govern and control.

TO HAVE AND TO HOLD all of the Assets unto Transferee, its successors and assigns, to its own use forever.

Transferor agrees that it will, at any time and from time to time, upon the request of Transferee, do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged or delivered, all such further acts, deeds, assignments, transfers, conveyances and assurances as reasonably may be required to effect the assignment, transfer, grant and conveyance of the Assets conveyed hereby and to confirm unto Transferee, and to reduce to the possession of Transferee, title to and possession of any and all of such Assets.

This Bill of Sale shall inure to the benefit of and be binding upon the respective successors and assigns of Transferor and Transferee.

This Bill of Sale shall be governed by and construed in accordance with the domestic laws of the State of Delaware without giving effect to any choice or conflict of law provision or rule that would cause the application of the laws of any jurisdiction other than the State of Delaware.

[Signature appears on the following page.]

IN WITNESS WHEREOF, this Bill of Sale has been duly executed and delivered by a duly authorized officer of Transferor to Transferee on this _____ day of _____, 20___.

[_____]

By: _____
Name: _____
Title: _____

[PROPER FORM OF NOTARY TO BE CONFIRMED BY LOCAL COUNSEL]

ACKNOWLEDGMENT

STATE OF _____)
) SS
COUNTY OF_____)

On this ___ day of _____, 20___, before me, _____, a Notary Public, duly commissioned, qualified and acting, within and for said County and State, appeared in person the within named _____ to me personally well known or satisfactorily proven, who stated that he/she was the _____ of _____, a _____[corporation/limited liability company/limited partnership], and was duly authorized in his/her capacity to execute the foregoing instruments for and in the name and behalf of said [corporation/limited liability company/limited partnership], and further stated and acknowledged that he had so signed, executed and delivered said foregoing instrument for the consideration, uses and purposes therein mentioned and set forth.

IN TESTIMONY WHEREOF, I have hereunto set my hand and official seal this ___day of _____, 20___.

_____
Notary Public

My commission expires:_____

[SEAL]

Exhibit A

Legal Description

Exhibit J

Form Collateral Assignment of Leases

See attached.

_____ **County,** _____

COLLATERAL ASSIGNMENT OF LEASE

THIS COLLATERAL ASSIGNMENT OF LEASE (this "**Assignment**") is dated this ____ day of _____, 20____, by [_____ a _____] ("**Assignor**"), whose address for notice is c/o LifePoint Health[, Inc.], 330 Seven Springs Way, Brentwood, TN 37027, Attn: General Counsel, to and for the benefit of MPT OF [_____]-LIMA, LLC, a Delaware limited liability company (together with its successors and assigns, collectively, "**Assignee**"), whose address for notice is c/o MPT Operating Partnership, L.P., Suite 501, 1000 Urban Center Drive, Birmingham, Alabama 35242, Attention: Legal Department.

RECITALS:

A. Assignor, as tenant, is a party (either directly or as successor-by-assignment) to that certain lease attached as **EXHIBIT A** hereto (the "**Collateral Lease**").

B. Assignor, Assignee, and certain of their respective affiliates are parties to that certain Real Property Asset Purchase Agreement, dated _____, 2019 (as amended, modified and supplemented from time to time, the "**Purchase Agreement**"), pursuant to which Assignee acquired an interest in certain real property and improvements comprising that certain [hospital facility and related medical facilities] located in the _____ County, _____ (collectively, the "**Facility**").

C. Immediately thereafter, Assignee leased the Facility back to the Assignor pursuant to that certain Master Lease Agreement among Assignor, Assignee, and their respective affiliates (the "**Facility Lease**").

D. Assignor is required pursuant to the terms and conditions of the Purchase Agreement and the Facility Lease to assign to Assignee all of Assignor's right, title and interest in the Collateral Lease and the leased premises leased pursuant to the Collateral Lease.

NOW, THEREFORE, IN CONSIDERATION of the foregoing and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, Assignor hereby covenants and agrees as follows:

1. **Collateral Assignment**. In order to induce Assignee to consummate the transactions contemplated by the Purchase Agreement and to enter into the Facility Lease, for the purpose of securing payment and performance of the obligations of Assignor and certain of its affiliates to the Assignee and certain of its affiliates pursuant to the Facility Lease and the "Obligation Documents" under and as defined in the Facility Lease (collectively, the "**Obligation Documents**"), and as additional collateral therefor, Assignor hereby collaterally assigns and grants a security interest in and to, all of Assignor's right, title, and interest in and to the Collateral Lease, to Assignee.

2. **Collateral Lease**. Assignor represents and warrants to Assignee as of the date hereof that a true, correct and complete copy of the Collateral Lease (together with all supplements, amendments, or modifications thereto) is attached hereto as ***Exhibit A***.

3. **Performance Under Collateral Lease**. Subject to Section 3 below, Assignor shall perform its obligations under the Collateral Lease as set forth therein, and Assignor acknowledges that Assignee assumes no obligations or duties under or with respect to the Collateral Lease. ASSIGNOR HEREBY

ACKNOWLEDGES THAT ASSIGNOR IS SOLELY AND ABSOLUTELY LIABLE FOR PERFORMING ANY AND ALL OBLIGATIONS AND PAYING ANY AND ALL AMOUNTS DUE TO ANY LANDLORD, TENANT, OR OWNER UNDER THE COLLATERAL LEASE AND THAT ASSIGNEE SHALL HAVE NO LIABILITY FOR PERFORMING ANY SUCH OBLIGATION OR PAYING ANY SUCH AMOUNT.

4. **Remedies**. Assignor agrees that, upon the occurrence of an Event of Default (as defined in the Facility Lease), and without limiting any other remedies available to Assignee, Assignee has the immediate right, but not the obligation, upon written notice to Assignor and the landlord or lessor under the Collateral Lease (the "**Landlord**"), to (a) exercise in the name and right of Assignor, or in the name and right of Assignees as assignees hereunder, all rights, interest, obligations, and remedies of Assignor under the Collateral Lease, and/or (b) assume Assignor's rights, duties, and obligations under the Collateral Lease, and/or (c) designate a replacement tenant under the Collateral Lease (which replacement tenant shall be selected at Assignees' sole discretion). The Landlord shall have the right to conclusively rely on such written notice from Assignees.

5. **No Termination, Modification, or Transfer**. Assignor shall provide Assignee prompt written notice of any monetary default or material nonmonetary default under the Collateral Lease and shall not terminate the Collateral Lease without the prior written consent of Assignee. Assignor acknowledges and agrees that Assignee has no obligation to cure such breach or default and may elect to do so in its sole and absolute discretion. Assignor shall not assign, transfer, modify, amend, or change any material provision of the Collateral Lease, without Assignee's prior written consent, which consent will not be unreasonably withheld, conditioned, or delayed, it being agreed that if Assignee fails to respond within thirty (30) days following receipt thereof by Assignee, then such request shall be deemed approved. Notwithstanding the foregoing, Assignor shall have the right to assign its interest in the Collateral Lease to any Subsidiary (as defined in the Facility Lease) of Lima HoldCo, LLC, a Delaware limited liability company.

6. **Consents**. [Landlord has executed this Assignment for the limited purposes of consenting to the collateral assignment of the Collateral Lease to Assignee hereunder and acknowledging the rights of Assignee and its successors and assigns under this Assignment.][1]

7. **Notices**. All notices, demands and other communications to be given or delivered under or by reason of the provisions of this Assignment shall be in writing and shall be deemed to have been given (a) when personally delivered, (b) when transmitted via telecopy (or other facsimile device) to the number set out below if the sender on the same day sends a confirming copy of such notice by a recognized overnight delivery service (charges prepaid), (c) the day following the day (except if not a Business Day then the next Business Day) on which the same has been delivered prepaid to a reputable national overnight air courier service or (d) the third Business Day following the day on which the same is sent by certified or registered mail, postage prepaid. Notices, demands and communications, in each case to the respective parties, shall be sent to the applicable address set forth below, unless another address has been previously specified in writing:

IF TO ASSIGNOR:	c/o LifePoint Health[, Inc.] 330 Seven Springs Way Brentwood, TN 37027 Attention: General Counsel Facsimile: (615) 920-8948
WITH A COPY TO:	Sidley Austin LLP 787 Seventh Avenue

[1] To be included only for such Collateral Leases where consent of the Landlord is required.

New York, NY 10019
[redacted]

WITH A COPY TO:

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219
[redacted]

IF TO ASSIGNEE:

c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242
[redacted]

WITH A COPY TO:

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
420 20th Street North
1400 Wells Fargo Tower
Birmingham, Alabama 35203
[redacted]

or to such other address with respect to a party as such party notifies the other in writing as above provided. For purposes of this Assignment, "**Business Day**" shall mean each Monday, Tuesday, Wednesday, Thursday, and Friday that is not a day on which money centers in the City of New York, New York are authorized or obligated by law or executive order to close.

8. **Binding Effect**. This Assignment shall be binding upon Assignor's successors and assigns and shall inure to the benefit of Assignee and its successors and assigns.

9. **No Waiver**. No delay or omission by Assignee in exercising any right or power hereunder shall impair any such right or power or be construed as a waiver thereof or any acquiescence therein, nor shall any single or partial exercise of any such right or power preclude other or further exercises thereof, or the exercise of any other right or power of Assignee hereunder or under such other writings.

10. **Assignment**. Neither this Assignment, nor any rights or obligations hereunder, is assignable or delegable by Assignor. The rights and interest of Assignee hereunder shall be freely assignable in part or in full to any third party, and any assignee of Assignee shall succeed to and be possessed of the rights of Assignee hereunder.

11. **Governing Law**. THIS ASSIGNMENT SHALL BE GOVERNED BY THE LAWS OF THE STATE OF [_____] AND THE APPLICABLE LAWS OF THE UNITED STATES OF AMERICA.

[*Signature Appears on Following Page*]

IN WITNESS WHEREOF, Assignor has executed this Assignment or caused it to be executed on its behalf by its duly authorized representatives on the day and year first above written.

ASSIGNOR:

[_____]

By: _____
Name: _____
Title: _____

[VERIFY NOTARY COMPLIES IN STATE WHERE FACILITY IS LOCATED]

STATE OF _____

_____ COUNTY

On this _____ day of _____, 20___, before me, _____ (here insert name of the officer), Notary Public of said State, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his authorized capacity, and that by his signature on the instrument, the person, or the entity upon behalf of which said person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of _____ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

[AFFIX NOTARY SEAL]

_____
NOTARY PUBLIC
Printed Name:_____
My Commission Expires: _____

LANDLORD CONSENT

Landlord hereby executes this Assignment for the limited purpose of consenting to the collateral assignment of the Collateral Lease hereunder and acknowledging the rights of Assignee and its successors and assigns under this Assignment:

[_____]

By: _____
Name: _____
Title: _____

Landlord's Address for Notice: _____
_____

EXHIBIT A

Collateral Lease

See Attached.

Exhibit K

Form of Deed

See attached.

TO BE RECORDED IN [ ] COUNTY, [ ].

[Facility Name/Description]
(Leasehold Parcel)
[_____] County, [_____]

THIS DOCUMENT PREPARED BY AND
AFTER RECORDING RETURN TO:
Baker Donelson Bearman Caldwell &
Berkowitz PC
420 20th Street North
Suite 1400 Wells Fargo Tower
Birmingham, Alabama 35203
Attention: Lynn Reynolds

SPECIAL WARRANTY DEED[1]

KNOW ALL MEN BY THESE PRESENTS:

FOR AND IN CONSIDERATION of the sum of TEN DOLLARS ($10.00), and other good and valuable consideration, in hand paid, the receipt and sufficiency of which is hereby acknowledged, [_____], a [_____] (hereinafter referred to as "Grantor"), whose address is c/o LifePoint Health, [Inc.], 330 Seven Springs Way, Brentwood, TN 37027, Attention: General Counsel, does hereby grant, bargain, sell and convey unto **MPT OF [_____]-LIMA, LLC**, a Delaware limited liability company, having a mailing address of 1000 Urban Center Drive, Suite 501, Birmingham, AL 35242 (hereinafter referred to as "Grantee"), certain real estate in [_____] County, [_____], as follows:

See ***Exhibit A*** attached hereto and made
a part hereof by reference and incorporation

TO HAVE AND TO HOLD the Property, together with all of Grantor's interest in all buildings, structures, fixtures and all other improvements and structural components affixed to or located on the land described on Exhibit A, and (i) all rights and appurtenances pertaining (including without limitation, easements appurtenant) thereto, (ii) all easements or rights of Grantor in

[1] NTD: Subject to review and revision by local counsel for local recording requirements.

rights-of-ways, adjacent roads and streets or in any adjacent alleys, strips, detentions or gores of land, (iii) all licenses and permits related to the property, (iv) all of Grantor's right, title and interest in all water rights and water stock appurtenant to the subject real property, development rights, utility rights, deposits, and approvals, (vi) all of Grantor's right, title and interest, if any, in drainage facilities, utility facilities, water and wastewater service allocated to the property, and (vii) all of Grantor's right, title and interest, if any, in and to the oil, gas and other minerals in, under and that may be produced from the property (collectively the "Property"), and the appurtenances, estate, title and interest thereunto belonging, to the said Grantee and the said Grantee's successors and assigns forever.

Grantor further covenants and binds itself, its successors and representatives, to warrant and forever defend the title to the Property to said Grantee, and the Grantee's successors and assigns, against the lawful claims of all persons claiming by, through or under Grantor, but not otherwise; provided, however, this conveyance is subject to the permitted exceptions set forth on ***Exhibit B*** attached hereto and made a part hereof by reference and incorporation.

[Intentionally Left Blank]

[Signatures on Following Page]

IN WITNESS WHEREOF, Grantor has caused this instrument to be executed and delivered on the ___ day of _____, 20___.

GRANTOR:

[_____]

By: _____
Name: _____
Title: _____

[NOTARY TO BE UPDATED BY LOCAL COUNSEL]

STATE OF _____)
) SS.
COUNTY OF _____)

On _____, 20___, before me, the undersigned, a Notary Public in and for said County and State personally appeared [_____] known to me to be the identical person who executed the within and foregoing instrument, and who acknowledged himself to be the _____ of [_____], a [_____], and acknowledged to me that as such officer, being authorized to do so, executed the within instrument on behalf of said limited partnership, as the sole member of said limited liability company, for the purposes therein contained.

IN TESTIMONY WHEREOF, I have hereunto set my hand and official seal on this _____, 20___.

_____
Notary Public in and for said County and State
My Commission Expires:_____

Exhibit A

Legal Description

Exhibit B

Permitted Exceptions

1. Ad valorem taxes and assessments for the year 20[___], a lien but not yet due and payable.

2. [INSERT OTHERS AT TIME OF CLOSING]

Exhibit L

Form of Environmental Indemnification Agreement

See attached.

ENVIRONMENTAL INDEMNIFICATION AGREEMENT

THIS ENVIRONMENTAL INDEMNIFICATION AGREEMENT (this "Agreement") is made and entered into as of the ____ day of _____, 20____, by and among **LIMA HOLDCO, LLC**, a Delaware limited liability company ("Lima Holdco"); the entities listed on ***ANNEX A*** hereto under the heading "Lessees" (hereinafter be referred to, individually, as a "Lessee" and, collectively, as the "Lessees") (Lima Holdco and the Lessees shall hereinafter be referred to, individually, as an "Indemnitor" and, collectively, as the "Indemnitors"); and the entities listed on ***ANNEX A*** hereto under the heading "MPT Parties" (hereinafter be referred to, individually, as a "MPT Party" and, collectively, as the "MPT Parties"). The Indemnitors and the MPT Parties are herein sometimes referred to individually as a "Party" and collectively, as the "Parties."

W I T N E S S E T H:

WHEREAS, MPT Parties and Lessees have entered into that certain Master Lease Agreement, dated of even date herewith (as the same may be amended, modified and restated from time to time, the "Master Lease"), whereby MPT Parties are leasing (or, as applicable, subleasing) to Lessees, and Lessees are leasing (or, as applicable, subleasing) from MPT Parties, certain real property consisting of multiple parcels of land, the improvements now or hereafter located thereon (including any improvements consisting of multiple hospital facilities), the fixtures now or hereafter attached thereto and all easements, licenses, rights-of-way, appurtenances and other matters and items relating thereto, all as more particularly described in the Master Lease (collectively, the "Leased Property");

WHEREAS, Lima Holdco has entered into that certain Guaranty Agreement, dated of even date herewith, in favor of the Secured Parties (as the same may be amended, modified and restated from time to time, the "Guaranty"), pursuant to which Lima Holdco guarantees the payment and performance of all of the respective obligations and liabilities of the Lessees under the Master Lease;

WHEREAS, the Indemnitors acknowledge that, as a result of the above described transactions, the Indemnitors will derive direct and indirect benefits in the form of economies of scale, access to capital and other important strategic operational benefits and, accordingly, the Indemnitors have concluded that it is in their best interest to enter into this Agreement; and

WHEREAS, the MPT Parties have required the execution and delivery of this Agreement as a condition precedent to the transactions and agreements contemplated by the Master Lease.

NOW, THEREFORE, in consideration of the premises, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto do hereby agree as follows:

1. **Defined Terms**. Capitalized terms used herein and not expressly defined herein shall have the respective meanings ascribed to them in this Section 1.

"Affiliate" means, with respect to any Person (i) any Person that, directly or indirectly, controls or is controlled by or is under common control with such Person, (ii) any other Person

that owns, beneficially, directly or indirectly, 10% or more of the outstanding capital stock, shares or equity interests of such Person, or (iii) any officer, director, employee, shareholder, partner, member, manager or trustee of such Person or any Person controlling, controlled by or under common control with such Person (excluding trustees and persons serving in similar capacities who are not otherwise an Affiliate of such Person). For the purposes of this definition, "control" (including the correlative meanings of the terms "controlled by" and "under common control with"), as used with respect to any Person, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, through the ownership of voting securities or otherwise.

"Business Day" means each Monday, Tuesday, Wednesday, Thursday and Friday that is not a day on which money centers in the City of New York, New York are authorized or obligated by law or executive order to close.

"Default Interest" means a per annum interest rate equal to the Lease Rate (as defined in the Master Lease), plus Five Percent (5%).

"Environmental Law" means each federal, state, local and foreign law and regulation relating to pollution or protection of the environment including ambient air, surface water, ground water, land surface or subsurface strata, and natural resources, and including each law and regulation relating to emissions, discharges, releases or threatened releases of Hazardous Materials, or otherwise relating to the manufacturing, processing, distribution, use, treatment, generation, storage, containment (whether above ground or underground), disposal, transport or handling of Hazardous Materials, and each law and regulation with regard to record keeping, notification, disclosure and reporting requirements respecting Hazardous Materials, including, without limitation, the Resource Conservation and Recovery Act of 1976 ("RCRA"), the Comprehensive Environmental Response, Compensation and Liability Act of 1980 ("CERCLA"), as amended by the Superfund Amendments and Reauthorization Act of 1986 ("SARA"), the Hazardous Materials Transportation Act, the Federal Water Pollution Control Act, the Clean Air Act, the Clean Water Act, the Toxic Substances Control Act, the Safe Drinking Water Act, in each case as amended from time to time and all similar federal, state and local environmental statutes, ordinances and the regulations, orders, or decrees hereafter promulgated thereunder.

"Hazardous Materials" means any substance deemed hazardous under any Environmental Law, including without limitation, asbestos or any substance containing asbestos, the group of organic compounds known as polychlorinated biphenyls, flammable explosives, radioactive materials, infectious wastes, biomedical and medical wastes, chemicals known to cause cancer or reproductive toxicity, lead and lead-based paints, radon, and any items included in the definition of hazardous or toxic wastes, materials or substances under any Environmental Law.

"Governmental Entity" means any national, federal, regional, state, provincial, municipal, foreign or multinational court or other governmental or regulatory authority, administrative body or government, department, board, body, tribunal, instrumentality or commission of competent jurisdiction.

"Obligations" means, with respect to each Indemnitor, the respective obligations, duties and liabilities (as applicable) of each Indemnitor and its Affiliates under or pursuant to (a) the

Master Lease, (b) the Guaranty, (c) each of the other Obligation Documents, and (d) any and all renewals, increases, and substitutions, amendments and extensions of the liabilities or obligations described or referred to in subsections (a), (b), and (c) above.

"Obligation Documents" has the meaning set forth in the Master Lease.

"Person" means an individual, a corporation, a limited liability company, a general or limited partnership, an unincorporated association, a joint venture, a governmental entity or another entity or group.

"Taxes" means any and all taxes, charges, fees, levies or other assessments, including, without limitation, any and all income, gross receipts, excise, real and personal property (including leaseholds and interests in leaseholds), sales, use, occupation, transfer, license, ad valorem, gains, profits, gift, minimum estimated, alternative minimum, social security, unemployment, disability, premium, recapture, credit, payroll, withholding, severance, stamp, capital stock, value added leasing, franchise and other taxes or similar charges of any kind including any interest and penalties on or additions thereto or attributable to any failure to comply with any requirement regarding any tax return.

2. **Representations and Warranties**. The Indemnitors hereby jointly and severally represent and warrant to the MPT Parties as of the date hereof that (a) each Indemnitor has full legal right, power and authority to enter into this Agreement, to incur the obligations provided for herein, and to execute and deliver the same to the MPT Parties, (b) this Agreement has been duly executed and delivered by each Indemnitor and constitutes a valid and legally binding obligation of each Indemnitor, enforceable against each Indemnitor in accordance with its terms, subject to bankruptcy, insolvency, reorganization, and similar laws affecting the enforcement of creditor's rights or contractual obligations generally and, as to enforcement, to general principles of equity, regardless of whether applied in a proceeding at law or in equity; (c) no approval or consent of any foreign, federal, state, county, local or other governmental or regulatory body, and no approval or consent of any other Person is required in connection with the execution and delivery by any Indemnitor of this Agreement or the consummation and performance by any Indemnitor of the transactions contemplated hereby, except such approvals or consents which have been obtained on or prior to the date hereof; (d) the execution and delivery of this Agreement and the obligations created hereby have been duly authorized by all necessary proceedings on the part of each Indemnitor, and will not conflict with or result in the breach or violation of any of the terms or conditions of, or constitute (or with notice or lapse of time or both would constitute) a default under the governing documents of any Indemnitor, any instrument, contract or other agreement to which any Indemnitor is a party or by or to which any Indemnitor or its assets or properties are bound or subject; or any statute or any regulation, order, judgment or decree of any court or governmental or regulatory body; and (e) no Indemnitor is a party to or, to the knowledge of each Indemnitor, is threatened with any litigation or judicial, administrative or arbitration proceeding which, if decided adversely to any Indemnitor, would restrain, prohibit or materially delay the transactions contemplated hereby.

3. **Covenants**.

(a) No Indemnitor shall cause or permit any third party to cause the presence or continuation of any event, condition or circumstance which occurs or exists on, under, in, about

or from any portion of the Leased Property prior to or as of the date hereof, and which is not, or fails to remain, in compliance in all material respects with all Environmental Laws.

(b) No Indemnitor shall cause or permit any third party to cause the presence, use, generation, release, discharge, storage, disposal or transportation of any Hazardous Materials on, under, in, about or from any portion of the Leased Property, except in compliance in all material respects with all Environmental Laws.

(c) Each Indemnitor shall cause the Leased Property to be operated, used, maintained, and preserved in compliance in all material respects with all Environmental Laws.

4. **Indemnification**.

(a) Subject to the limitations set forth in this Section 4, each Indemnitor agrees, jointly and severally, to indemnify, defend and hold harmless each of the MPT Parties, the MPT Parties' Affiliates and their respective officers, directors, members, (general and limited) partners, shareholders, employees, agents and representatives (collectively, the "MPT Indemnified Parties") from and against all demands, claims, actions, losses, damages, liabilities, penalties, Taxes, costs and expenses (including, without limitation, attorneys' and accountants' fees, settlement costs, arbitration costs and any reasonable other expenses for investigating or defending any action or threatened action) (each, a "Claim") asserted against or incurred by any of the MPT Indemnified Parties related to or arising from events, conditions or circumstances which occurred or existed on, under, in, about, to or from any portion of the Leased Property prior to execution of this Agreement and that give rise to a liability under Environmental Laws, or any Claim arising out of or, in connection with or resulting from any breach under this Agreement (including any immaterial violations or breaches of this Agreement) or any liability under Environmental Laws arising out of the ownership or operation of any portion of the Leased Property (collectively, "MPT Damages"), except to the extent any such Claim or MPT Damages is found to have resulted from the bad faith, gross negligence or willful misconduct of any MPT Indemnified Party. All such MPT Damages shall be due and payable by Indemnitors, jointly and severally, within fifteen (15) days after any MPT Party's demand therefor.

(b) In the event any of the MPT Indemnified Parties has a claim for MPT Damages resulting from the assertion of liability by a third party, the MPT Parties will give Indemnitors notice of any such third-party claim, and Indemnitors shall be jointly and severally obligated to undertake the defense thereof by counsel of its own choosing. No Indemnitor shall settle any such third-party claim without the consent of the MPT Indemnified Parties, which consent shall not be unreasonably conditioned or delayed. Any of the MPT Parties may, by counsel, participate in such proceedings, negotiations or defense, at their own expense. The MPT Parties shall furnish to Indemnitors in reasonable detail such information as the MPT Parties may have with respect to such claim, including all records and materials that are reasonably required in the defense of such third-party claim. In the event that Indemnitors do not collectively defend the third-party claim in a diligent manner, any MPT Party will have the right (at Indemnitors' sole expense) to undertake the defense, compromise or settlement of such claim and any Indemnitor may elect to participate in such proceedings, negotiations or defense at any time at their own expense. No MPT Party shall settle any such third-party claim without the consent of Indemnitors, which consent shall not be unreasonably conditioned or delayed.

5. **Remedial Work**. In the event that any investigation or monitoring of site conditions or any clean-up, containment, restoration, repair, removal or other remedial work ("Remedial Work") is required (a) under any Environmental Laws, or (b) by any judicial, arbitral or administrative order, or (c) in order to comply with any agreements set forth in the Master Lease and the other Obligation Documents, Indemnitors shall be jointly and severally obligated to perform or cause to be performed such Remedial Work to the extent required to avoid any material violation of Environmental Laws; provided, that any Indemnitor may withhold commencement of such Remedial Work pending resolution of any good faith contest regarding the application, interpretation or validity of any law, regulation, order or agreement, subject to the requirements of Section 6 below. All Remedial Work shall be conducted (i) in a diligent and timely fashion by a qualified environmental consultant, (ii) pursuant to a written plan for the Remedial Work approved by any Governmental Entity with a legal or contractual right to such approval, (iii) with such insurance coverage pertaining to liabilities arising out of the Remedial Work as is then customarily maintained with respect to such activities, naming each MPT Party as an additional insured and (iv) only following receipt of all required permits, licenses or approvals, in the case of (i) through (iv) above, to the extent required by Environmental Laws. In addition, each Indemnitor shall submit to the MPT Parties promptly upon receipt or preparation, copies of any and all material reports, studies, analyses, correspondence, governmental comments or approvals, proposed removal or other Remedial Work contracts and similar information prepared or received by any Indemnitor in connection with any Remedial Work relating to any portion of the Leased Property. All costs and expenses of such Remedial Work shall be paid by Indemnitors, jointly and severally, including, without limitation, the charges of the Remedial Work performed by the contractors and the consulting environmental engineer, and any taxes or penalties assessed in connection with the Remedial Work. In the event the Indemnitors should fail to commence or cause to be commenced such Remedial Work, in violation of this Agreement, such Remedial Work, any of the MPT Parties may, but shall not be required to, cause such Remedial Work to be performed, and all costs and expenses thereof, or incurred in connection therewith shall be MPT Damages within the meaning of Section 4 above.

6. **Permitted Contests**. Notwithstanding any provision of this Agreement to the contrary, any Indemnitor may contest by appropriate action any Remedial Work requirement imposed by any Governmental Entity, and no MPT Party shall have the right to perform such required Remedial Work on any Indemnitor's behalf during the pendency of such contest, provided that (a) such Indemnitor has given the MPT Parties written notice that such Indemnitor is contesting or shall contest and such Indemnitor does in fact contest the application, interpretation or validity of the law, regulation, order or agreement pertaining to the Remedial Work in good faith, and (b) such contest shall not subject any MPT Party, or any of the MPT Parties' Affiliates or any assignee of all or any portion of any MPT Party's interest in any portion of the Leased Property to civil or criminal liability and does not jeopardize any such party's interest in any portion of the Leased Property.

7. **Reports and Claims**. Each Indemnitor shall deliver to MPT Parties copies of any material reports, analyses, correspondence, notices, licenses, approvals, orders or other written materials relating to any Remedial Work and the environmental condition of any portion of the Leased Property subject to Remedial Work promptly upon receipt, completion or delivery thereof. Each Indemnitor shall give notice to MPT Parties of any material claim, action, administrative proceeding (including, without limitation, informal proceedings) by any governmental agency or other third party involving MPT Damages or Remedial Work within

thirty (30) days of such claim or other demand first becoming known to any Indemnitor. Receipt of any such notice shall not be deemed to create any obligation on any MPT Party to defend or otherwise respond to any claim or demand.

8. **Notices.** All notices, demands and other communications to be given or delivered under or by reason of the provisions of this Agreement shall be in writing and shall be deemed to have been given (a) when personally delivered, (b) when transmitted via telecopy (or other facsimile device) to the number set out below if the sender on the same day sends a confirming copy of such notice by a recognized overnight delivery service (charges prepaid), (c) the day following the day (except if not a Business Day then the next Business Day) on which the same has been delivered prepaid to a reputable national overnight air courier service or (d) the third Business Day following the day on which the same is sent by certified or registered mail, postage prepaid. Notices, demands and communications, in each case to the respective parties, shall be sent to the applicable address set forth below, unless another address has been previously specified in writing:

IF TO ANY INDEMNITOR:

c/o LifePoint Health[, Inc.]
330 Seven Springs Way
Brentwood, TN 37027
Attention: General Counsel
Facsimile: (615) 920-8948

WITH A COPY TO:

Sidley Austin LLP
787 Seventh Avenue
New York, NY 10019
[redacted]

WITH A COPY TO:

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219
[redacted]

IF TO ANY MPT PARTY:

c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242
[redacted]

WITH A COPY TO:

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
420 20th Street North
1400 Wells Fargo Tower
Birmingham, Alabama 35203
[redacted]

or to such other address with respect to a party as such party notifies the other in writing as above provided.

9. **Defense of Claims**. If for any reason, any claim, action, notice, administrative proceeding (including, without limitation, informal proceedings) or other demand is made by any governmental agency or other third party which implicates MPT Damages or Remedial Work, each Indemnitor shall reasonably cooperate with the MPT Parties in any defense or other appropriate response to any such claim or other demand. Each Indemnitor's obligation to cooperate and right to participate in the defense or response to any such claim or demand shall not be deemed to limit or otherwise modify any Indemnitor's obligations under this Agreement. The MPT Parties shall give notice to Indemnitors of any claim or demand governed by this Section 9 at the time such claim or other demand first becomes known to the MPT Parties.

10. **Subrogation of Indemnity Rights**. If any Indemnitor fails to fully perform its obligations under Sections 4 and 5 above, each MPT Party shall be subrogated to any rights or claims any Indemnitor may have against any present, future or former MPT Parties, tenants or other occupants or users of the Leased Property, any portion thereof, or any adjacent or proximate properties, relating to the recovery of MPT Damages or the performance of Remedial Work.

11. **Binding Effect; Assignment.** This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns, except that neither this Agreement nor any of the rights, interests or obligations hereunder may be assigned or delegated by Indemnitor without the prior written consent of the MPT Parties. Notwithstanding the foregoing, any MPT Party may at any time and without the consent of any Indemnitor assign all of its rights and obligations hereunder to any other Person.

12. **Default Interest**. In addition to all other rights and remedies of any MPT Party against any Indemnitor as provided herein, or under applicable law, each Indemnitor shall be jointly and severally obligated to pay to the MPT Parties, immediately upon demand therefor, Default Interest on any MPT Damages and other payments required to be paid by any Indemnitor to any MPT Party under this Agreement which are not paid within fifteen (15) days after demand therefor. Default Interest shall be jointly and severally paid by Indemnitors from the date such payment becomes delinquent through and including the date of payment of such delinquent sums.

13. **Indemnitor Waiver**. The Indemnitors hereby waive any and all rights or defenses arising by reason of: (i) any "one action" or "anti-deficiency" law or any other law which may prevent the MPT Parties from bringing any action, including a claim for deficiency, against any one or more of the Indemnitors, before or after the MPT Parties commencement or completion of any foreclosure or similar action or actions, either judicially or by exercise of a power of sale; (ii) any election of remedies by the MPT Parties which destroys or otherwise adversely affects any one or more of the Indemnitors' subrogation rights or any such Indemnitor's rights to proceed against any Person for reimbursement, including without limitation, any loss of rights the Indemnitors may suffer by reason of any law limiting, qualifying, or discharging the Obligations, if any, (iii) any disability or other defense of any other Person, other than payment in full in legal tender, of the Obligations; (iv) any right to claim discharge of the Obligations on the basis of

unjustified impairment of any collateral for the Obligations; (v) any statute of limitations; (vi) any defenses given to guarantors, sureties, and/or co-makers at law or in equity other than actual payment and performance of the Obligations; or (vii) any action by the MPT Parties to enforce their respective rights and remedies under the Master Lease and the other Obligation Documents. If payment on the Obligations is made by any third party, and thereafter the MPT Parties are forced to remit the amount of that payment under any federal or state bankruptcy law or law for the relief of debtors, the Obligations shall be considered unpaid for the purpose of enforcement of this Agreement and the other Obligation Documents against the Indemnitors.

14. **Governing Law; Jurisdiction and Venue; Waiver of Jury Trial**.

(a) This Agreement shall be governed by and construed in accordance with the laws of the State of Delaware applicable to contracts executed and performed in such State, without giving effect to conflicts of law principles.

(b) THE PARTIES HERETO CONSENT TO PERSONAL JURISDICTION IN THE STATE OF DELAWARE. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, THE PARTIES AGREE THAT ANY ACTION OR PROCEEDING ARISING FROM OR RELATED TO THIS AGREEMENT SHALL BE BROUGHT AND TRIED EXCLUSIVELY IN THE STATE OR FEDERAL COURTS OF DELAWARE. EACH OF THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY OBJECTION TO THE LAYING OF VENUE OF ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. THE PARTIES EXPRESSLY ACKNOWLEDGE THAT DELAWARE IS A FAIR, JUST AND REASONABLE FORUM AND AGREE NOT TO SEEK REMOVAL OR TRANSFER OF ANY ACTION FILED BY THE OTHER PARTIES IN SAID COURTS. FURTHER, THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY CLAIM THAT SUCH SUIT, ACTION OR PROCEEDING HAS BEEN BROUGHT IN AN INCONVENIENT FORUM. SERVICE OF ANY PROCESS, SUMMONS, NOTICE OR DOCUMENT BY CERTIFIED MAIL ADDRESSED TO A PARTY AT THE ADDRESS DESIGNATED PURSUANT TO SECTION 8 SHALL BE EFFECTIVE SERVICE OF PROCESS AGAINST SUCH PARTY FOR ANY ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. A FINAL JUDGMENT IN ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT MAY BE ENFORCED IN ANY OTHER COURT TO WHOSE JURISDICTION ANY OF THE PARTIES IS OR MAY BE SUBJECT.

(c) TO THE MAXIMUM EXTENT PERMITTED BY LAW, THE PARTIES HEREBY KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVE THE RIGHT TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION BASED HEREON, ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT, OR ANY COURSE OF CONDUCT, COURSE OF DEALING, STATEMENT (WHETHER VERBAL OR WRITTEN) OR ACTION OF ANY PARTY OR ANY EXERCISE OF ANY PARTY OF THEIR RESPECTIVE RIGHTS HEREUNDER OR IN ANY WAY RELATING TO THIS AGREEMENT OR THE COLLATERAL (INCLUDING ANY CLAIM OR DEFENSE ASSERTING THAT THIS AGREEMENT WAS FRAUDULENTLY INDUCED OR IS OTHERWISE VOID OR VOIDABLE). THIS WAIVER IS A MATERIAL INDUCEMENT FOR THE MPT PARTIES TO ENTER INTO THIS AGREEMENT AND THE OTHER OBLIGATION DOCUMENTS.

15. **Delivery by Electronic Transmission**. This Agreement and any signed agreement entered into in connection herewith or contemplated hereby, and any amendments hereto or thereto, to the extent signed and delivered by means of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail, shall be treated in all manner and respects as an original contract and shall be considered to have the same binding legal effects as if it were the original signed version thereof delivered in person. At the request of any party hereto or to any such contract, each other party hereto or thereto shall re-execute original forms thereof and deliver them to all other parties. No party hereto or to any such contract shall raise the use of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail to deliver a signature or the fact that any signature or contract was transmitted or communicated through the use of facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail as a defense to the formation of a contract and each such party forever waives any such defense

16. **No-Third Party Beneficiaries**. Nothing expressed or referred to in this Agreement will be construed to give any Person other than the parties to this Agreement any legal or equitable right, remedy, or claim under or with respect to this Agreement or any provision of this Agreement.

17. **No Waiver**. Any provision of this Agreement or Exhibits hereto may be amended or waived only in a writing signed by the parties hereto. No waiver of any provision hereunder or any breach or default thereof shall extend to or affect in any way any other provision or prior or subsequent breach or default.

18. **Necessary Action**. Each party shall perform any further acts and execute and deliver any documents that may be reasonably necessary to carry out the provisions of this Agreement.

19. **Counterparts**. This Agreement may be executed in multiple counterparts, any one of which need not contain the signature of more than one party, but all such counterparts taken together shall constitute one and the same instrument.

20. **Joint Drafting**. The parties hereto and their respective counsel have participated in the drafting and redrafting of this Agreement and the general rules of construction which would construe any provisions of this Agreement in favor of or to the advantage of one party as opposed to the other as a result of one party drafting this Agreement as opposed to the other or in resolving any conflict or ambiguity in favor of one party as opposed to the other on the basis of which party drafted this Agreement are hereby expressly waived by all parties to this Agreement.

21. **Joint and Several Obligations**. The Indemnitors shall be jointly and severally liable for all of the liabilities and obligations of the Indemnitors under this Agreement. Additionally, each Indemnitor acknowledges and agrees that all of the representations, warranties, covenants, obligations, conditions, agreements and other terms contained in this Agreement shall be applicable to and shall be binding upon and enforceable against any one or more or all of the Indemnitors.

22. **Entire Agreement**. This Agreement and the documents referred to herein contain the complete agreement between the parties hereto and supersede any prior understandings, agreements or representations by or between the parties, written or oral, which may have related to the subject matter hereof in any way.

23. **Severability**. Whenever possible, each provision of this Agreement shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Agreement, unless the severance of such provision would be in opposition to the parties' intent with respect to such provision.

24. **Representatives**.

(a) The Indemnitors hereby appoint Lima Holdco as their duly authorized agent and representative (the "Indemnitor Representative") to take all actions and enforce all rights of the Indemnitors under this Agreement, including, without limitation, (i) giving and receiving any notice or instruction permitted or required under this Agreement; (ii) interpreting all of the terms and provisions of this Agreement; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with the MPT Parties under this Agreement; (v) conducting negotiations and dealing with the MPT Parties under this Agreement; and (vi) taking any other actions on behalf of the Indemnitors relating to the Indemnitors' rights, claims, duties and obligations under this Agreement. In the performance of the MPT Parties' duties and obligations hereunder, the MPT Parties shall be authorized and permitted to correspond and transact with the Indemnitor Representative on behalf of all the Indemnitors and shall be entitled to rely upon any document or instrument executed and delivered by the Indemnitor Representative.

(b) The MPT Parties hereby appoint MPT of Johnstown-Lima, LLC as their duly authorized agent and representative (the "MPT Representative") to take all actions and enforce all rights of the MPT Parties under this Agreement, including, without limitation, (i) giving and receiving any notice or instruction permitted or required under this Agreement; (ii) interpreting all of the terms and provisions of this Agreement; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with the Indemnitors under this Agreement; (v) conducting negotiations and dealing with the Indemnitors under this Agreement; and (vi) taking any other actions on behalf of the MPT Parties relating to the MPT Parties' rights, claims, duties and obligations under this Agreement. In the performance of the Indemnitors duties and obligations hereunder, the Indemnitors shall be authorized and permitted to correspond and transact with the MPT Representative on behalf of all the MPT Parties and shall be entitled to rely upon any document or instrument executed and delivered by the MPT Representative.

[***Signatures appear on the following pages.***]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the day and year first written above.

LIMA HOLDCO, LLC

By:_____
Name:_____
Title:_____

DODGE CITY HEALTHCARE GROUP, LLC
d/b/a Western Plains Medical Complex

By:_____
Name:_____
Title:_____

DLP CONEMAUGH MINERS MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

DLP CONEMAUGH MEMORIAL MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

SOUTHWESTERN MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

DLP CONEMAUGH MEYERSDALE MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

RCHP-OTTUMWA, LLC
d/b/a Ottumwa Regional Health Center

By:_____
Name:_____
Title:_____

PALESTINE PRINCIPAL HEALTHCARE LIMITED PARTNERSHIP
d/b/a Palestine Regional Medical Center

By:_____
Name:_____
Title:_____

PALESTINE-PRINCIPAL G.P., INC.

By:_____
Name:_____
Title:_____

RIVERTON MEMORIAL HOSPITAL, LLC
d/b/a SageWest Health Care - Riverton Campus and SageWest Health Care - Lander Campus

By:_____
Name:_____
Title:_____

NASON MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

MPT PARTIES:

MPT OF DODGE CITY-LIMA, LLC
MPT OF HASTINGS-LIMA, LLC
MPT OF JOHNSTOWN-LIMA, LLC
MPT OF LANDER-LIMA, LLC
MPT OF LAWTON-LIMA, LLC
MPT OF MEYERSDALE-LIMA, LLC
MPT OF OTTUMWA-LIMA, LLC
MPT OF PALESTINE-LIMA, LLC
MPT OF RIVERTON-LIMA, LLC
MPT OF ROARING SPRINGS-LIMA, LLC

By: MPT Operating Partnership, L.P.
Its: Sole Member of each above-referenced entity

By:_____
Name:_____
Title:_____

ANNEX A
Lessees and MPT Parties

LESSEES

1. DODGE CITY HEALTHCARE GROUP, LLC
2. DLP CONEMAUGH MINERS MEDICAL CENTER, LLC
3. DLP CONEMAUGH MEMORIAL MEDICAL CENTER, LLC
4. SOUTHWESTERN MEDICAL CENTER, LLC
5. DLP CONEMAUGH MEYERSDALE MEDICAL CENTER, LLC
6. RCHP-OTTUMWA, LLC
7. PALESTINE PRINCIPAL HEALTHCARE LTD. PARTNERSHIP
8. PALESTINE-PRINCIPAL G.P., INC.
9. RIVERTON MEMORIAL HOSPITAL, LLC
10. NASON MEDICAL CENTER, LLC

LESSORS

1. MPT OF DODGE CITY-LIMA, LLC
2. MPT OF HASTINGS-LIMA, LLC
3. MPT OF JOHNSTOWN-LIMA, LLC
4. MPT OF LANDER-LIMA, LLC
5. MPT OF LAWTON-LIMA, LLC
6. MPT OF MEYERSDALE-LIMA, LLC
7. MPT OF OTTUMWA-LIMA, LLC
8. MPT OF PALESTINE-LIMA, LLC
9. MPT OF RIVERTON-LIMA, LLC
10. MPT OF ROARING SPRINGS-LIMA, LLC

Exhibit M

Form of Joinder to Existing Intercreditor Agreement

See attached.

JOINDER TO
INTERCREDITOR AGREEMENT
(Future MPT/Holdings Transaction)

THIS JOINDER TO INTERCREDITOR AGREEMENT is dated this [•] day of [•], 2019 (this "Joinder"), by and among MPT OF HARTSVILLE-CAPELLA, LLC, MPT OF MCMINNVILLE-CAPELLA, LLC, MPT OF KERSHAW-CAPELLA, LLC, MPT OF HOT SPRINGS-CAPELLA, LLC, MPT OF LEWISTON-RCCH, LLC, MPT OF OLYMPIA-CAPELLA HOSPITAL, LLC and MPT OF PASCO-RCCH, LLC (together with their successors and assigns, collectively, the "Existing MPT Lessors"), each a Delaware limited liability company, WILMINGTON TRUST, NATIONAL ASSOCIATION, as notes collateral agent under the Leasehold Mortgagee Notes Collateral Agreement (as defined in the Intercreditor Agreement (as defined below)) and its successors and assigns ("Leasehold Notes Mortgagee"), CITIBANK, N.A., as collateral agent under the First Lien Credit Agreement (as defined in the Intercreditor Agreement (as defined below)) and its successors and assigns ("Leasehold Term Mortgagee", and together with the Leasehold Notes Mortgagee, the "Leasehold Mortgagee"), and the entities set forth on the signature pages hereto as "New MPT Lessors" (the "New MPT Lessors") with respect to certain leasing and financing arrangements with LIFEPOINT HEALTH, INC., a Delaware corporation ("Holdings"), and its indirect subsidiaries that are MPT Operators (as defined in the Intercreditor Agreement).

WITNESSETH:

WHEREAS, the Existing MPT Lessors, Leasehold Notes Mortgagee, Leasehold Term Mortgagee and Holdings are parties to that certain Intercreditor Agreement, dated as of April 29, 2016 (as the same has been or hereafter may be modified, amended or restated or joined from time to time, the "Intercreditor Agreement"), pursuant to which Leasehold Notes Mortgagee, Leasehold Term Mortgagee and the Existing MPT Lessors agreed and clarified their respective remedies and interests and certain other rights and priorities as provided therein;

WHEREAS, certain subsidiaries of Holdings set forth on the signature pages hereto as the "New MPT Operators" (the "New MPT Operators") have entered into a master lease (the "New Master Lease") with the New MPT Lessors;

WHEREAS, pursuant to Section 2.6(c) of the Intercreditor Agreement, Future MPT/Holdings Transactions shall be joined to the Intercreditor Agreement, with the lessors thereunder becoming MPT Parties and the lessees thereunder becoming MPT Operators; and

WHEREAS, the parties hereto desire to agree to join the New Master Lease to the Intercreditor Agreement as a Future MPT/Holdings Transaction and to acknowledge the New MPT Lessors as MPT Parties and the New MPT Operators as MPT Operators;

NOW, THEREFORE, in consideration of mutual covenants, conditions and agreements herein contained, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending to be legally bound, do hereby covenant and agree as follows:

1. **Capitalized Terms**. Capitalized terms used and not otherwise defined in this Joinder shall have the meanings ascribed thereto in the Intercreditor Agreement.

2. **Joinders, Additions and Amendments**. Pursuant to Section 2.6(c) of the Intercreditor Agreement, the parties hereto hereby agree as follows:

(a) New Master Lease. The New Master Lease is joined and added as a "Future MPT/Holdings Transaction" under the Intercreditor Agreement.

(b) New MPT Parties. Each New MPT Lessor is joined and added as a "MPT Party" under the Intercreditor Agreement.

(c) New MPT Operators. Each New MPT Operator is joined and added as a "MPT Operator" under the Intercreditor Agreement.

(d) MPT Documents. The New Master Lease and all other related documents and agreements executed by the New MPT Lessors, the New MPT Operators, and their respective affiliates are joined and added as "MPT Documents" under the Intercreditor Agreement.

(e) MPT Collateral. The "Reserves" under and as defined in the New Master Lease are joined and added as "MPT Collateral" under the Intercreditor Agreement.

3. **Binding Effect**. This Joinder shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns.

4. **Ratification**. Except as expressly modified hereby, the parties hereby confirm and ratify the Intercreditor Agreement in all respects.

5. **Governing Law**. This Joinder shall be governed as to validity, interpretations, enforcement and effect by the laws of the State of New York without giving effect to conflicts of law principles thereunder.

6. **Severability**. This Joinder, including the exhibits attached hereto, and other written agreements executed and delivered in connection herewith by the parties, shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Joinder is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Joinder, unless the severance of such provision would be in opposition to the parties' intent with respect to such provision.

7. **Counterparts**. This Joinder may be executed in multiple counterparts, any one of which need not contain the signature of more than one party, but all such counterparts taken together shall constitute one and the same instrument.

[*Remainder of page intentionally left blank*]

IN WITNESS WHEREOF, the parties hereto have executed or caused their duly authorized representatives to execute this Joinder as of the date first above written.

EXISTING MPT LESSORS:

MPT OF HARTSVILLE-CAPELLA, LLC
MPT OF MCMINNVILLE-CAPELLA, LLC
MPT OF KERSHAW-CAPELLA, LLC
MPT OF HOT SPRINGS-CAPELLA, LLC
MPT OF LEWISTON-RCCH, LLC
MPT OF PASCO-RCCH, LLC

By: MPT Operating Partnership, L.P.
Its: Sole Member of each above-referenced entity

By:_____
Name: _____
Title: _____

MPT OF OLYMPIA-CAPELLA HOSPITAL, LLC

By: MPT Development Services, Inc.
Its: Sole Member

By:_____
Name: _____
Title: _____

NEW MPT LESSORS:

[SIGNATURE BLOCKS TO COME]

NEW MPT OPERATORS:

[SIGNATURE BLOCKS TO COME]

MPT OPERATORS:

HARTSVILLE, LLC

By: Carolina Pines Holdings, LLC
Its: Managing Member

By:_____
Name: Howard T. Wall III
Title: Executive Vice President, Chief Administrative Officer and Secretary

KERSHAW HOSPITAL, LLC
WILLAMETTE VALLEY MEDICAL CENTER, LLC
ST. JOSEPH HOSPITAL, LLC

By:_____
Name: Howard T. Wall III
Title: Executive Vice President, Chief Administrative Officer and Secretary

HOT SPRINGS NATIONAL PARK HOSPITAL HOLDINGS, LLC

By: NPMC Holdings, LLC
Its: Managing Member

By:_____
Name: Howard T. Wall III
Title: Executive Vice President, Chief Administrative Officer and Secretary

LOURDES HOSPITAL, LLC

By:_____
Name: Howard T. Wall III
Title: Executive Vice President, Chief Administrative Officer and Secretary

COLUMBIA CAPITAL MEDICAL CENTER LIMITED PARTNERSHIP

By: Capital Medical Center Partner, LLC
Columbia Olympic Management, Inc.
WPC Holdco, LLC
Its: General Partners

By:_____
Name: Howard T. Wall III
Title: Executive Vice President, Chief Administrative Officer and Secretary

[Signature page to Joinder to Intercreditor Agreement (Future MPT/Holdings Transaction)]

COLUMBIA CAPITAL MEDICAL CENTER LIMITED PARTNERSHIP

By: Capital Medical Center Partner, LLC
Columbia Olympic Management, Inc.
WPC Holdco, LLC
Its: General Partners

By:_____
Name: Howard T. Wall III
Title: Executive Vice President, Chief Administrative Officer and Secretary

[Signature page to Joinder to Intercreditor Agreement (Future MPT/Holdings Transaction)]

LIFEPOINT HEALTH, INC., a Delaware corporation

By:_____
Name: _____
Title: _____

LEASEHOLD NOTES MORTGAGEE:
WILMINGTON TRUST, NATIONAL ASSOCIATION, in its capacity as Notes Collateral Agent

By:_____
Name: _____
Title: _____

[Signature page to Joinder to Intercreditor Agreement (Future MPT/Holdings Transaction)]

LEASEHOLD TERM MORTGAGEE:
CITIBANK, N.A., in its capacity as Collateral Agent under the First Lien Credit Agreement

By:_____
Name: _____
Title: _____

[Signature page to Joinder to Intercreditor Agreement (Future MPT/Holdings Transaction)]

Exhibit N

Persons specified for purposes of Knowledge of Lima Parties

1. David M. Dill
2. Michael S. Coggin
3. Victor E. Giovanetti
4. Jennifer C. Peters
5. Martin Rash

Exhibit O

Form of LifePoint Noncompetition Agreement

See attached.

NON-COMPETITION AGREEMENT

THIS NON-COMPETITION AGREEMENT (this "Agreement") is made and entered into this ___ day of _____, 20_____, by and among [LIFEPOINT HEALTH, INC., a Delaware corporation][1] ("LifePoint"); the entities listed on ***ANNEX A*** hereto under the heading "MPT Parties" (hereinafter be referred to, individually, as an "MPT Party" and, collectively, as the "MPT Parties"). LifePoint and the MPT Parties are herein sometimes referred to individually as a "Party" and collectively, as the "Parties."

W I T N E S S E T H:

WHEREAS, MPT Parties and certain subsidiaries of LifePoint (each a "Lessee" and collectively the "Lessees") have entered into that certain Master Lease Agreement, dated of even date herewith (as the same may be amended, modified and restated from time to time with LifePoint's written consent, the "Master Lease"), whereby MPT Parties are leasing (or, as applicable, subleasing) to Lessees, and Lessees are leasing (or, as applicable, subleasing) from MPT Parties, certain real property consisting of multiple parcels of land, the improvements now or hereafter located thereon (including any improvements consisting of multiple hospital facilities), the fixtures now or hereafter attached thereto and all easements, licenses, rights-of-way, appurtenances and other matters and items relating thereto, all as more particularly described in the Master Lease (collectively, the "Leased Property");

WHEREAS, LifePoint hereby acknowledges that, as a result of the above described transactions, LifePoint and/or the Lessees will derive direct and indirect benefits in the form of economies of scale, access to capital and other important strategic operational benefits and, accordingly, LifePoint has concluded that it is in its best interests to enter into this Agreement; and

WHEREAS, as a condition to the closing of the transactions contemplated by and referenced in the Master Lease, and as an inducement to cause the MPT Parties to enter into and close such transactions, LifePoint has agreed to enter into and to be bound by the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the premises, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto do hereby agree as follows:

1. **Capitalized Terms; Definitions**. Any capitalized term or phrase which is used herein (including the Recitals) and not expressly defined herein shall have the meaning ascribed to such term or phrase in the Master Lease. For the purposes of this Agreement, (i) the term "Wholly-Owned Subsidiary" shall mean "With respect to any Person (herein referred to as the "parent"), any corporation, partnership, association or other business entity of which securities or other ownership interests representing 100% of the economic interests and (x) 100% of the ordinary

---

[1] **Note to Draft**: To be updated if conversion has occurred.

voting power (or board representation, including through block voting arrangements) or (y) 100% of the general partnership interests are, at the time any determination is being made, directly or indirectly, owned or held by the parent or one or more wholly owned subsidiaries of the parent", and the term "Non-Wholly-Owned Subsidiary" shall mean "Any Subsidiary that is not a Wholly-Owned Subsidiary."

2. **Non-Competition Provisions of LifePoint**.

(a) No Competing Business. LifePoint agrees that while the Master Lease remains in effect and, if the Master Lease is terminated due to an "Event of Default" thereunder, then for a period of three (3) years thereafter (the "LifePoint Noncompete Period"), neither LifePoint nor any of its Wholly-Owned Subsidiaries shall, directly or indirectly, acquire, finance, guarantee indebtedness, own, lease, manage, develop or provide services in connection with the acquisition, ownership, operation or development of any real estate located within ten (10) miles of any point on or within the Leased Property, which real estate is used in a Competing Business (other than for the avoidance of doubt a Permitted Activity) (a "Restricted Activity"), *provided, however,* that the restrictions in this Section 2(a) shall not apply to real estate: described on ***ANNEX B*** hereto ("Non-Core Real Estate") with respect to Restricted Activities in which Lima HoldCo or any of its Subsidiaries is performing, conducting or otherwise involved as of the date hereof or otherwise reasonably related to the divestiture of such Non-Core Real Estate. Any violation of the provisions of this Section 2 shall suspend and toll the LifePoint Noncompete Period for the duration of such violation. The term "Competing Business" means any healthcare business which involves the operation of a facility other than on the Leased Property in which general acute care services, long term care services, rehabilitation or skilled nursing services are provided; provided, however, that the foregoing shall not prohibit LifePoint or its Affiliates from conducting, performing or otherwise being involved in any Restricted Activity that will not as of the time such Restricted Activity is commenced have a material and adverse effect on the relevant Market of the effected Facility or the ability of any Lessee to perform its obligations under the Master Lease, in each case, as determined in the reasonable discretion of the MPT Parties (a "Permitted Activity"). The term "Market" shall mean "with respect to (a) any of the Johnstown Facility, the Meyersdale Facility, the Hastings Facility, or the Roaring Springs Facility, the business conducted by all such Facilities taken together as a single market, (b) any of the Lander Facility or the Riverton Facility, the business conducted by all such Facilities taken together as a single market, and (c) with respect to any other Facility, the business conducted by such Facility is considered a single market." Notwithstanding the foregoing, in no event shall the provisions of this Section 2(a) apply to any MPT Party or any other Person that, directly or indirectly, controls or is under common control with any such MPT Party. For the avoidance of doubt, the prohibition on Restricted Activities set forth herein shall not apply with respect to direct or indirect Non-Wholly-Owned Subsidiaries of LifePoint; provided, however, LifePoint shall not, and shall not permit its Wholly-Owned Subsidiaries to, vote any Equity Interest it holds in a Non-Wholly Owned Subsidiary in favor of, otherwise approve in its capacity as a holder of such Equity Interests, or voluntarily fund any Restricted Activity that would otherwise be prohibited with respect to a Wholly-Owned Subsidiary except to the extent in its good faith judgement such party is required to do so by applicable Law (including fiduciary duties) or contract. Furthermore, to the extent that LifePoint or any of its Wholly-Owned Subsidiaries seeks to become a holder of Equity Interests in any additional Non-Wholly Owned Subsidiary in the future, in connection with the initial acquisition of such Equity Interests, it shall negotiate in

good faith with any other current or prospective third party holders of Equity Interests in such entity so that the governing documents of such entity permit Lima HoldCo to treat such entity as a Wholly-Owned Subsidiary hereunder; provided that the parties hereto acknowledge and agree that nothing herein shall prohibit LifePoint or its Subsidiaries from entering into, adopting, approving or otherwise being bound by any such governing documents inconsistent with the foregoing or prevent Lima HoldCo or its Wholly-Owned Subsidiaries from becoming a holder of Equity Interests in any Non-Wholly Owned Subsidiary.

(b) Injunctive or Equitable Relief. LifePoint agrees that the restrictions contained herein are reasonable and necessary to protect the legitimate interests of the MPT Parties, and that any violation of the provisions would result in damages which cannot be adequately compensated by money alone. LifePoint hereby agrees that the MPT Parties will be entitled to injunctive or other equitable relief without proving actual damages or posting any bond in the event of any violation of the restrictions contained herein, provided, however, that the foregoing shall not limit or be construed to prohibit or limit the right of the MPT Parties to pursue any other legal and equitable remedies available to it on account of such breach or violation, including the recovery of damages from LifePoint.

(c) Reasonableness of Limitations. If any court shall hold that the duration or scope of this Agreement (geographic or otherwise) is unreasonable or invalid, then the provisions of this Agreement shall remain in effect for whatever time period or geographic area that such court does not declare to be unreasonable or invalid. In addition, if any court shall hold that the duration or scope (geographic or otherwise) of this Agreement is unreasonable or invalid, then, to the extent permitted by law, the court may prescribe a maximum duration or scope (geographic or otherwise) that is judicially enforceable and not unreasonable and the parties agree to accept such judicial determination, which the parties agree shall be substituted in place of any and every judicially unenforceable provision of this Agreement, and that this Agreement, as so modified, shall be fully enforceable as if originally executed in such manner.

(d) Good Faith Negotiations. This Agreement is intended to comply with all applicable rules and regulations of all governmental and regulating authorities. Accordingly, the parties agree to renegotiate, in good faith, any term, condition or provision of this Agreement, or any other relationship between the parties, determined to be in contravention of any regulation, policy or law of any such authority. All other provisions hereof shall remain enforceable to the fullest extent permitted by law.

3. **Representations and Warranties of LifePoint**. LifePoint hereby represents and warrants to the MPT Parties that as of the date hereof (a) it has full legal right, power and authority to enter into this Agreement, to incur the obligations provided for herein, and to execute and deliver the same to the MPT Parties; (b) this Agreement has been duly executed and delivered by it and constitutes a valid and legally binding obligation, enforceable against LifePoint in accordance with its terms, subject to bankruptcy, insolvency, reorganization, and similar laws affecting the enforcement of creditor's rights or contractual obligations generally and, as to enforcement, to general principles of equity, regardless of whether applied in a proceeding at law or in equity; (c) no approval or consent of any foreign, federal, state, county, local or other governmental or regulatory body, and no approval or consent of any other Person is required in connection with the execution and delivery by LifePoint of this Agreement or the

consummation and performance by it of the transactions contemplated hereby, except such approvals or consents as shall have be obtained on or prior to the date hereof; (d) the execution and delivery of this Agreement and the obligations created hereby have been duly authorized by all necessary proceedings on the part of LifePoint, and will not conflict with or result in the breach or violation of any of the terms or conditions of, or constitute (or with notice or lapse of time or both would constitute) a default under the governing documents of LifePoint, any instrument, contract or other agreement to which LifePoint is a party or by or to which it or any of its assets or properties are bound or subject, or any statute or any regulation, order, judgment or decree of any court or governmental or regulatory body; and (e) LifePoint is not a party to or, to the knowledge of LifePoint, threatened with any litigation or judicial, administrative or arbitration proceeding which, if decided adversely to it, would restrain, prohibit or materially delay the transactions contemplated hereby.

4. **Legal Fees and Expenses.** In the event any claim is made by one party to this Agreement against another party to this Agreement, the Non-Prevailing Party (as herein defined), and only the Non-Prevailing Party, shall be responsible for paying and/or reimbursing the reasonable costs (including costs of investigation), expenses and reasonable legal fees of the other party to the claim. "Non-Prevailing Party" shall mean, with respect to any claim between any parties hereto, such party determined as the non-prevailing party by a court with proper jurisdiction.

5. **Binding Effect; No-Third Party Beneficiaries**. This Agreement shall bind and inure to the benefit of the parties and their successors and assigns; provided, however, that (a) this Agreement shall not inure to the benefit of any assignee pursuant to an assignment which violates the terms of this Agreement and (b) neither this Agreement nor any other agreement contemplated in this Agreement shall be deemed to confer upon any Person not a party to this Agreement any rights or remedies contained in this Agreement.

6. **Section Captions**. Section and other captions contained in this Agreement are for reference purposes only and are in no way intended to describe, interpret, define or limit the scope, extent or intent of this Agreement or any provision hereof.

7. **Notices**. All notices, demands and other communications to be given or delivered under or by reason of the provisions of this Agreement shall be in writing and shall be deemed to have been given (a) when personally delivered, (b) when transmitted via telecopy (or other facsimile device) to the number set out below if the sender on the same day sends a confirming copy of such notice by a recognized overnight delivery service (charges prepaid), (c) the day following the day (except if not a Business Day then the next Business Day) on which the same has been delivered prepaid to a reputable national overnight air courier service or (d) the third Business Day following the day on which the same is sent by certified or registered mail, postage prepaid. Notices, demands and communications, in each case to the respective parties, shall be sent to the applicable address set forth below, unless another address has been previously specified in writing:

If to LifePoint: 330 Seven Springs Way
Brentwood, Tennessee 37027
Attention: Jennifer Peters, General Counsel

Facsimile: (615) 920-8948

with a copy to:

Sidley Austin LLP
787 Seventh Avenue
New York, NY 10019
[redacted]

with a copy to:

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, Tennessee 37219
[redacted]

if to any MPT Party:

c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242
[redacted]

with a copy to:

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
420 20th Street North
1400 Wells Fargo Tower
Birmingham, Alabama 35203
[redacted]

or to such other address with respect to a party as such party notifies the other in writing as above provided.

8. **Governing Law; Jurisdiction and Venue; Waiver of Jury Trial**.

(a) This Agreement shall be governed by and construed in accordance with the laws of the State of Delaware applicable to contracts executed and performed in such State, without giving effect to conflicts of law principles.

(b) THE PARTIES HERETO CONSENT TO PERSONAL JURISDICTION IN THE STATE OF DELAWARE. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, THE PARTIES AGREE THAT ANY ACTION OR PROCEEDING ARISING FROM OR RELATED TO THIS AGREEMENT SHALL BE BROUGHT AND TRIED EXCLUSIVELY IN THE STATE OR FEDERAL COURTS OF DELAWARE. EACH OF THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY OBJECTION TO THE LAYING OF VENUE OF ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. THE PARTIES EXPRESSLY ACKNOWLEDGE THAT DELAWARE IS A FAIR, JUST AND REASONABLE FORUM AND AGREE NOT TO SEEK REMOVAL OR TRANSFER OF ANY ACTION FILED BY THE OTHER PARTIES IN SAID COURTS. FURTHER, THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY

CLAIM THAT SUCH SUIT, ACTION OR PROCEEDING HAS BEEN BROUGHT IN AN INCONVENIENT FORUM. SERVICE OF ANY PROCESS, SUMMONS, NOTICE OR DOCUMENT BY CERTIFIED MAIL ADDRESSED TO A PARTY AT THE ADDRESS DESIGNATED PURSUANT TO SECTION 7 SHALL BE EFFECTIVE SERVICE OF PROCESS AGAINST SUCH PARTY FOR ANY ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. A FINAL JUDGMENT IN ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT MAY BE ENFORCED IN ANY OTHER COURT TO WHOSE JURISDICTION ANY OF THE PARTIES IS OR MAY BE SUBJECT.

(c) TO THE MAXIMUM EXTENT PERMITTED BY LAW, THE PARTIES HEREBY KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVE THE RIGHT TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION BASED HEREON, ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT, OR ANY COURSE OF CONDUCT, COURSE OF DEALING, STATEMENT (WHETHER VERBAL OR WRITTEN) OR ACTION OF ANY PARTY OR ANY EXERCISE OF ANY PARTY OF THEIR RESPECTIVE RIGHTS HEREUNDER OR IN ANY WAY RELATING TO THIS AGREEMENT OR THE COLLATERAL (INCLUDING ANY CLAIM OR DEFENSE ASSERTING THAT THIS AGREEMENT WAS FRAUDULENTLY INDUCED OR IS OTHERWISE VOID OR VOIDABLE). THIS WAIVER IS A MATERIAL INDUCEMENT FOR THE MPT PARTIES TO ENTER INTO THIS AGREEMENT AND THE OTHER OBLIGATION DOCUMENTS.

9. **Severability**. Whenever possible, each provision of this Agreement shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Agreement, unless the severance of such provision would be in opposition to the parties' intent with respect to such provision.

10. **No Waiver**. No failure by either party to insist upon the strict performance of any term of this Agreement or to exercise any right, power or remedy consequent upon a breach thereof, and no acceptance of full or partial performance under the terms of this Agreement during the continuance of any such breach, shall constitute a waiver of any such breach or any such term. To the extent permitted by law, no waiver of any breach shall affect or alter this Agreement, which shall continue in full force and effect with respect to any other then existing or subsequent breach. The parties agree that no waiver shall be effective hereunder unless it is in writing.

11. **Necessary Action**. Each party shall perform any further acts and execute and deliver any documents that may be reasonably necessary to carry out the provisions of this Agreement.

12. **Binding Effect; Assignment**. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns, except that neither this Agreement nor any of the rights, interests or obligations hereunder may be assigned or delegated by LifePoint without the prior written consent of the MPT Parties. Each of the MPT Parties may at any time and without the consent of LifePoint assign all of its rights and obligations hereunder to any other Person to whom the rights as Lessor under the Master Lease are properly assigned in accordance with its terms.

13. **Joint Drafting**. The parties hereto and their respective counsel have participated in the drafting and redrafting of this Agreement and the general rules of construction which would construe any provisions of this Agreement in favor of or to the advantage of one party as opposed to the other as a result of one party drafting this Agreement as opposed to the other or in resolving any conflict or ambiguity in favor of one party as opposed to the other on the basis of which party drafted this Agreement are hereby expressly waived by all parties to this Agreement.

14. **Delivery by Electronic Transmission**. This Agreement and any signed agreement entered into in connection herewith or contemplated hereby, and any amendments hereto or thereto, to the extent signed and delivered by means of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail, shall be treated in all manner and respects as an original contract and shall be considered to have the same binding legal effects as if it were the original signed version thereof delivered in person. At the request of any party hereto or to any such contract, each other party hereto or thereto shall re-execute original forms thereof and deliver them to all other parties. No party hereto or to any such contract shall raise the use of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail to deliver a signature or the fact that any signature or contract was transmitted or communicated through the use of facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail as a defense to the formation of a contract and each such party forever waives any such defense.

15. **Entire Agreement; Modification**. This Agreement together with all annexes and the documents referred to herein contain the complete agreement between the parties hereto and supersede any prior understandings, agreements or representations by or between the parties, written or oral, which may have related to the subject matter hereof in any way. Neither this Agreement, any annex attached hereto, nor any provision hereof or thereof may be modified or amended except by an instrument in writing signed by the Parties.

16. **Counterparts**. This Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which together shall constitute one (1) and the same instrument.

17. **Representatives**. The MPT Parties hereby appoint MPT of Johnstown-Lima, LLC as their duly authorized agent and representative (the "MPT Representative") to take all actions and enforce all rights of the MPT Parties under this Agreement, including, without limitation, (i) giving and receiving any notice or instruction permitted or required under this Agreement; (ii) interpreting all of the terms and provisions of this Agreement; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with LifePoint under this Agreement; (v) conducting negotiations and dealing with LifePoint under this Agreement; and (vi) taking any other actions on behalf of the MPT Parties relating to their rights, claims, duties and obligations under this Agreement. In the performance of LifePoint's duties and obligations hereunder, LifePoint shall be authorized and permitted to correspond and transact with the MPT Representative on behalf of all the MPT Parties and shall be entitled to rely upon any document or instrument executed and delivered by the MPT Representative.

[Signatures appear on the following pages]

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement as of the day and year first above written.

LifePoint Health, [Inc.]

By:_____
Name:_____
Title:_____

MPT PARTIES:

MPT OF DODGE CITY-LIMA, LLC
MPT OF HASTINGS-LIMA, LLC
MPT OF JOHNSTOWN-LIMA, LLC
MPT OF LANDER-LIMA, LLC
MPT OF LAWTON-LIMA, LLC
MPT OF MEYERSDALE-LIMA, LLC
MPT OF OTTUMWA-LIMA, LLC
MPT OF PALESTINE-LIMA, LLC
MPT OF RIVERTON-LIMA, LLC
MPT OF ROARING SPRINGS-LIMA, LLC

By: MPT Operating Partnership, L.P.
Its: Sole Member of each above-referenced entity

By:_____
Name:_____
Title:_____

ANNEX A
MPT PARTIES

1. MPT OF DODGE CITY-LIMA, LLC
2. MPT OF HASTINGS-LIMA, LLC
3. MPT OF JOHNSTOWN-LIMA, LLC
4. MPT OF LANDER-LIMA, LLC
5. MPT OF LAWTON-LIMA, LLC
6. MPT OF MEYERSDALE-LIMA, LLC
7. MPT OF OTTUMWA-LIMA, LLC
8. MPT OF PALESTINE-LIMA, LLC
9. MPT OF RIVERTON-LIMA, LLC
10. MPT OF ROARING SPRINGS-LIMA, LLC

ANNEX B

Non-Core Real Estate

	Facility	Survey/Tax Parcel/Hastings Bldg No.	Property Name[2]	Owner	Address	City	State
1.	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	DLP Conemaugh Memorial Medical Center, LLC	1125 Milford Street	Johnstown	PA
2.	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	DLP Conemaugh Memorial Medical Center, LLC	1133 Milford Street Johnstown, PA	Johnstown	PA
3.	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	DLP Conemaugh Memorial Medical Center, LLC	1121 Milford Street	Johnstown	PA
4.	Conemaugh Memorial Medical Center	78-009.-204.000 (same as Hospital)	GME housing	DLP Conemaugh Memorial Medical Center, LLC	138 Skelly Street	Johnstown	PA
5.	Conemaugh Memorial Medical Center	78-009.-204.000 (same as Hospital)	Physician on-call housing (green house)	DLP Conemaugh Memorial Medical Center, LLC	134 Skelly Street	Johnstown	PA
6.	Conemaugh Memorial Medical Center	78-010.-302.000	GME Housing - Duplex	DLP Conemaugh Memorial Medical Center, LLC	20 Rose Street	Johnstown	PA
7.	Conemaugh Memorial Medical Center	78-010.-303.000	GME Housing - Duplex	DLP Conemaugh Memorial Medical Center, LLC	18 Rose Street	Johnstown	PA
8.	Conemaugh Memorial	78-010A.-111.000	GME Housing	DLP Conemaugh Memorial Medical	R. 16 Osborne Street (Actually on Otto Court)	Johnstown	PA

[2] **Note**: Excludes leased properties unless under hospital lease.

	Facility	Survey/Tax Parcel/Hastings Bldg No.	Property Name[2]	Owner	Address	City	State
	Medical Center			Center, LLC			
9.	Conemaugh Memorial Medical Center	78.009.-504.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	1113 Barnett Street	Johnstown	PA
10.	Conemaugh Memorial Medical Center	78.009.-505.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	1115 Barnett Street	Johnstown	PA
11.	Conemaugh Memorial Medical Center	78-008.-209.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	Franklin St.	Johnstown	PA
12.	Conemaugh Memorial Medical Center	75.002.-204.000 per Assessor: 075-000647	Unused Parking lot	DLP Conemaugh Memorial Medical Center, LLC	522 Sherman Street	Johnstown	PA
13.	Conemaugh Memorial Medical Center	72.002.-115.000	Locust Plaza	DLP Conemaugh Memorial Medical Center, LLC	315 Locust Street	Johnstown	PA
14.	Conemaugh Memorial Medical Center	75.001.-100.000	Vacant MRI Building and land surrounding UPMC Conemaugh Cancer Center	DLP Conemaugh Memorial Medical Center, LLC	331- 337 Somerset St (331: MRI, 337: Cancer Ctr)	Johnstown	PA
15.	Conemaugh Memorial Medical Center	83.002.-106.000	Part of unused "I" Parking lot	DLP Conemaugh Memorial Medical Center, LLC	Walnut Street/River Avenue	Johnstown	PA
16.	Conemaugh Memorial Medical Center	62.008.-109.003	Vacant Medical Office Building	DLP Conemaugh Memorial Medical Center, LLC	318 Goucher Street	Johnstown	PA
17.	Conemaugh Memorial Medical Center	50.037.-427.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	Rear Hostetler Road	Johnstown	PA
18.	Conemaugh Memorial Medical Center	46.002.-114.000	Office Building (LHC- Home Health)	DLP Conemaugh Memorial Medical Center, LLC	813 Jefferson	Portage	PA
19.	Conemaugh Memorial Medical Center	522-027-071-00	MOB and adjacent Parking Lot	DLP Conemaugh Memorial Medical Center, LLC	1609 & 1611 W Pitt St	Jennerstown	PA
20.	Conemaugh Memorial	E.09-E.04-103	Medical Office Building	DLP Conemaugh Memorial Medical	140 South Anderson St	Bedford	PA

	Facility	Survey/Tax Parcel/Hastings Bldg No.	Property Name[2]	Owner	Address	City	State
	Medical Center			Center, LLC			
21.	Palestine Regional Medical Center	TX40707 6910-00007-00118 R0064347	Memorial Mother Frances	Palestine Principal Healthcare Ltd Partnership	100 W. Brazos/duplex with below	Palestine	TX
22.	Palestine Regional Medical Center	TX40708 6910-00007-00118 R0064347 (same as above)	Memorial Mother Frances	Palestine Principal Healthcare Ltd Partnership	1004 S Magnolia/shares tax parcel with 100 W. Brazos	Palestine	TX
23.	Palestine Regional Medical Center	TX40710 6910-12000-00400 R0034954	Vacant - Clinic	Palestine Principal Healthcare Ltd Partnership	804 S. Sycamore	Palestine	TX

Exhibit P

Form of Lima Noncompetition Agreement

See attached.

NON-COMPETITION AGREEMENT

THIS NON-COMPETITION AGREEMENT (this "Agreement") is made and entered into this ___ day of _____, 20____, by and among LIMA HOLDCO, LLC, a Delaware limited liability company ("Lima HoldCo"); the entities listed on ***ANNEX A*** hereto under the heading "MPT Parties" (hereinafter be referred to, individually, as an "MPT Party" and, collectively, as the "MPT Parties"). Lima HoldCo and the MPT Parties are herein sometimes referred to individually as a "Party" and collectively, as the "Parties."

W I T N E S S E T H:

WHEREAS, MPT Parties and certain subsidiaries of Lima HoldCo (each a "Lessee" and collectively the "Lessees") have entered into that certain Master Lease Agreement, dated of even date herewith (as the same may be amended, modified and restated from time to time, the "Master Lease"), whereby MPT Parties are leasing (or, as applicable, subleasing) to Lessees, and Lessees are leasing (or, as applicable, subleasing) from MPT Parties, certain real property consisting of multiple parcels of land, the improvements now or hereafter located thereon (including any improvements consisting of multiple hospital facilities), the fixtures now or hereafter attached thereto and all easements, licenses, rights-of-way, appurtenances and other matters and items relating thereto, all as more particularly described in the Master Lease (collectively, the "Leased Property");

WHEREAS, Lima HoldCo hereby acknowledges that, as a result of the above described transactions, Lima HoldCo and/or the Lessees will derive direct and indirect benefits in the form of economies of scale, access to capital and other important strategic operational benefits and, accordingly, Lima HoldCo has concluded that it is in its best interests to enter into this Agreement; and

WHEREAS, as a condition to the closing of the transactions contemplated by and referenced in the Master Lease, and as an inducement to cause the MPT Parties to enter into and close such transactions, Lima HoldCo has agreed to enter into and to be bound by the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the premises, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto do hereby agree as follows:

1. **Capitalized Terms; Definitions**. Any capitalized term or phrase which is used herein (including the Recitals) and not expressly defined herein shall have the meaning ascribed to such term or phrase in the Master Lease. For the purposes of this Agreement, (i) the term "Wholly-Owned Subsidiary" shall mean "With respect to any Person (herein referred to as the "parent"), any corporation, partnership, association or other business entity of which securities or other ownership interests representing 100% of the economic interests and (x) 100% of the ordinary voting power (or board representation, including through block voting arrangements) or (y) 100% of the general partnership interests are, at the time any determination is being made, directly or indirectly, owned or held by the parent or one or more wholly owned subsidiaries of

the parent", and the term "Non-Wholly-Owned Subsidiary" shall mean "Any Subsidiary that is not a Wholly-Owned Subsidiary".

2. **Non-Competition Provisions of Lima HoldCo**.

(a) No Competing Business. Lima HoldCo agrees that while the Master Lease remains in effect and, if the Master Lease is terminated due to an "Event of Default" thereunder, then for a period of three (3) years thereafter (the "Lima Noncompete Period"), neither Lima HoldCo nor any of its Wholly-Owned Subsidiaries shall, directly or indirectly, acquire, finance, guarantee indebtedness, own, lease, manage, develop or provide services in connection with the acquisition, ownership, operation or development of any real estate located within ten (10) miles of any point on or within the Leased Property, which real estate is used in a Competing Business (other than for the avoidance of doubt a Permitted Activity) (a "Restricted Activity"), *provided, however,* that the restrictions in this Section 2(a) shall not apply to real estate described on ***ANNEX B*** hereto ("Non-Core Real Estate") with respect to Restricted Activities in which Lima HoldCo or any of its Subsidiaries is performing, conducting or otherwise involved as of the date hereof or otherwise reasonably related to the divestiture of such Non-Core Real Estate. Any violation of the provisions of this Section 2 shall suspend and toll the Lima Noncompete Period for the duration of such violation. The term "Competing Business" means any healthcare business which involves the operation of a facility other than on the Leased Property in which general acute care services, long term care services, rehabilitation or skilled nursing services are provided; provided, however, that the foregoing shall not prohibit Lima HoldCo or its Affiliates from conducting, performing or otherwise being involved in any Restricted Activity that will not as of the time such Restricted Activity is commenced have a material and adverse effect on the relevant Market of the effected Facility or the ability of any Lessee to perform its obligations under the Master Lease, in each case, as determined in the reasonable discretion of the MPT Parties (a "Permitted Activity"). The term "Market" shall mean "with respect to (a) any of the Johnstown Facility, the Meyersdale Facility, the Hastings Facility, or the Roaring Springs Facility, the business conducted by all such Facilities taken together as a single market, (b) any of the Lander Facility or the Riverton Facility, the business conducted by all such Facilities taken together as a single market, and (c) with respect to any other Facility, the business conducted by such Facility is considered a single market." Notwithstanding the foregoing, in no event shall the provisions of this Section 2(a) apply to any MPT Party or any other Person that, directly or indirectly, controls or is under common control with any such MPT Party. For the avoidance of doubt, the prohibition on Restricted Activities set forth herein shall not apply with respect to direct or indirect Non-Wholly-Owned Subsidiaries of LifePoint; provided, however, Lima HoldCo shall not, and shall not permit its Wholly-Owned Subsidiaries to, vote any Equity Interest it holds in a Non-Wholly Owned Subsidiary in favor of, otherwise approve in its capacity as a holder of such Equity Interests, or voluntarily fund any Restricted Activity that would otherwise be prohibited with respect to a Wholly-Owned Subsidiary except to the extent in its good faith judgement such party is required to do so by applicable Law (including fiduciary duties) or contract. Furthermore, to the extent that Lima HoldCo or any of its Wholly-Owned Subsidiaries seeks to become a holder of Equity Interests in any additional Non-Wholly Owned Subsidiary in the future, in connection with the initial acquisition of such Equity Interests, it shall negotiate in good faith with any other current or prospective third party holders of Equity Interests in such entity so that the governing documents of such entity permit Lima HoldCo to treat such entity as a Wholly-Owned Subsidiary hereunder; provided that the parties hereto

acknowledge and agree that nothing herein shall prohibit Lima HoldCo or its Subsidiaries from entering into, adopting, approving or otherwise being bound by any such governing documents inconsistent with the foregoing or prevent Lima HoldCo or its Wholly-Owned Subsidiaries from becoming a holder of Equity Interests in any Non-Wholly Owned Subsidiary.

(b) Injunctive or Equitable Relief. Lima HoldCo agrees that the restrictions contained herein are reasonable and necessary to protect the legitimate interests of the MPT Parties, and that any violation of the provisions would result in damages which cannot be adequately compensated by money alone. Lima HoldCo hereby agrees that the MPT Parties will be entitled to injunctive or other equitable relief without proving actual damages or posting any bond in the event of any violation of the restrictions contained herein, provided, however, that the foregoing shall not limit or be construed to prohibit or limit the right of the MPT Parties to pursue any other legal and equitable remedies available to it on account of such breach or violation, including the recovery of damages from Lima HoldCo.

(c) Reasonableness of Limitations. If any court shall hold that the duration or scope of this Agreement (geographic or otherwise) is unreasonable or invalid, then the provisions of this Agreement shall remain in effect for whatever time period or geographic area that such court does not declare to be unreasonable or invalid. In addition, if any court shall hold that the duration or scope (geographic or otherwise) of this Agreement is unreasonable or invalid, then, to the extent permitted by law, the court may prescribe a maximum duration or scope (geographic or otherwise) that is judicially enforceable and not unreasonable and the parties agree to accept such judicial determination, which the parties agree shall be substituted in place of any and every judicially unenforceable provision of this Agreement, and that this Agreement, as so modified, shall be fully enforceable as if originally executed in such manner.

(d) Good Faith Negotiations. This Agreement is intended to comply with all applicable rules and regulations of all governmental and regulating authorities. Accordingly, the parties agree to renegotiate, in good faith, any term, condition or provision of this Agreement, or any other relationship between the parties, determined to be in contravention of any regulation, policy or law of any such authority. All other provisions hereof shall remain enforceable to the fullest extent permitted by law.

3. **Representations and Warranties of Lima HoldCo**. Lima HoldCo hereby represents and warrants to the MPT Parties that as of the date hereof (a) it has full legal right, power and authority to enter into this Agreement, to incur the obligations provided for herein, and to execute and deliver the same to the MPT Parties; (b) this Agreement has been duly executed and delivered by it and constitutes a valid and legally binding obligation, enforceable against Lima HoldCo in accordance with its terms, subject to bankruptcy, insolvency, reorganization, and similar laws affecting the enforcement of creditor's rights or contractual obligations generally and, as to enforcement, to general principles of equity, regardless of whether applied in a proceeding at law or in equity; (c) no approval or consent of any foreign, federal, state, county, local or other governmental or regulatory body, and no approval or consent of any other Person is required in connection with the execution and delivery by Lima HoldCo of this Agreement or the consummation and performance by it of the transactions contemplated hereby, except such approvals or consents as shall have be obtained on or prior to the date hereof; (d) the execution

and delivery of this Agreement and the obligations created hereby have been duly authorized by all necessary proceedings on the part of Lima HoldCo, and will not conflict with or result in the breach or violation of any of the terms or conditions of, or constitute (or with notice or lapse of time or both would constitute) a default under the governing documents of Lima HoldCo, any instrument, contract or other agreement to which Lima HoldCo is a party or by or to which it or any of its assets or properties are bound or subject, or any statute or any regulation, order, judgment or decree of any court or governmental or regulatory body; and (e) Lima HoldCo is not a party to or, to the knowledge of Lima HoldCo, threatened with any litigation or judicial, administrative or arbitration proceeding which, if decided adversely to it, would restrain, prohibit or materially delay the transactions contemplated hereby.

4. **Legal Fees and Expenses.** In the event any claim is made by one party to this Agreement against another party to this Agreement, the Non-Prevailing Party (as herein defined), and only the Non-Prevailing Party, shall be responsible for paying and/or reimbursing the reasonable costs (including costs of investigation), expenses and reasonable legal fees of the other party to the claim. "Non-Prevailing Party" shall mean, with respect to any claim between any parties hereto, such party determined as the non-prevailing party by a court with proper jurisdiction.

5. **Binding Effect; No-Third Party Beneficiaries**. This Agreement shall bind and inure to the benefit of the parties and their successors and assigns; provided, however, that (a) this Agreement shall not inure to the benefit of any assignee pursuant to an assignment which violates the terms of this Agreement and (b) neither this Agreement nor any other agreement contemplated in this Agreement shall be deemed to confer upon any Person not a party to this Agreement any rights or remedies contained in this Agreement.

6. **Section Captions**. Section and other captions contained in this Agreement are for reference purposes only and are in no way intended to describe, interpret, define or limit the scope, extent or intent of this Agreement or any provision hereof.

7. **Notices**. All notices, demands and other communications to be given or delivered under or by reason of the provisions of this Agreement shall be in writing and shall be deemed to have been given (a) when personally delivered, (b) when transmitted via telecopy (or other facsimile device) to the number set out below if the sender on the same day sends a confirming copy of such notice by a recognized overnight delivery service (charges prepaid), (c) the day following the day (except if not a Business Day then the next Business Day) on which the same has been delivered prepaid to a reputable national overnight air courier service or (d) the third Business Day following the day on which the same is sent by certified or registered mail, postage prepaid. Notices, demands and communications, in each case to the respective parties, shall be sent to the applicable address set forth below, unless another address has been previously specified in writing:

If to Lima HoldCo:

c/o LifePoint Health, Inc.
330 Seven Springs Way
Brentwood, Tennessee 37027
Attention: General Counsel
Facsimile: (615) 920-8948

with a copy to: Sidley Austin LLP
787 Seventh Avenue
New York, NY 10019
[redacted]

with a copy to: Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, Tennessee 37219
[redacted]

if to any MPT Party: c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242
[redacted]

with a copy to: Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
420 20th Street North
1400 Wells Fargo Tower
Birmingham, Alabama 35203
[redacted]

or to such other address with respect to a party as such party notifies the other in writing as above provided.

8. **Governing Law; Jurisdiction and Venue; Waiver of Jury Trial**.

(a) This Agreement shall be governed by and construed in accordance with the laws of the State of Delaware applicable to contracts executed and performed in such State, without giving effect to conflicts of law principles.

(b) THE PARTIES HERETO CONSENT TO PERSONAL JURISDICTION IN THE STATE OF DELAWARE. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, THE PARTIES AGREE THAT ANY ACTION OR PROCEEDING ARISING FROM OR RELATED TO THIS AGREEMENT SHALL BE BROUGHT AND TRIED EXCLUSIVELY IN THE STATE OR FEDERAL COURTS OF DELAWARE. EACH OF THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY OBJECTION TO THE LAYING OF VENUE OF ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. THE PARTIES EXPRESSLY ACKNOWLEDGE THAT DELAWARE IS A FAIR, JUST AND REASONABLE FORUM AND AGREE NOT TO SEEK REMOVAL OR TRANSFER OF ANY ACTION FILED BY THE OTHER PARTIES IN SAID COURTS. FURTHER, THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY CLAIM THAT SUCH SUIT, ACTION OR PROCEEDING HAS BEEN BROUGHT IN AN

INCONVENIENT FORUM. SERVICE OF ANY PROCESS, SUMMONS, NOTICE OR DOCUMENT BY CERTIFIED MAIL ADDRESSED TO A PARTY AT THE ADDRESS DESIGNATED PURSUANT TO SECTION 7 SHALL BE EFFECTIVE SERVICE OF PROCESS AGAINST SUCH PARTY FOR ANY ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. A FINAL JUDGMENT IN ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT MAY BE ENFORCED IN ANY OTHER COURT TO WHOSE JURISDICTION ANY OF THE PARTIES IS OR MAY BE SUBJECT.

(c) TO THE MAXIMUM EXTENT PERMITTED BY LAW, THE PARTIES HEREBY KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVE THE RIGHT TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION BASED HEREON, ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT, OR ANY COURSE OF CONDUCT, COURSE OF DEALING, STATEMENT (WHETHER VERBAL OR WRITTEN) OR ACTION OF ANY PARTY OR ANY EXERCISE OF ANY PARTY OF THEIR RESPECTIVE RIGHTS HEREUNDER OR IN ANY WAY RELATING TO THIS AGREEMENT OR THE COLLATERAL (INCLUDING ANY CLAIM OR DEFENSE ASSERTING THAT THIS AGREEMENT WAS FRAUDULENTLY INDUCED OR IS OTHERWISE VOID OR VOIDABLE). THIS WAIVER IS A MATERIAL INDUCEMENT FOR THE MPT PARTIES TO ENTER INTO THIS AGREEMENT AND THE OTHER OBLIGATION DOCUMENTS.

9. **Severability**. Whenever possible, each provision of this Agreement shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Agreement, unless the severance of such provision would be in opposition to the parties' intent with respect to such provision.

10. **No Waiver**. No failure by either party to insist upon the strict performance of any term of this Agreement or to exercise any right, power or remedy consequent upon a breach thereof, and no acceptance of full or partial performance under the terms of this Agreement during the continuance of any such breach, shall constitute a waiver of any such breach or any such term. To the extent permitted by law, no waiver of any breach shall affect or alter this Agreement, which shall continue in full force and effect with respect to any other then existing or subsequent breach. The parties agree that no waiver shall be effective hereunder unless it is in writing.

11. **Necessary Action**. Each party shall perform any further acts and execute and deliver any documents that may be reasonably necessary to carry out the provisions of this Agreement.

12. **Binding Effect; Assignment**. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns, except that neither this Agreement nor any of the rights, interests or obligations hereunder may be assigned or delegated by Lima HoldCo without the prior written consent of the MPT Parties. Each of the MPT Parties may at any time and without the consent of Lima HoldCo assign all of its rights and obligations hereunder to any other Person to whom the rights as Lessor under the Master Lease are properly assigned in accordance with its terms.

13. **Joint Drafting**. The parties hereto and their respective counsel have participated in the drafting and redrafting of this Agreement and the general rules of construction which would construe any provisions of this Agreement in favor of or to the advantage of one party as opposed to the other as a result of one party drafting this Agreement as opposed to the other or in resolving any conflict or ambiguity in favor of one party as opposed to the other on the basis of which party drafted this Agreement are hereby expressly waived by all parties to this Agreement.

14. **Delivery by Electronic Transmission**. This Agreement and any signed agreement entered into in connection herewith or contemplated hereby, and any amendments hereto or thereto, to the extent signed and delivered by means of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail, shall be treated in all manner and respects as an original contract and shall be considered to have the same binding legal effects as if it were the original signed version thereof delivered in person. At the request of any party hereto or to any such contract, each other party hereto or thereto shall re-execute original forms thereof and deliver them to all other parties. No party hereto or to any such contract shall raise the use of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail to deliver a signature or the fact that any signature or contract was transmitted or communicated through the use of facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail as a defense to the formation of a contract and each such party forever waives any such defense.

15. **Entire Agreement; Modification**. This Agreement together with all annexes and the documents referred to herein contain the complete agreement between the parties hereto and supersede any prior understandings, agreements or representations by or between the parties, written or oral, which may have related to the subject matter hereof in any way. Neither this Agreement, any annex attached hereto, nor any provision hereof or thereof may be modified or amended except by an instrument in writing signed by the Parties.

16. **Counterparts**. This Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which together shall constitute one (1) and the same instrument.

17. **Representatives**. The MPT Parties hereby appoint MPT of Johnstown-Lima, LLC as their duly authorized agent and representative (the "MPT Representative") to take all actions and enforce all rights of the MPT Parties under this Agreement, including, without limitation, (i) giving and receiving any notice or instruction permitted or required under this Agreement; (ii) interpreting all of the terms and provisions of this Agreement; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with Lima HoldCo under this Agreement; (v) conducting negotiations and dealing with Lima HoldCo under this Agreement; and (vi) taking any other actions on behalf of the MPT Parties relating to their rights, claims, duties and obligations under this Agreement. In the performance of Lima HoldCo's duties and obligations hereunder, Lima HoldCo shall be authorized and permitted to correspond and transact with the MPT Representative on behalf of all the MPT Parties and shall be entitled to rely upon any document or instrument executed and delivered by the MPT Representative.

[Signatures appear on the following pages]

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement as of the day and year first above written.

LIMA HOLDCO, LLC

By:_____
Name:_____
Title:_____

MPT PARTIES:

MPT OF DODGE CITY-LIMA, LLC
MPT OF HASTINGS-LIMA, LLC
MPT OF JOHNSTOWN-LIMA, LLC
MPT OF LANDER-LIMA, LLC
MPT OF LAWTON-LIMA, LLC
MPT OF MEYERSDALE-LIMA, LLC
MPT OF OTTUMWA-LIMA, LLC
MPT OF PALESTINE-LIMA, LLC
MPT OF RIVERTON-LIMA, LLC
MPT OF ROARING SPRINGS-LIMA, LLC

By: MPT Operating Partnership, L.P.
Its: Sole Member of each above-referenced entity

By:_____
Name:_____
Title:_____

ANNEX A
MPT PARTIES

1. MPT OF DODGE CITY-LIMA, LLC
2. MPT OF HASTINGS-LIMA, LLC
3. MPT OF JOHNSTOWN-LIMA, LLC
4. MPT OF LANDER-LIMA, LLC
5. MPT OF LAWTON-LIMA, LLC
6. MPT OF MEYERSDALE-LIMA, LLC
7. MPT OF OTTUMWA-LIMA, LLC
8. MPT OF PALESTINE-LIMA, LLC
9. MPT OF RIVERTON-LIMA, LLC
10. MPT OF ROARING SPRINGS-LIMA, LLC

ANNEX B

Non-Core Real Estate

	Facility	Survey/Tax Parcel/Hastings Bldg No.	Property Name[1]	Owner	Address	City	State
1.	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	DLP Conemaugh Memorial Medical Center, LLC	1125 Milford Street	Johnstown	PA
2.	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	DLP Conemaugh Memorial Medical Center, LLC	1133 Milford Street Johnstown, PA	Johnstown	PA
3.	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	DLP Conemaugh Memorial Medical Center, LLC	1121 Milford Street	Johnstown	PA
4.	Conemaugh Memorial Medical Center	78-009.-204.000 (same as Hospital)	GME housing	DLP Conemaugh Memorial Medical Center, LLC	138 Skelly Street	Johnstown	PA
5.	Conemaugh Memorial Medical Center	78-009.-204.000 (same as Hospital)	Physician on-call housing (green house)	DLP Conemaugh Memorial Medical Center, LLC	134 Skelly Street	Johnstown	PA
6.	Conemaugh Memorial Medical Center	78-010.-302.000	GME Housing - Duplex	DLP Conemaugh Memorial Medical Center, LLC	20 Rose Street	Johnstown	PA
7.	Conemaugh Memorial Medical Center	78-010.-303.000	GME Housing - Duplex	DLP Conemaugh Memorial Medical Center, LLC	18 Rose Street	Johnstown	PA
8.	Conemaugh Memorial Medical Center	78-010A.-111.000	GME Housing	DLP Conemaugh Memorial Medical Center, LLC	R. 16 Osborne Street (Actually on Otto Court)	Johnstown	PA

[1] **Note**: Excludes leased properties unless under hospital lease.

	Facility	Survey/Tax Parcel/Hastings Bldg No.	Property Name[1]	Owner	Address	City	State
9.	Conemaugh Memorial Medical Center	78.009.-504.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	1113 Barnett Street	Johnstown	PA
10.	Conemaugh Memorial Medical Center	78.009.-505.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	1115 Barnett Street	Johnstown	PA
11.	Conemaugh Memorial Medical Center	78-008.-209.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	Franklin St.	Johnstown	PA
12.	Conemaugh Memorial Medical Center	75.002.-204.000 per Assessor: 075-000647	Unused Parking lot	DLP Conemaugh Memorial Medical Center, LLC	522 Sherman Street	Johnstown	PA
13.	Conemaugh Memorial Medical Center	72.002.-115.000	Locust Plaza	DLP Conemaugh Memorial Medical Center, LLC	315 Locust Street	Johnstown	PA
14.	Conemaugh Memorial Medical Center	75.001.-100.000	Vacant MRI Building and land surrounding UPMC Conemaugh Cancer Center	DLP Conemaugh Memorial Medical Center, LLC	331- 337 Somerset St (331: MRI, 337: Cancer Ctr)	Johnstown	PA
15.	Conemaugh Memorial Medical Center	83.002.-106.000	Part of unused "I" Parking lot	DLP Conemaugh Memorial Medical Center, LLC	Walnut Street/River Avenue	Johnstown	PA
16.	Conemaugh Memorial Medical Center	62.008.-109.003	Vacant Medical Office Building	DLP Conemaugh Memorial Medical Center, LLC	318 Goucher Street	Johnstown	PA
17.	Conemaugh Memorial Medical Center	50.037.-427.000	Vacant tract	DLP Conemaugh Memorial Medical Center, LLC	Rear Hostetler Road	Johnstown	PA
18.	Conemaugh Memorial Medical Center	46.002.-114.000	Office Building (LHC- Home Health)	DLP Conemaugh Memorial Medical Center, LLC	813 Jefferson	Portage	PA
19.	Conemaugh Memorial Medical Center	522-027-071-00	MOB and adjacent Parking Lot	DLP Conemaugh Memorial Medical Center, LLC	1609 & 1611 W Pitt St	Jennerstown	PA
20.	Conemaugh Memorial Medical Center	E.09-E.04-103	Medical Office Building	DLP Conemaugh Memorial Medical Center, LLC	140 South Anderson St	Bedford	PA
21.	Palestine	TX40707	Memorial Mother Frances	Palestine Principal	100 W. Brazos/duplex with	Palestine	TX

	Facility	Survey/Tax Parcel/Hastings Bldg No.	Property Name[1]	Owner	Address	City	State
	Regional Medical Center	6910-00007-00118 R0064347		Healthcare Ltd Partnership	below		
22.	Palestine Regional Medical Center	TX40708 6910-00007-00118 R0064347 (same as above)	Memorial Mother Frances	Palestine Principal Healthcare Ltd Partnership	1004 S Magnolia/shares tax parcel with 100 W. Brazos	Palestine	TX
23.	Palestine Regional Medical Center	TX40710 6910-12000-00400 R0034954	Vacant - Clinic	Palestine Principal Healthcare Ltd Partnership	804 S. Sycamore	Palestine	TX

Exhibit Q

Form of Subordination of Management Agreement

See attached

SUBORDINATION OF MANAGEMENT AGREEMENT

THIS SUBORDINATION OF MANAGEMENT AGREEMENT (this "Agreement") is made this ___ day of _____, 2020, by and among [_____], a [_____] ("Manager"); **LIMA HOLDCO, LLC**, a Delaware limited liability company ("Lima Holdco"); the entities listed on ***ANNEX A***[1] hereto under the heading "Lessees" (hereinafter be referred to, individually, as a "Lessee" and, collectively, as the "Lessees") (Lima Holdco and Lessees shall hereinafter be referred to, individually, as an "Obligor" and, collectively, as the "Obligors"); and the entities listed on ***ANNEX A*** hereto under the heading "Lessors" (hereinafter be referred to, individually, as a "Lessor" and, collectively, as the "Lessors") (Manager, Obligors, and Lessors shall hereinafter be referred to, individually, as a "Party" and, collectively, as the "Parties").[2]

W I T N E S S E T H:

WHEREAS, Lessors and Lessees have entered into that certain Master Lease Agreement, dated of even date herewith (as the same may be amended, modified and restated from time to time, the "Master Lease"), whereby Lessors are leasing (or, as applicable, subleasing) to Lessees, and Lessees are leasing (or, as applicable, subleasing) from Lessors, certain real property consisting of multiple parcels of land, the improvements now or hereafter located thereon (including any improvements consisting of multiple hospital facilities), the fixtures now or hereafter attached thereto and all easements, licenses, rights-of-way, appurtenances and other matters and items relating thereto, all as more particularly described in the Master Lease (collectively, the "Leased Property");

WHEREAS, LifePoint Health, [Inc.] and Lima Holdco has each entered into those certain Guaranty Agreements, dated of even date herewith, in favor of the Lessors (collectively, as the same may be amended, modified and restated from time to time, the "Guaranty"), pursuant to which Lima Holdco guarantees the payment and performance of all of the respective obligations and liabilities of the Lessees under the Master Lease;

WHEREAS, pursuant to that certain [Management Services Agreement, dated as of _____, 20___], by and among Manager and certain of the Lessees (the "Management Agreement Counterparties"), a copy of which is attached hereto as ***EXHIBIT A*** (as the same may be amended, modified or restated from time to time, the "Management Agreement"), Manager provides management services to such Management Agreement Counterparties with respect to the operation of each of the hospital facilities (each a "Facility" and collectively the "Facilities") located, respectively, on any of the Leased Property;

WHEREAS, Manager and the Obligors acknowledge that, as a result of the above described transactions, Manager and the Obligors will derive direct and indirect benefits in the form of economies of scale, access to capital and other important strategic operational benefits and, accordingly, Manager and the Obligors have concluded that it is in their best interest to enter into this Agreement; and

---

[1] To be revised to reflect Lessees as of the initial closing.

[2] To be entered into with respect to each Management Agreement.

WHEREAS, Lessors have required the execution and delivery of this Agreement as a condition precedent to the transactions and agreements contemplated in the Master Lease and the other Obligation Documents (as defined below).

NOW, THEREFORE, in consideration of the premises, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto do hereby agree as follows:

1. **Defined Terms**. Capitalized terms used herein and not expressly defined herein shall have the respective meanings ascribed to them in this Section 1.

"Affiliate" means, with respect to any Person (i) any Person that, directly or indirectly, controls or is controlled by or is under common control with such Person, (ii) any other Person that owns, beneficially, directly or indirectly, 10% or more of the outstanding capital stock, shares or equity interests of such Person, or (iii) any officer, director, employee, shareholder, partner, member, manager or trustee of such Person or any Person controlling, controlled by or under common control with such Person (excluding trustees and persons serving in similar capacities who are not otherwise an Affiliate of such Person). For the purposes of this definition, "control" (including the correlative meanings of the terms "controlled by" and "under common control with"), as used with respect to any Person, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, through the ownership of voting securities or otherwise.

"Business Day" means each Monday, Tuesday, Wednesday, Thursday and Friday that is not a day on which money centers in the City of New York, New York are authorized or obligated by law or executive order to close.

"Major Event of Default" means the occurrence of any of the following events: (a) the occurrence of a "Major Event of Default" under and as defined in the Master Lease; (b) the occurrence of a "Major Event of Default" under and as defined in any of the other Obligation Documents; or (c) the failure of any of the Obligors to punctually and properly perform in all material respects (without duplication of any materiality qualifier herein) any covenant or obligation contained herein if the same shall remain uncured within a period of thirty (30) days after receipt by Obligors of written notice thereof from the Lessors, unless such failure cannot with due diligence be cured within a period of thirty (30) days (in the Lessors' reasonable discretion), in which case such failure shall not be deemed to continue so long as Obligors commence to cure such failure within the thirty (30) day period and proceed with due diligence to complete the curing thereof within sixty (60) days after receipt by Obligors of the Lessors' notice of default (or such longer period as is reasonably required in the determination of the Lessors to effect such cure if Obligors are diligently proceeding to do so); provided, however, in no event shall the Lessors be required to give more than two (2) notices and cure period for Obligors' failure to observe or perform the same (or repetitive) covenant or condition in any consecutive twelve (12) month period.

"MPT Documents" means, collectively, Master Lease and the other Obligation Documents

"Obligation Documents" has the meaning set forth in the Master Lease.

"Person" means an individual, a corporation, a limited liability company, a general or limited partnership, an unincorporated association, a joint venture, a governmental entity or another entity or group.

2. **Management Agreement**. Manager and Obligors hereby jointly and severally represent and warrant to the Lessors as follows: (a) attached hereto as ***EXHIBIT A*** is a true, correct and complete copy of the Management Agreement; (b) the Management Agreement is the only "Management Agreement" (as defined in the Master Lease) between Obligors and Manager, and any of their respective Affiliates with respect to the Leased Property; (c) the Management Agreement remains unmodified and in full force and effect as of the date hereof, without default thereunder by either Manager or any Obligor; and (d) Manager has been paid all amounts due for all services, if any, furnished as of this date with respect to the Leased Property, except for amounts due and payable with respect to services, if any, furnished during the calendar month in which this Agreement is made. The Management Agreement Counterparties represent and warrant to the Lessors that, other than this Agreement, neither the Management Agreement Counterparties nor Manager has entered into any subordination agreement with respect to the Management Agreement. Manager further acknowledges that the Lessees are leasing the Leased Property from the applicable Lessors pursuant to the Master Lease, which are secured by liens encumbering certain assets, including, but not limited to, the Management Agreement Counterparties' rights and interests under the Management Agreement.

3. **Subordination of Management Fees**. Manager acknowledges and agrees that the liens created by the MPT Documents, and the Lessors' right to payment thereunder, shall be superior to and have priority over the right of the Manager to receive payment under the Management Agreement. In furtherance of the foregoing, Manager fully and completely subordinates to the liens created by the MPT Documents, and to the Lessors' right to payment thereunder, any right to payment of Manager arising out of or in any way connected with its services performed under the Management Agreement. Manager further agrees that neither Manager nor its Affiliates: (a) shall demand, collect or accept from any of the Management Agreement Counterparties' or their Affiliates any payment or collateral on account of any amounts due or to become due under the Management Agreement (the "Subordinated Amounts") or any part thereof or realize upon or enforce any collateral securing such Subordinated Amounts, nor commence any action or proceeding against any of the Management Agreement Counterparties or their Affiliates in any court or other tribunal to recover all or any part of such Subordinated Amounts, except with respect to any payment to Manager permitted under Section 5 hereof; (b) shall have given or shall hereafter give any subordination or enter into any subordination agreement in respect of the Subordinated Amounts or transfer or assign any of the Subordinated Amounts to any Person other than the Lessors or their Affiliates; (c) will commence or join with any of the other creditors of the Management Agreement Counterparties or their Affiliates in commencing any bankruptcy, reorganization, receivership or insolvency proceeding against any of the Management Agreement Counterparties or their Affiliates; or (d) shall take or permit any action prejudicial to or inconsistent with the Lessors' priority position over Manager and its Affiliates that is created by this Agreement.

4. **Rights of Lessors Following a Major Event of Default**. Notwithstanding anything to the contrary in the Management Agreement, during the continuation of a Major Event of Default,

unless waived in writing by the Lessors, the Lessors shall have the right, upon written notice to Manager:

(a) to require Manager to continue performance under and in accordance with the Management Agreement, on behalf of the Lessors, with respect to any one or more of the Facilities as the Lessors may elect, for so long as the Lessors may elect, in consideration of the compensation due and payable under the Management Agreement with respect to such period of time; or

(b) to require the Management Agreement Counterparties to immediately remove any one or more of the Facilities (including all if so elected by the Lessors) from coverage under the Management Agreement, which shall terminate the management of such Facility or Facilities and, within five (5) days after receipt of such written notice, execute and deliver to the Lessors an amendment to the Management Agreement evidencing such removal.

Upon the removal of any one or more of the Facilities from coverage under the Management Agreement, as provided in subsection (ii) above (each, a "Removed Facility"), no termination fee or other compensation shall be due to Manager with respect to such Removed Facility; *provided, however*, that subject to the subordination provisions of this Agreement, nothing in this Agreement shall limit the Management Agreement Counterparties' obligation to pay to Manager the fees due under the Management Agreement for services rendered through the date of such removal.

5. **Permitted Receipt of Subordinated Amounts**. Notwithstanding anything to the contrary in this Agreement, so long as no Major Event Default has occurred and is continuing, the Management Agreement Counterparties may pay, and Manager may receive, the Subordinated Amounts (so long as such payment does not give rise to a Major Event of Default); *provided, that*: (a) nothing herein shall limit the accrual of the Subordinated Amounts during the existence of a Major Event of Default for Manager's services during such period and (b) if such Major Event of Default is cured or waived in writing by the Lessors, subject to the proviso below, any such accrued amounts shall be paid as provided under the Management Agreement; *provided, however*, that in no event shall any such accrued amount be payable to Manager if, as a result of a Major Event of Default, (i) the Master Lease is terminated (or Lessees' right of possession is terminated thereunder), or (ii) the Management Agreement is terminated (except to the extent provided therein), and in no event shall any such amounts continue to accrue with respect to a Removed Facility after the removal of such Removed Facility.

6. **Payment of Subordinated Amounts Following Certain Events**. Notwithstanding anything to the contrary in the Management Agreement, (a) during the continuation of a Major Event of Default, if Manager receives payment of or security for any Subordinated Amounts from any Obligor; or (b) after the date of removal of any one or more Removed Facilities, if Manager receives payment of or security for any Subordinated Amounts from any Obligor relating to such Removed Facilities, in either such case, Manager shall forthwith deliver such payment or security to the Lessors in precisely the form received (except for Manager's endorsement when necessary) for application in accordance with the MPT Documents. Until delivered such payment or security shall be held in trust by Manager as the property of the Lessors. In the event of the failure of Manager to endorse any instrument for the payment of

money so received, each Lessor is hereby appointed attorney-in-fact, which is coupled with an interest, for Manager with full power to make such endorsement and with full power of substitution.

7. **Remedies Upon Termination**. Upon any termination of the Management Agreement with respect to one or more Removed Facilities and the portion or portions of the Leased Property relating thereto, Manager may pursue those remedies set forth in the Management Agreement with regard to the Management Agreement Counterparties, so long as all such rights and remedies in respect of the Subordinated Amounts are subordinate to Lessors' rights and remedies under this Agreement and pursuant to the MPT Documents. Upon any such termination of the Management Agreement with respect to a Removed Facility, except as otherwise provided in Section 4, Manager shall have no right of specific performance and no lien or charge upon such Removed Facility, the portion or portions of the Leased Property relating thereto, or income from or relating to such Removed Facility or the portion or portions of the Leased Property relating thereto, with respect to the Subordinated Amounts, until all liabilities and obligations under the MPT Documents have been fully paid and satisfied (other than contingent indemnification obligations for which no claim has been asserted that expressly survive the termination of this Agreement).

8. **Bankruptcy; Liquidation**. In the event of any distribution, division or application, partial or complete, voluntary or involuntary, by operation of law or otherwise, of all or any part of the assets of the Obligors or the proceeds thereof to creditors of the Obligors, by reason of the liquidation, dissolution or other winding up of the Obligors or the business of the Obligors or, in the event of any sale, receivership, insolvency or bankruptcy case or proceeding by or against the Obligors for any relief under any bankruptcy or insolvency law or laws relating to the relief of debtors, readjustments of indebtedness, liquidations, reorganizations, compositions, or extensions, then, and in any such event, any payment or distribution of any kind or character, either in cash, securities or other property, which shall be payable or deliverable to Manager solely with respect to the Subordinated Amounts (and not any other amount payable to the Manager pursuant to the Management Agreement or otherwise) shall be paid or delivered directly to Lessors for application against any obligations or liabilities of Obligors under the MPT Documents, whether due or not due, until all such obligations shall have been fully paid and satisfied.

9. **Grant of Security Interest**. As an additional inducement to Lessors to enter into the MPT Documents and this Agreement, Manager hereby grants to the Lessors a security interest in all of Manager's fees, accounts receivable, and other amounts, due or to become due, arising from or related to the Management Agreement. The Lessors shall have the right at any time to file a UCC-1 financing statement without Manager's signature where authorized by law, but the failure of Lessors to do so shall not impair the validity or enforceability of this Agreement. Upon Lessors' request, and at Manager's expense, Manager shall promptly execute any and all documents (including all bank/lender required documents) and take all other actions as Lessors reasonably deem necessary to perfect its security interest as provided herein. Notwithstanding any provision of this Section to the contrary, Manager shall be entitled to receive and apply, without restriction, any Subordinated Amounts earned and received pursuant to the Management Agreement as permitted under Section 5 hereof.

10. **Receipt of Security Instruments**. Manager acknowledges receipt of a copy of the security instruments being delivered by Obligors to the Lessors in connection with the MPT Documents. Furthermore, Manager acknowledges that all rents or other funds that may hereafter be held by Manager, as agent for Obligors, are subject to the liens and security interests granted to the Lessors pursuant to the MPT Documents, and shall remit such funds to or as directed by the Lessors pursuant to the MPT Documents.

11. **Amendment of Management Agreement; Prepayment and Accrual of Fees**. Subject to the proviso set forth in Section 39.9 of the Master Lease, Manager and Obligors (a) shall not terminate or materially amend or modify the Management Agreement unless (i) they have obtained the prior written consent of the Lessors, which consent shall not be unreasonably withheld, conditioned or delayed, or (ii) such amendment or modification would not adversely affect the rights of the Lessors, in the reasonable determination of Lessors, (b) shall not make or accept any prepayment or advance payment of fees or other obligations due under the Management Agreement, and (c) neither shall accrue any fees, expenses and other amounts due under the Management Agreement in excess of one (1) month, unless, they have obtained the prior written consent of the Lessors, which consent shall not be unreasonably withheld, conditioned or delayed.

12. **Notice of Defaults**. Notwithstanding anything to the contrary in the Management Agreement, in the event the Management Agreement Counterparties default in the payment of any amounts due to Manager under the Management Agreement, Manager shall provide prompt written notice of such default to the Lessors, whereupon, the Lessors shall have the right, but not the obligation, within fifteen (15) days after receipt of such notice, to cure such default by paying directly to Manager any amounts due or outstanding under the Management Agreement so as to put the Management Agreement Counterparties in good standing thereunder.

13. **Representations and Warranties of Manager and Obligors**. Manager, individually and as to itself only, and each Obligor, jointly and severally, hereby represent and warrant to the Lessors as of the date hereof that (a) each of them has full legal right, power and authority to enter into this Agreement, to incur the obligations provided for herein, and to execute and deliver the same to the Lessors; (b) this Agreement has been duly executed and delivered by each of them and constitutes their valid and legally binding obligation, enforceable against them in accordance with its terms, subject to bankruptcy, insolvency, reorganization, and similar laws affecting the enforcement of creditor's rights or contractual obligations generally and, as to enforcement, to general principles of equity, regardless of whether applied in a proceeding at law or in equity; (c) no approval or consent of any foreign, federal, state, county, local or other governmental or regulatory body, and no approval or consent of any other Person is required in connection with the execution and delivery by any of them of this Agreement or the consummation and performance by any of them of the transactions contemplated hereby, except such approvals or consents as shall have been obtained on or prior to the date hereof; (d) the execution and delivery of this Agreement and the obligations created hereby have been duly authorized by all necessary proceedings on the part of each of them and will not conflict with or result in the material breach or violation of any of the terms or conditions of, or constitute (or with notice or lapse of time or both would constitute) a default under the governing documents of any of them, any material instrument, contract or other agreement to which any of them is a party or by or to which any of them or their respective assets or properties are bound or subject, or any

statute or any regulation, order, judgment or decree of any court or governmental or regulatory body; (e) ***Schedule 13(e)*** attached hereto sets forth, as of the date hereof, the ownership of Manager and, except as set forth therein, no other Person has, and none of them have offered to any Person, any written option to acquire same; (f) none of them is a party to or, to their knowledge, threatened with any litigation or judicial, administrative or arbitration proceeding which, if decided adversely to any of them, would restrain, prohibit or materially delay the transactions contemplated hereby; (g) the Management Agreement is the only "Management Agreement" (as defined in the Master Lease) between any of the Management Agreement Counterparties and Manager, with respect to the management of the Leased Property; (h) other than this Agreement, none of the Management Agreement Counterparties, nor Manager, has entered into any subordination agreement with respect to the Management Agreement; and (i) the Management Agreement remains unmodified and in full force and effect as of the date hereof, without default thereunder by any Obligor or Manager under the Management Agreement.

14. **Accounting of Services**. Manager and the Management Agreement Counterparties shall render to the Lessors from time to time upon the Lessors' reasonable request therefor an accounting of all amounts paid by any Obligor to Manager, which accounting shall include copies of all related invoices and receipts.

15. **Absolute and Unconditional Obligations**. Manager will perform its obligations under this Agreement regardless of any law now or hereafter in effect in any jurisdiction or venue affecting any of the terms of any of the MPT Documents or the rights of the Lessors with respect thereto. The obligations of Manager under this Agreement are independent of the MPT Documents, and a separate action or actions may be brought and prosecuted against Manager to enforce this Agreement, irrespective of whether any action is brought against any Obligor or their respective Affiliates or whether any Obligor or their respective Affiliates is joined in any such action or actions. The obligations of Manager under this Agreement shall be absolute and unconditional irrespective of:

(a) any lack of validity or enforceability of any of the MPT Documents;

(b) the validity of any lien granted to the Lessors or their Affiliates in any of the assets of the Management Agreement Counterparties;

(c) any change in the time, manner or place of payment or performance of, or in any other term of, any of the MPT Documents, or any other amendment thereof, or waiver of any provision thereof, including, without limitation, any increase in any indebtedness owed from the Obligors to the Lessors or their Affiliates resulting from the extension of additional credit to the Obligors or otherwise;

(d) any taking, exchange, release or non perfection of any lien granted to Lessors or their Affiliates in any of the assets of the Obligors;

(e) any manner of application of the assets of the Obligors, or proceeds thereof, to all or any of the indebtedness of the Obligors to the Lessors or their Affiliates, or any manner of sale or other disposition of any of such assets for all or any of such indebtedness of the Obligors to the Lessors or their Affiliates;

(f) any change, restructuring or termination of the organizational structure or existence of the Obligors; or

(g) any other circumstance which might otherwise constitute a defense available to, or a discharge of, the Obligors.

16. **Waiver of Notice**. The Obligors and Manager hereby waive promptness, diligence, notice of acceptance and any other notice with respect to this Agreement, the MPT Documents, and any requirement that the Lessors perfect or insure any lien or any collateral or exhaust any right or take any action against the Obligors, their respective Affiliates, Manager, or any other person or any collateral securing the indebtedness of the Obligors to the Lessors or their Affiliates.

17. **No Waiver**. Any provision of this Agreement or Exhibits hereto may be amended or waived only in a writing signed by the parties hereto. No waiver of any provision hereunder or any breach or default thereof shall extend to or affect in any way any other provision or prior or subsequent breach or default.

18. **Necessary Action**. Each party shall perform any further acts and execute and deliver any documents that may be reasonably necessary to carry out the provisions of this Agreement.

19. **Notices**. All notices, demands and other communications to be given or delivered under or by reason of the provisions of this Agreement shall be in writing and shall be deemed to have been given (a) when personally delivered, (b) when transmitted via telecopy (or other facsimile device) to the number set out below if the sender on the same day sends a confirming copy of such notice by a recognized overnight delivery service (charges prepaid), (c) the day following the day (except if not a Business Day then the next Business Day) on which the same has been delivered prepaid to a reputable national overnight air courier service or (d) the third Business Day following the day on which the same is sent by certified or registered mail, postage prepaid. Notices, demands and communications, in each case to the respective parties, shall be sent to the applicable address set forth below, unless another address has been previously specified in writing:

IF TO MANAGER:
[_____]
[_____]
[_____]
Attn: [_____]
Fax: [(___) [_____]

WITH A COPY TO:
[_____]
[_____]
[_____]
Attn: [_____]
Fax: [(___) [_____]

IF TO ANY OBLIGOR:
c/o LifePoint Health, [Inc.]
330 Seven Springs Way
Brentwood, TN 37027

Attention: General Counsel
[redacted]

WITH A COPY TO:

Sidley Austin LLP
787 Seventh Avenue
New York, NY 10019
[redacted]

WITH A COPY TO:

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219
[redacted]

IF TO ANY LESSOR:

c/o MPT Operating Partnership, L.P.
1000 Urban Center Drive, Suite 501
Birmingham, Alabama 35242
[redacted]

WITH A COPY TO:

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
420 20th Street North
1400 Wells Fargo Tower
Birmingham, Alabama 35203
[redacted]

or to such other address with respect to a party as such party notifies the other in writing as above provided.

20. **Severability**. Whenever possible, each provision of this Agreement shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Agreement, unless the severance of such provision would be in opposition to the parties' intent with respect to such provision.

21. **Entire Agreement**. This Agreement and the documents referred to herein contain the complete agreement between the parties hereto and supersede any prior understandings, agreements or representations by or between the parties, written or oral, which may have related to the subject matter hereof in any way.

22. **Governing Law; Jurisdiction and Venue; Waiver of Jury Trial**.

(a) This Agreement shall be governed by and construed in accordance with the laws of the State of Delaware applicable to contracts executed and performed in such State, without giving effect to conflicts of law principles.

(b) THE PARTIES HERETO CONSENT TO PERSONAL JURISDICTION IN THE STATE OF DELAWARE. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, THE PARTIES AGREE THAT ANY ACTION OR PROCEEDING ARISING FROM OR RELATED TO THIS AGREEMENT SHALL BE BROUGHT AND TRIED EXCLUSIVELY IN THE STATE OR FEDERAL COURTS OF DELAWARE. EACH OF THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY OBJECTION TO THE LAYING OF VENUE OF ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. THE PARTIES EXPRESSLY ACKNOWLEDGE THAT DELAWARE IS A FAIR, JUST AND REASONABLE FORUM AND AGREE NOT TO SEEK REMOVAL OR TRANSFER OF ANY ACTION FILED BY THE OTHER PARTIES IN SAID COURTS. FURTHER, THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY CLAIM THAT SUCH SUIT, ACTION OR PROCEEDING HAS BEEN BROUGHT IN AN INCONVENIENT FORUM. SERVICE OF ANY PROCESS, SUMMONS, NOTICE OR DOCUMENT BY CERTIFIED MAIL ADDRESSED TO A PARTY AT THE ADDRESS DESIGNATED PURSUANT TO SECTION 19 SHALL BE EFFECTIVE SERVICE OF PROCESS AGAINST SUCH PARTY FOR ANY ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT. A FINAL JUDGMENT IN ANY SUCH ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT MAY BE ENFORCED IN ANY OTHER COURT TO WHOSE JURISDICTION ANY OF THE PARTIES IS OR MAY BE SUBJECT.

(c) TO THE MAXIMUM EXTENT PERMITTED BY LAW, THE PARTIES HEREBY KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVE THE RIGHT TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION BASED HEREON, ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT, OR ANY COURSE OF CONDUCT, COURSE OF DEALING, STATEMENT (WHETHER VERBAL OR WRITTEN) OR ACTION OF ANY PARTY OR ANY EXERCISE OF ANY PARTY OF THEIR RESPECTIVE RIGHTS HEREUNDER OR IN ANY WAY RELATING TO THIS AGREEMENT OR THE COLLATERAL (INCLUDING ANY CLAIM OR DEFENSE ASSERTING THAT THIS AGREEMENT WAS FRAUDULENTLY INDUCED OR IS OTHERWISE VOID OR VOIDABLE). THIS WAIVER IS A MATERIAL INDUCEMENT FOR THE LESSORS TO ENTER INTO THIS AGREEMENT AND THE OTHER OBLIGATION DOCUMENTS.

23. **No-Third Party Beneficiaries**. Nothing expressed or referred to in this Agreement will be construed to give any Person other than the parties to this Agreement any legal or equitable right, remedy, or claim under or with respect to this Agreement or any provision of this Agreement.

24. **Binding Effect; Assignment**. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns, except that neither this Agreement nor any of the rights, interests or obligations hereunder may be assigned or delegated by Manager or any Obligor without the prior written consent of the Lessors. Any Lessor may at any time and without the consent of Manager or the Obligors assign all of its rights and obligations hereunder to any other Person.

25. **Delivery by Electronic Transmission**. This Agreement and any signed agreement entered into in connection herewith or contemplated hereby, and any amendments hereto or thereto, to the extent signed and delivered by means of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail, shall be treated in all manner and respects as an original contract and shall be considered to have the same binding legal effects as if it were the original signed version thereof delivered in person. At the request of any party hereto or to any such contract, each other party hereto or thereto shall re-execute original forms thereof and deliver them to all other parties. No party hereto or to any such contract shall raise the use of a facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail to deliver a signature or the fact that any signature or contract was transmitted or communicated through the use of facsimile machine or by .pdf, .tif, .gif, .jpeg or similar attachment to electronic mail as a defense to the formation of a contract and each such party forever waives any such defense.

26. **Counterparts**. This Agreement may be executed in multiple counterparts, any one of which need not contain the signature of more than one party, but all such counterparts taken together shall constitute one and the same instrument.

27. **Joint Drafting**. The parties hereto and their respective counsel have participated in the drafting and redrafting of this Agreement and the general rules of construction which would construe any provisions of this Agreement in favor of or to the advantage of one party as opposed to the other as a result of one party drafting this Agreement as opposed to the other or in resolving any conflict or ambiguity in favor of one party as opposed to the other on the basis of which party drafted this Agreement are hereby expressly waived by all parties to this Agreement.

28. **Representatives**.

(a) The Obligors hereby appoint Lima Holdco as their duly authorized agent and representative (the "Obligor Representative") to take all actions and enforce all rights of the Obligors under this Agreement, including, without limitation, (i) giving and receiving any notice or instruction permitted or required under this Agreement; (ii) interpreting all of the terms and provisions of this Agreement; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with the other parties hereto under this Agreement; (v) conducting negotiations and dealing with the Lessors under this Agreement; and (vi) taking any other actions on behalf of the Obligors relating to the Obligors' rights, claims, duties and obligations under this Agreement. In the performance of the Lessors' duties and obligations hereunder, the Lessors shall be authorized and permitted to correspond and transact with the Obligor Representative on behalf of all the Obligors and shall be entitled to rely upon any document or instrument executed and delivered by the Obligor Representative.

(b) The Lessors hereby appoint MPT of Johnstown-Lima, LLC as their duly authorized agent and representative (the "MPT Representative") to take all actions and enforce all rights of the Lessors under this Agreement, including, without limitation, (i) giving and receiving any notice or instruction permitted or required under this Agreement; (ii) interpreting all of the terms and provisions of this Agreement; (iii) authorizing payments or obtaining reimbursement as may be provided for herein; (iv) consenting to, compromising or settling all disputes with the other parties hereto under this Agreement; (v) conducting negotiations and dealing with the Obligors under this Agreement; and (vi) taking any other actions on behalf of

the Lessors relating to the Lessors' rights, claims, duties and obligations under this Agreement. In the performance of the Obligors duties and obligations hereunder, the Obligors shall be authorized and permitted to correspond and transact with the MPT Representative on behalf of all the Lessors and shall be entitled to rely upon any document or instrument executed and delivered by the MPT Representative.

[*Signatures Appear on Following Pages*]

IN WITNESS WHEREOF, this Agreement is executed and delivered as of the day and year first above written.

MANAGER:

[_____]

By:_____
Name:_____
Title:_____

[Signatures Continue on Following Pages]

OBLIGORS:

LIMA HOLDCO, LLC

By:_____
Name:_____
Title:_____

DODGE CITY HEALTHCARE GROUP, LLC
d/b/a Western Plains Medical Complex

By:_____
Name:_____
Title:_____

DLP CONEMAUGH MINERS MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

DLP CONEMAUGH MEMORIAL MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

SOUTHWESTERN MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

DLP CONEMAUGH MEYERSDALE MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

RCHP-OTTUMWA, LLC
d/b/a Ottumwa Regional Health Center

By:_____
Name:_____
Title:_____

PALESTINE PRINCIPAL HEALTHCARE LIMITED PARTNERSHIP
d/b/a Palestine Regional Medical Center

By:_____
Name:_____
Title:_____

PALESTINE-PRINCIPAL G.P., INC.

By:_____
Name:_____
Title:_____

RIVERTON MEMORIAL HOSPITAL, LLC
d/b/a SageWest Health Care - Riverton Campus and SageWest Health Care - Lander Campus

By:_____
Name:_____
Title:_____

NASON MEDICAL CENTER, LLC

By:_____
Name:_____
Title:_____

LESSORS:

MPT OF DODGE CITY-LIMA, LLC
MPT OF HASTINGS-LIMA, LLC
MPT OF JOHNSTOWN-LIMA, LLC
MPT OF LANDER-LIMA, LLC
MPT OF LAWTON-LIMA, LLC
MPT OF MEYERSDALE-LIMA, LLC
MPT OF OTTUMWA-LIMA, LLC
MPT OF PALESTINE-LIMA, LLC
MPT OF RIVERTON-LIMA, LLC
MPT OF ROARING SPRINGS-LIMA, LLC

By: MPT Operating Partnership, L.P.
Its: Sole Member of each above-referenced entity

By:_____
Name:_____
Title:_____

ANNEX A
Lessees and Lessors

LESSEES

1. DODGE CITY HEALTHCARE GROUP, LLC
2. DLP CONEMAUGH MINERS MEDICAL CENTER, LLC
3. DLP CONEMAUGH MEMORIAL MEDICAL CENTER, LLC
4. SOUTHWESTERN MEDICAL CENTER, LLC
5. DLP CONEMAUGH MEYERSDALE MEDICAL CENTER, LLC
6. RCHP-OTTUMWA, LLC
7. PALESTINE PRINCIPAL HEALTHCARE LIMITED PARTNERSHIP
8. PALESTINE-PRINCIPAL G.P., INC.
9. RIVERTON MEMORIAL HOSPITAL, LLC
10. NASON MEDICAL CENTER, LLC

LESSORS

1. MPT OF DODGE CITY-LIMA, LLC
2. MPT OF HASTINGS-LIMA, LLC
3. MPT OF JOHNSTOWN-LIMA, LLC
4. MPT OF LANDER-LIMA, LLC
5. MPT OF LAWTON-LIMA, LLC
6. MPT OF MEYERSDALE-LIMA, LLC
7. MPT OF OTTUMWA-LIMA, LLC
8. MPT OF PALESTINE-LIMA, LLC
9. MPT OF RIVERTON-LIMA, LLC
10. MPT OF ROARING SPRINGS-LIMA, LLC

EXHIBIT A

Management Agreement

[See attached.]

Schedule 13(e)

Ownership of Manager

DISCLOSURE SCHEDULES

TO

REAL PROPERTY ASSET PURCHASE AGREEMENT

dated as of November 4, 2019

by and among

LIMA HOLDCO, LLC

THE LIMA SUBSIDIARIES SET FORTH ON ANNEX A TO THE
REAL PROPERTY ASSET PURCHASE AGREEMENT, AND
THE MPT PARTIES SET FORTH ON ANNEX A TO THE
REAL PROPERTY ASSET PURCHASE AGREEMENT

INTRODUCTION

This document and the exhibits hereto, each of which is incorporated by reference herein (collectively, these "Disclosure Schedules") are being delivered pursuant to the Real Property Asset Purchase Agreement, dated as of November 4, 2019 (the "Agreement"), by and among Lima HoldCo, LLC, a Delaware limited liability company ("Lima"), the Lima Subsidiaries set forth on Annex A to the Agreement (the "Lima Subsidiaries"), and the MPT Parties set forth on Annex A to the Agreement (the "MPT Parties"). Unless the context requires otherwise, capitalized terms used but not otherwise defined herein shall have the meanings assigned to such terms in the Agreement, and all references to section numbers contained in these Disclosure Schedules refer to sections of the Agreement.

The statements in these Disclosure Schedules, and those in any supplement hereto, are qualified in their entirety by reference to the specific provisions of the Agreement and do not constitute, and shall not be construed as constituting, representations, warranties or covenants of the Lima Parties, except as and to the extent expressly provided in the Agreement. The statements in these Disclosure Schedules, and those in any supplement hereto, relate to the provisions in the Section of the Agreement to which they expressly relate; provided, however, that any information set forth in one section of the Schedules shall also be deemed to apply to any other section to which its relevance is reasonably apparent on its face.

Matters reflected in any Section of these Disclosure Schedules are not necessarily limited to matters required by the Agreement to be so reflected. Such additional matters are set forth for informational purposes and do not necessarily include other matters of a similar nature. It is understood and agreed that the specification of any dollar amount in the representations and warranties contained in the Agreement or these Disclosure Schedules is not intended to imply that such amounts or higher or lower amounts are or are not material, and neither party shall use the fact of the setting of such amounts in these Disclosure Schedules in any dispute or controversy between the parties as to whether any obligation, item or matter not described in the Agreement or included in these Disclosure Schedules is or is not material for purposes of the Agreement.

No reference to or disclosure of any item or other matter in these Disclosure Schedules shall be construed as an admission or indication that such item or other matter is material or that such item or other matter is required to be referred to or disclosed in the Agreement. Without limiting the foregoing, no such reference to or disclosure of a possible breach or violation of any Contract or Law shall be construed as an admission or indication that a breach or violation exists or has actually occurred. In disclosing the information in these Disclosure Schedules, the Lima Parties expressly do not waive any attorney-client privilege or other applicable privilege associated with such information or any protection afforded by the work-product doctrine with respect to any of the matters disclosed or discussed herein.

This introductory language and the headings in these Disclosure Schedules are inserted for convenience only and shall not create a different standard for disclosure than the language set forth in the Agreement. This information is disclosed in confidence for the purposes contemplated in the Agreement and is subject to the confidentiality and use provisions of the Agreement and the Confidentiality Agreement.

Schedule 2.2

Excluded Assets

	Facility	Survey / Tax Parcel / Hastings Bldg No.	Property Name	Address	City	State	Estimated SF	Use of Property (per Hospital 2018)	Comments
CONEMAUGH MEMORIAL	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	1125 Milford Street	Johnstown	PA	Unknown	Student Housing	non-core disposition project - value unknown
	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	1133 Milford Street Johnstown, PA	Johnstown	PA	Unknown	Student Housing	non-core disposition project - value unknown
	Conemaugh Memorial Medical Center	78-010.-602.000 (same as Hospital)	GME Housing	1121 Milford Street	Johnstown	PA	Unknown	Student Housing	non-core disposition project - value unknown
	Conemaugh Memorial Medical Center	78-009.-204.000 (same as Hospital)	GME housing	138 Skelly Street	Johnstown	PA	Unknown	Student Housing	non-core disposition project - value unknown

	Conemaugh Memorial Medical Center	78-009.-204.000 (same as Hospital)	Physician on-call housing (green house)	134 Skelly Street	Johnstown	PA	3,651SF	On-call Housing	non-core disposition project - value unknown
	Conemaugh Memorial Medical Center	78-010.-302.000	GME Housing - Duplex	20 Rose Street	Johnstown	PA	Lot Size: 42'x62'	Student Housing	non-core disposition project - value unknown
	Conemaugh Memorial Medical Center	78-010.-303.000	GME Housing - Duplex	18 Rose Street	Johnstown	PA	Lot Size: 42'x61'	Student Housing	non-core disposition project - value unknown
	Conemaugh Memorial Medical Center	78-010A.111-000	GME Housing	R. 16 Osborne Street (Actually on Otto Court)	Johnstown	PA	Lot Size: 40'x50'	Student Housing	non-core disposition project - value unknown
	Conemaugh Memorial Medical Center	78.009.-504.000	Vacant tract	1113 Barnett Street	Johnstown	PA	56.6'x120'	None	Very steep terrain - hillside non-core disposition project - No Value
	Conemaugh Memorial Medical Center	78.009.-505.000	Vacant tract	1115 Barnett Street	Johnstown	PA	53'x120'	None	Very steep terrain - hillside non-core disposition project - No Value

	Conemaugh Memorial Medical Center	78-008.-209.000	Vacant tract	Franklin St.	Johnstown	PA	55'x165'	None	non-core disposition project - no value
	Conemaugh Memorial Medical Center	75.002.-204.000 per Assessor: 075-000647	Unused Parking lot	522 Sherman Street	Johnstown	PA	18,951SF	Parking Lot	was held for future Med Park parking, but currently proposing land swap for another parcel closer to Hospital - currently in escrow for land swap
	Conemaugh Memorial Medical Center	72.002.-115.000	Locust Plaza	315 Locust Street	Johnstown	PA	46,731SF	MOB	non-core disposition project - approx value $199,000
	Conemaugh Memorial Medical Center	75.001.-100.000	Vacant MRI Building and land surrounding UPMC Conemaugh Cancer Center	331- 337 Somerset St (331: MRI, 337: Cancer Ctr)	Johnstown	PA	MRI Bldg 5,540SF	MOB's	MRI Building is Vacant non-core disposition project approx value $290,000
	Conemaugh Memorial Medical Center	83.002.-106.000	Part of unused "I" Parking lot	Walnut Street/River Avenue	Johnstown	PA	Unknown	Parking Lot	"I Lot" Currently not being used non-core disposition project - Approx Value - $10,000
	Conemaugh Memorial Medical Center	62.008.-109.003	Vacant Medical Office Building	318 Goucher Street	Johnstown	PA	3,002SF	MOB	non-core disposition project - in escrow $175,000

	Conemaugh Memorial Medical Center	50.037.-427.000	Vacant tract	Rear Hostetler Road	Johnstown	PA	134,667SF	None	Landlocked non-core disposition project - No Value
	Conemaugh Memorial Medical Center	46.002.-114.000	Office Building (LHC-Home Health)	813 Jefferson	Portage	PA	1,510SF	MOB or Office Building	LHC will vacate at 12/31/18 non-core disposition project - Approx value $45,000
	Conemaugh Memorial Medical Center	522-027-071-00	MOB and adjacent Parking Lot	1609 & 1611 W Pitt St	Jennerstown	PA	11,442SF	MOB/Parking Lot	non-core disposition project. Offer of $86,000; Contract in process to be signed.
	Conemaugh Memorial Medical Center	E.09-E.04-103	Medical Office Building	140 South Anderson ST	Bedford	PA	1,314SF	MOB	Used Thursday only by CPG-Cardiology non-core disposition project
PALESTINE	Palestine Regional Medical Center	TX40707 6910-00007-00118 R0064347	Memorial Mother Frances	100 W. Brazos/duplex with below	Palestine	TX	11,686	off site storage building	can't occupy; in non-core disposition project - $0 value, trying to donate

	Palestine Regional Medical Center	TX40708 6910-00007-00118 R0064347 (same as above)	Memorial Mother Frances	1004 S Magnolia/shares tax parcel with 100 W. Brazos	Palestine	TX	1,728	TDH is in this space	in non-core disposition project - $0 value, trying to donate
	Palestine Regional Medical Center	TX40710 6910-12000-00400 R0034954	Vacant - Clinic	804 S. Sycamore	Palestine	TX	5,641	off site storage building	can't occupy; in non-core disposition project - $0 value, trying to donate

Schedule 2.3(a)

Assumed Lima Leases

1.	Lease by and between the City of Lander, as Lessor, and Lander Valley Regional Medical Center, as Lessee, dated July 10, 1982, as amended by that certain Amendment No. One to Lease, dated April 24, 1985, as assigned by Assignment and Assumption of Lease (Lander Valley Medical Center) by and between Qualicare of Wyoming, Inc., as Assignor, and NAHC of Wyoming, Inc., as Assignee, dated January 31, 1998, as amended by that certain First Amendment to Lease, dated July 1, 1991, and as further amended by that certain Third Amendment to Lease dated March 15, 1998. A Second Amendment of Lease was never fully executed and therefore is not effective. Lease expires December 31, 2073.

Schedule 2.3(b)

MOB Ground Leases

1.	Ground Lease by and between RCHP-Ottumwa, Inc., a Delaware corporation, now known as RCHP-Ottumwa, LLC, a Delaware limited liability company, as Lessor, and Ottumwa MOB, LLC, a Georgia limited liability company, as Lessee, dated November 22, 2010, as assigned by Assignment and Assumption of Lessee's Interest in Ground Lease by and between Ottumwa MOB, LLC, a Georgia limited liability company, and Ottumwa Medical Properties, LLC, an Iowa limited liability company. Ground Lease expires November 21, 2060.
2.	Amended and Restated Ground Lease by and between Southwestern Medical Center, LLC, a Delaware limited liability company, as lessor, and Southwestern MOB I, LLC, a Delaware limited liability company, as lessee, dated January 7, 2008, as assigned by Assignment and Assumption of Ground Lease by and between Southwestern MOB I, LLC, a Delaware limited liability company, and G&E HC REIT II Lawton MOB Portfolio LLC, dated December 30, 2010. Ground Lease expires January 6, 2058.
3.	Ground Lease by and between Southwestern Medical Center, LLC, a Delaware limited liability company, as lessor, and Southwestern MOB I, LLC, a Delaware limited liability company, as lessee, dated January 7, 2008, as assigned by Assignment and Assumption of Ground Lease by and between Southwestern MOB I, LLC, a Delaware limited liability company, and G&E HC REIT II Lawton MOB Portfolio LLC, dated December 30, 2010. Ground Lease expires January 6, 2058.
4.	Lease Agreement by and between Nason Hospital, a Pennsylvania non-profit corporation, as landlord, and Altoona-Logan Township Mobile Medical Emergency Department Authority, a Pennsylvania corporation f/k/a Roaring Spring Ambulance Service, Inc., a Pennsylvania non-profit corporation, as tenant, dated June 1, 1992, as assigned by Assignment and Assumption of Leases by and between Nason Hospital, a Pennsylvania non-profit, as Assignor, and Nason Medical Center, LLC, a Delaware limited liability company, as Assignee.

Schedule 3.4

Allocation of Purchase Price

Real Estate	City	State	Allocated Purchase Price
Conemaugh Memorial Medical Center	Johnstown	Pennsylvania	$294,956,923
Conemaugh Meyersdale Medical Center	Meyersdale	Pennsylvania	$5,337,621
Conemaugh Miners Medical Center	Hastings	Pennsylvania	$10,675,241
Conemaugh Nason Medical Center	Roaring Springs	Pennsylvania	$12,673,051
SageWest Health Care-Lander Regional Hospital	Lander	Wyoming	$47,641,423
SageWest Health Care – Riverton Memorial Hospital	Riverton	Wyoming	$33,837,665
Southwestern Medical Center	Lawton	Oklahoma	$73,153,622
Palestine Regional Medical Center	Palestine	Texas	$106,088,647
Western Plains Medical Complex	Dodge City	Kansas	$58,607,076
Ottumwa Regional Health Center	Ottumwa	Iowa	$57,028,731
TOTAL			**$700,000,000**

Schedule 4.1

Ownership of Lima Parties

Ownership as of the date of the Agreement:

Lima Party	Equity Authorized/Issued/Outstanding	Direct Record Owner	Indirect Record Owner(s) (through LifePoint)
Lima HoldCo, LLC	100% LLC membership interest	LifePoint Health, Inc.	N/A
Nason Medical Center, LLC	100% LLC membership interest	LifePoint Holdings 2, LLC	LifePoint Health, Inc. owns 100% of the stock of Legacy LifePoint Health, Inc. Legacy LifePoint Health, Inc. owns 100% of the membership interest of Historic LifePoint Hospitals, LLC Historic LifePoint Hospitals, LLC owns 100% of the membership interest of LifePoint Hospitals Holdings, LLC LifePoint Hospitals Holdings, LLC owns 100% of the membership interest of LifePoint Holdings 2, LLC
Riverton Memorial Hospital, LLC	100% LLC membership interest	LifePoint Hospitals Holdings, LLC	LifePoint Health, Inc. owns 100% of the stock of Legacy LifePoint Health, Inc. Legacy LifePoint Health, Inc. owns 100% of the membership interest of Historic LifePoint Hospitals, LLC Historic LifePoint Hospitals, LLC owns 100% of the membership interest of LifePoint Hospitals Holdings, LLC
Southwestern Medical Center, LLC	100% LLC membership interest	Lawton Holdings, LLC	LifePoint Health, Inc. owns 100% of the membership interest of Capella Health Holdings, LLC

Lima Party	Equity Authorized/Issued/Outstanding	Direct Record Owner	Indirect Record Owner(s) (through LifePoint)
			Capella Health Holdings, LLC owns 100% of the membership interest of Capella Holdings, LLC Capella Holdings, LLC owns 100% of the membership interest of Capella Healthcare, LLC Capella Healthcare, LLC owns 100% of the membership interest of Lawton Holdings, LLC
Palestine Principal Healthcare Limited Partnership	1% general partner interest 99% Class A Limited Partner Interest	Palestine-Principal G.P., Inc. (1% General Partner) Principal Hospital Company of Nevada, Inc. (99% Limited Partner)	LifePoint Health, Inc. owns 100% of the stock of Legacy LifePoint Health, Inc. Legacy LifePoint Health, Inc. owns 100% of the membership interest of Province Healthcare Company, LLC Province Healthcare Company, LLC owns 100% of the stock of (i) Principal Hospital Company of Nevada, Inc. and (ii) Palestine-Principal GP, Inc.
Palestine-Principal G.P., Inc.	100% stock	Province Healthcare Company, LLC	LifePoint Health, Inc. owns 100% of the stock of Legacy LifePoint Health, Inc. Legacy LifePoint Health, Inc. owns 100% of the membership interest of Province Healthcare Company, LLC
Dodge City Healthcare Group, LLC	100% LLC membership interest	Western Plains Regional Hospital, LLC	LifePoint Health, Inc. owns 100% of the stock of Legacy LifePoint Health, Inc. Legacy LifePoint Health, Inc. owns 100% of the membership interest of Historic LifePoint Hospitals, LLC Historic LifePoint Hospitals, LLC owns 100% of the membership interest of LifePoint Hospitals Holdings, LLC LifePoint Hospitals Holdings, LLC owns 100% of the membership interest of Western Plains Regional Hospital, LLC

Lima Party	Equity Authorized/Issued/Outstanding	Direct Record Owner	Indirect Record Owner(s) (through LifePoint)
RCHP-Ottumwa, LLC	100% LLC membership interest	RCHP-Ottumwa Holdings, Inc.	LifePoint Health, Inc. owns 100% of the membership interest of RCHP, LLC. RCHP, LLC owns 100% of the stock of RegionalCare Hospital Partners, Inc. RegionalCare Hospital Partners, Inc. owns 100% of stock of RCHP-Ottumwa Holdings, Inc.
DLP Conemaugh Memorial Medical Center, LLC	100% LLC membership interest	DLP Conemaugh Holding Company, LLC	LifePoint Health, Inc. owns 100% of the stock of Legacy LifePoint Health, Inc. Legacy LifePoint Health, Inc. owns 100% of the membership interest of Historic LifePoint Hospitals, LLC Historic LifePoint Hospitals, LLC owns 100% of the membership interest of LifePoint Hospitals Holdings, LLC LifePoint Hospitals Holdings, LLC owns 100% of the membership interest of LifePoint Holdings 2, LLC LifePoint Holdings 2, LLC owns 100% of the membership interest of DLP Partner, LLC DLP Partner, LLC owns 97% of the membership interest of DLP Healthcare, LLC DLP Healthcare, LLC owns 100% of the membership interest of DLP Conemaugh Holding Company, LLC
DLP Conemaugh Miners Medical Center, LLC	100% LLC membership interest	DLP Conemaugh Holding Company, LLC	LifePoint Health, Inc. owns 100% of the stock of Legacy LifePoint Health, Inc. Legacy LifePoint Health, Inc. owns 100% of the membership interest of Historic LifePoint Hospitals, LLC

Lima Party	Equity Authorized/Issued/Outstanding	Direct Record Owner	Indirect Record Owner(s) (through LifePoint)
			Historic LifePoint Hospitals, LLC owns 100% of the membership interest of LifePoint Hospitals Holdings, LLC LifePoint Hospitals Holdings, LLC owns 100% of the membership interest of LifePoint Holdings 2, LLC LifePoint Holdings 2, LLC owns 100% of the membership interest of DLP Partner, LLC DLP Partner, LLC owns 97% of the membership interest of DLP Healthcare, LLC DLP Healthcare, LLC owns 100% of the membership interest of DLP Conemaugh Holding Company, LLC
DLP Conemaugh Meyersdale Medical Center, LLC	100% LLC membership interest	DLP Conemaugh Holding Company, LLC	LifePoint Health, Inc. owns 100% of the stock of Legacy LifePoint Health, Inc. Legacy LifePoint Health, Inc. owns 100% of the membership interest of Historic LifePoint Hospitals, LLC Historic LifePoint Hospitals, LLC owns 100% of the membership interest of LifePoint Hospitals Holdings, LLC LifePoint Hospitals Holdings, LLC owns 100% of the membership interest of LifePoint Holdings 2, LLC LifePoint Holdings 2, LLC owns 100% of the membership interest of DLP Partner, LLC DLP Partner, LLC owns 97% of the membership interest of DLP Healthcare, LLC DLP Healthcare, LLC owns 100% of the membership interest of DLP Conemaugh Holding Company, LLC

Ownership upon consummation of the LifePoint Upper Tier Restructuring Transaction:

Lima Party	Equity Authorized/Issued/Outstanding	Record Owner	Indirect Record Owner(s) (through LifePoint)
Lima HoldCo, LLC	100% LLC membership interest	LifePoint Health, LLC (f/k/a LifePoint Health, Inc.)	N/A
Nason Medical Center, LLC	100% LLC membership interest	Lima HoldCo, LLC	LifePoint Health, LLC (f/k/a LifePoint Health, Inc.) owns 100% of the membership interest of Lima HoldCo, LLC
Riverton Memorial Hospital, LLC	100% LLC membership interest	Lima HoldCo, LLC	LifePoint Health, LLC (f/k/a LifePoint Health, Inc.) owns 100% of the membership interest of Lima HoldCo, LLC
Southwestern Medical Center, LLC	100% LLC membership interest	Lawton Holdings, LLC	LifePoint Health, LLC (f/k/a LifePoint Health, Inc.) owns 100% of the membership interest of Lima HoldCo, LLC Lima HoldCo, LLC owns 100% of the membership interest of Lawton Holdings, LLC
Palestine Principal Healthcare Limited Partnership	1% general partner interest 99% Class A Limited Partner Interest	Palestine-Principal G.P., Inc. (1% General Partner) Lima HoldCo, LLC (99% Limited Partner)	LifePoint Health, LLC (f/k/a LifePoint Health, Inc.) owns 100% of the membership interest of Lima HoldCo, LLC Lima HoldCo, LLC owns 100% of the stock of Palestine-Principal, GP, Inc.
Palestine-Principal G.P., Inc.	100% stock	Lima HoldCo, LLC	LifePoint Health, LLC (f/k/a LifePoint Health, Inc.) owns 100% of the membership interest of Lima HoldCo, LLC
Dodge City Healthcare Group, LLC	100% LLC membership interest	Western Plains Regional Hospital, LLC	LifePoint Health, LLC (f/k/a LifePoint Health, Inc.) owns 100% of the membership interest of Lima HoldCo, LLC Lima HoldCo, LLC owns 100% of the membership interest of Western Plains Regional Hospital, LLC
RCHP-Ottumwa, LLC	100% LLC membership interest	RCHP-Ottumwa Holdings, Inc.	LifePoint Health, LLC (f/k/a LifePoint Health, Inc.) owns 100% of the membership interest of Lima HoldCo, LLC Lima HoldCo, LLC owns 100% of the stock of RCHP-Ottumwa Holdings, Inc.
DLP Conemaugh Memorial Medical Center, LLC	100% LLC membership interest	DLP Conemaugh Holding Company, LLC	LifePoint Health, LLC owns 100% of the membership interest of Lima HoldCo, LLC

Lima Party	Equity Authorized/Issued/Outstanding	Record Owner	Indirect Record Owner(s) (through LifePoint)
			Lima HoldCo, LLC owns 100% of the membership interest of DLP Lima Partner, LLC DLP Lima Partner, LLC owns 97% of the membership interest of DLP Conemaugh Holding Company, LLC
DLP Conemaugh Miners Medical Center, LLC	100% LLC membership interest	DLP Conemaugh Holding Company, LLC	LifePoint Health, LLC owns 100% of the membership interest of Lima HoldCo, LLC Lima HoldCo, LLC owns 100% of the membership interest of DLP Lima Partner, LLC DLP Lima Partner, LLC owns 97% of the membership interest of DLP Conemaugh Holding Company, LLC
DLP Conemaugh Meyersdale Medical Center, LLC	100% LLC membership interest	DLP Conemaugh Holding Company, LLC	LifePoint Health, LLC owns 100% of the membership interest of Lima HoldCo, LLC Lima HoldCo, LLC owns 100% of the membership interest of DLP Lima Partner, LLC DLP Lima Partner, LLC owns 97% of the membership interest of DLP Conemaugh Holding Company, LLC

Schedule 4.3

Absence of Conflicts

(a)

None.

(b)

None.

(c)

None.

(d)

None.

(e)

The following properties have existing mortgages:

- Ottumwa Regional:
  - Mortgage, Security Agreement, Assignment of Rents and Leases and Fixture Filing, dated September 26, 2016, filed September 30, 2016, in Book 2016, Page 4197, executed by RCHP - Ottumwa, LLC, as mortgagor, to Wilmington Trust, as mortgagee.
- Southwestern:
  - Mortgage, Security Agreement, Assignment of Rents and Leases and Fixture Filing dated September 26, 2016, executed by Southwestern Medical Center, LLC, in favor of Wilmington Trust, National Association, as trustee, and filed for record September 28, 2016 at 3:18 PM in Book 7686, Page 130, Securing the Principal Sum of $36,870,000.00.

The following material Contracts may require the provision of notice and/or waiver of termination right in connection with the consummation of the Sale/Leaseback Transaction:

1. Property Leasing Management Agreement by and between LifePoint Corporate Services General Partnership and Cushman & Wakefield US, Inc. (f/k/a Cassidy Turley Midwest, Inc.), dated May 18, 2011.

2. Hospital Services Agreement by and between Lander Regional Hospital and Connecticut General Life Insurance Company, dated January 1, 2014.

3. Hospital Services Agreement by and between Riverton Memorial Hospital and Cigna Health and Life Insurance Company, dated January 1, 2014.

4. Hospital Services Agreement by and between Palestine Regional Medical Center and CIGNA HealthCare of Texas, Inc., dated March 5, 2010.

5. Hospital Services Agreement by and between Conemaugh Health System and Connecticut General Life Insurance Company, dated April 1, 2013.

The following material Contracts may require the provision of notice and/or waiver of termination right in connection with the LifePoint Upper Tier Restructuring Transaction:

1. Commitment Agreement - Pharmaceutical Products Distribution Services HealthTrust Purchasing Group Members by and between LifePoint Health and AmerisourceBergen Drug Corporation, dated November 2, 2016.[1]

2. BlueTraditional Network Participating Hospital Agreement for Acute Care Hospitals by and between Capella Healthcare, LLC d/b/a Southwestern Medical Center and Blue Cross and Blue Shield of Oklahoma, dated April 1, 2018.

3. Facility Participation Agreement by and among Palestine Regional Medical Center Psychiatric Services Center, United HealthCare of Texas, Inc. and United HealthCare Insurance Company, dated November 22, 2013.

4. Facility Participation Agreement by and among Palestine Regional Medical Center, United HealthCare of Texas, Inc. and United HealthCare Insurance Company, dated July 1, 2006.

5. Facility Participation Agreement by and between Lander Valley Medical Center and United HealthCare Insurance Company, dated December 13, 2006.

6. Facility Participation Agreement by and between Riverton Memorial Hospital and United HealthCare Insurance Company, dated March 15, 2007.

7. Hospital Participation Agreement by and between Western Plains Regional Hospital and Principal Health Care, Inc. - PPO Wichita Division, dated July 1, 1994.

Schedule 4.4 is incorporated by reference herein in its entirety.

[1] Notice required if LifePoint Health, Inc. is converted to a limited liability company.

Schedule 4.4

Consents and Approvals

The following actions are required by the Government Authorities specified below with respect to the Lima Parties in connection with the consummation of the LifePoint Upper Tier Restructuring Transaction.

1. Pennsylvania Hospital License. Submit notice letter.[2]
2. Oklahoma Hospital License. Submit notice letter.
3. Kansas Hospital License. Submit notice letter.
4. Iowa Hospital License. Submit notice letter.
5. Medicare. Submit change of information filing.
6. Medicaid. Submit change of information filing for each State.

The following material Contracts may require the counterparty's consent and/or the provision of notice in connection with the Sale/Leaseback transaction:

1. Hospital Services Agreement by and between Riverton Memorial Hospital and Cigna Health and Life Insurance Company, dated January 1, 2017.

2. Medicare Advantage Psychiatric and Substance Abuse Provider Agreement by and between Conemaugh Valley Memorial Hospital and Highmark Inc., dated March 1, 2010.

3. Facility Agreement by and between Conemaugh Valley Memorial Hospital and Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, dated July 1, 2008.

4. Facility Agreement by and between Meyersdale Community Hospital d/b/a Meyersdale Medical Center and Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, dated July 1, 2008.

5. Facility Agreement by and between Nason Hospital and Highmark Inc., dated August 13, 2007.

The following material Contracts may require the counterparty's consent and/or the provision of notice in connection with the LifePoint Upper Tier Restructuring Transaction:

1. Hospital Services Agreement by and between Palestine Principal Healthcare Limited Partnership and Aetna Health, Inc., dated April 1, 2010.

2. Physician Group Agreement by and between Palestine Principal Healthcare Limited Partnership and Aetna Health, Inc., dated April 1, 2010.

3. Community Health Reinvestment Grant Agreement by and between Advantage Point Health Alliance Laurel Highlands, LLC and Highmark, Inc., dated March 13, 2017.

4. Facility Agreement by and between Nason Hospital and Highmark Inc., dated August 13, 2007.

5. Hospital Services Agreement by and between Riverton Memorial Hospital and Cigna Health and Life Insurance Company, dated January 1, 2017.

---

[2] Following notice, the Pennsylvania Department of Health will make a determination of whether the transaction will constitute a change of ownership for any of the Facilities in Pennsylvania. A change of ownership typically will require a new hospital application be submitted with the transaction.

6. UPMCHP/UPMCHN/UPMCFY Provider Group Agreement by and among Penn Highlands Health Plan, UPMC Health Plan, Inc., UPMC Health Network Inc., and UPMC For You, Inc., dated August 1, 2005.

7. UPMCH/UPMCHN/UPMCFY Hospital Agreement by and among Penn Highlands Health Plan, UPMC Health Plan, Inc., UPMC Health Network Inc., and UPMC For You, Inc., dated August 1, 2005.

8. UPMCH/UPMCHN/UPMCFY Ancillary Provider Agreement by and among Penn Highlands Health Plan, UPMC Health Plan, Inc., UPMC Health Network Inc., and UPMC For You, Inc., dated August 1, 2005.

9. PHC-Ancillary Provider Agreement by and between Western Plains Regional Hospital and Preferred Health Care, Inc., dated August 1, 1994.

10. Hospital Services Agreement by and between Connecticut General Life Insurance Company and Lander Regional Hospital, dated January 1, 2014.

11. Hospital Services Agreement by and between Connecticut General Life Insurance Company and Riverton Memorial Hospital, dated January 1, 2014.

Schedule 4.3(e) is incorporated by reference herein in its entirety

The Collateral Leases identified on Schedule 4.5(c)(ii) as requiring consent and/or notice to collaterally assign are incorporated by reference herein in their entirety.

Schedule 4.5(b)

Tenant Leases that Include ROFR Purchase Rights

1. Asset Purchase Agreement by and among Conemaugh Health System Inc., Conemaugh Valley Memorial Hospital, Meyersdale Community Hospital, Miners Hospital, Conemaugh Health Initiatives, Inc., Conemaugh Enterprises, Inc., 1086 Real Estate, LLC, DLP Conemaugh Memorial Medical Center, LLC, DLP Conemaugh Meyersdale Medical Center, LLC, DLP Conemaugh Miners Medical Center, LLC, DLP Conemaugh Physician Practices, LLC and DLP Conemaugh JV, LLC, dated August 20, 2014, as amended.

2. Lease Agreement by and between East Hills Professional Building Associates, as predecessor-in-interest to 1086 Real Estate, LLC, as Lessor, and Pasquerilla Enterprises, LP, as predecessor-in-interest to Crown American Associates, as Lessee, dated April 13, 1986, as amended by Lease Amendment dated December 19, 1988, as further amended by Second Amendment of Lease dated December 20, 2006, as assigned by Assignment and Assumption of Lease by and between 1086 Real Estate, LLC, as Assignor, and DLP Conemaugh Memorial Medical Center, LLC, as Assignee, dated September 1, 2014. (Holiday Inn Express)

3. Lease Agreement by and between East Hill Professional Building Associates, as predecessor-in-interest to 1086 Real Estate, LLC, as Lessor, and Pasquerilla Enterprises, LP, as predecessor-in-interest to Crown American Associates, as Lessee, dated April 13, 1986, as amended by Lease Amendment dated December 19, 1988, as further amended by Second Amendment of Lease dated December 6, 2006, as assigned by Assignment and Assumption of Lease by and between 1086 Real Estate, LLC, as Assignor, and DLP Conemaugh Memorial Medical Center, LLC, as Assignee, dated September 1, 2014. (Parking lot for Holiday Inn Express)

Schedule 4.5(c)(i)

Tenant Leases

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
Alternative Community Resource Program, Inc.	DLP Conemaugh Memorial Medical Center, LLC	62106.29642C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	9/5/2013	6/17/2028	Full Time - Suite/Unit Lot J - 119 Walnut St
Cambria-Somerset Radiology & Nuclear Medicine Group, Inc.	DLP Conemaugh Memorial Medical Center, LLC	62106.30966C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	1/1/2018	12/31/2019	FT Lease- 1086 Franklin Street Suite M1078
Cambria-Somerset Radiology & Nuclear Medicine Group, Inc.	DLP Conemaugh Memorial Medical Center, LLC	62106.30967C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	1/1/2018	12/31/2019	PT Lease- 1086 Franklin Street Suite M1082
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29651C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	11/1/2013	12/31/2019	Part Time - 236 Jamesway Rd (Full day 8:00am - 5:00pm) every 2nd and 4th Tuesday and every Thursday.
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29675C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	8/1/2015	7/31/2020	FT Lease: - Suite/Unit 300 - 1111 Franklin Street (OBGYN)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29676C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	5/1/2016	12/31/2019	FT Lease: Suite #1 @ 236 Jamesway (Medwell-Ebensburg)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29686C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	11/1/2013	10/31/2021	Full Time - Suite/Unit M3000-3008 - 1086 Franklin St
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29694C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	12/15/2014	12/31/2019	PT Lease- Ebensburg Care Center 236 Jamesway Rd - Speciality Suite
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29695C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	12/15/2014	12/31/2019	FT Lease- 1111 Franklin Street Suite 130
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29706C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	8/1/2015	8/31/2020	Full Time - 564 Theater Drive (St. Benedict Rural Health Clinic)

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29726C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	11/1/2015	10/31/2020	Full Time - Suite/Unit Cardiac Surgery Suite - 1086 Franklin St
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29728C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	2/1/2015	1/31/2020	1st Amend to renew eff 2/1/2017
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29733C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	3/7/2015	3/31/2020	PT Lease- 140 S. Anderson Street (Cardiology)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29742C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	4/1/2016	3/31/2020	FT Lease- portion of 2nd floor at Lee Campus 320 Main St. (Conemaugh Counseling Associates)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29749C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	11/18/2013	11/30/2019	Full Time - Wessel Building - 1015 Franklin Street
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29755C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	6/1/2015	5/31/2020	Full Time - 1060 Lloyd Street
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29756C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	5/1/2015	4/30/2020	FT Lease: GS1000 @ 1020 Franklin (Medical Oncology)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29773C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	7/1/2015	6/30/2021	FT Lease: Suite GS1000 @ 1020 Franklin (Good Sam-Admin)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.32786C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	4/1/2015	12/31/2019	FT Lease- Ebensburg Care Center 236 Jamesway Rd Suite 20
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.33740C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	6/1/2015	5/31/2020	Full Time- Conemaugh Medical Park- 1 Tech Park Drive
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.45243C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	11/14/2016	10/31/2021	Full Time 5-year Lease

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.47141C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	5/1/2017	4/30/2020	FT Lease at 1111 Franklin Street, Suite 230
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.50031C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	2/1/2018	12/31/2019	PT Agreement: Specialty Suite @ 236 Jamesway
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.51431C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	2/19/2018	2/28/2028	FT Lease: Suite 0200 @ 1450 Scalp Avenue (CPG-East Hills)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.51432C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	2/19/2018	2/18/2028	FT Lease: Suite 1000 @ East Hills (Medwell-East Hills)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.52288C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	6/1/2018	5/31/2020	PT Agreement: Suite 0301 @ 1450 Scalp Avenue
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.53687C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	7/1/2018	6/30/2021	FT Lease: Room GS1020 in the Good Sam Bldg-1020 Franklin (Oncology Billers & Trans)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.54084C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	8/15/2018	8/14/2028	FT Lease: Suite 0302 @ East Hills MOB (CPG-Breast Surgery)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.54436C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	9/15/2018	9/14/2021	FT Lease: 415 Napoleon Place (General Surgery)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.54437C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	9/15/2018	9/14/2021	FT Lease: 425 Napoleon Place (Weight Mgmt. & Bariatric Surgery)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.54851C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	7/16/2018	7/15/2028	FT Lease: Suite 0303 at 1450 Scalp Avenue (OBGYN)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.69708C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	1/1/2019	12/31/2020	FT Lease: 815 2nd Street Cresson, PA (Cresson Family Practice)

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.71569C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	10/1/2019	9/30/2024	FT Lease: Suite 140 @ 1111 Franklin (Pulmonology)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.71636C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	10/1/2019	9/30/2024	FT Lease: entire building at 927 Menoher Blvd, Johnstown, PA
DLP Conemaugh Physician Practices,LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.29670C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	12/1/2012	9/30/2021	Full Time - Medical Building of Johnstown Suite/Unit 410 - 1111 Franklin Street
DLP-Conemaugh Physician Practices, LLC d/b/a DLP-CPP-Cardiology	DLP Conemaugh Memorial Medical Center, LLC	62106.30540C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	6/1/2015	12/31/2019	Part Time Lease Amendment For DLP CPP, LLC (DLP CPP-Cardiology/ECC)
Highlands Health	DLP Conemaugh Memorial Medical Center, LLC	62106.29734C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	1/1/2016	12/31/2019	Full Time - ground floor @ 340 Main Street
Johnstown Cardiovascular Associates	DLP Conemaugh Memorial Medical Center, LLC	62106.50263C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	1/1/2018	12/31/2019	Parking Lot Lease: Lot #2 Franklin Street, Johnstown, PA
L. Keith Fammartino, DMC, PA	DLP Conemaugh Memorial Medical Center, LLC	62106.29672C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	12/1/2009	11/30/2021	Full Time - 1609 W Pitt St (portion of bldg.)
Laurel Cardiology	DLP Conemaugh Memorial Medical Center, LLC	62106.29769C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	2/1/2016	1/31/2020	FT Lease - portion of 4th floor at Wessel Building - 1015 Franklin Street
Laurel Group Anesthesia, P.C.	DLP Conemaugh Memorial Medical Center, LLC	62106.71192C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	6/15/2019	6/30/2020	FT Lease: portion of 4th floor @ 320 Main
Laurel Group Anesthesia, PC	DLP Conemaugh Memorial Medical Center, LLC	62106.29717C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	12/1/2015	12/31/2021	FT Lease- Main Campus 1086 Franklin Street (M4004 & M4007)
Lori's Gifts, Inc.	DLP Conemaugh Memorial Medical Center, LLC	62106.69481C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	6/1/2019	5/31/2022	Gift Shop Lease: portion of 3rd floor @ 1086 Franklin

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
Maharajh, Balkisoon	DLP Conemaugh Memorial Medical Center, LLC	62106.29766C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	12/1/2011	11/30/2021	Full Time - Suite/Unit A - 1015 Franklin St
Mart Enterprises, Inc.	DLP Conemaugh Memorial Medical Center, LLC	62106.71405C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	10/1/2019	9/30/2021	Parking Lot: 5 spaces at Lot #23 at Valley Pike
MedCare Equipment Company, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.55893C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	1/1/2019	12/31/2020	FT Lease: Suite S172C at 320 Main Street
MedCare Equipment Company, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.55895C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	1/1/2019	12/31/2020	FT Lease: Room #E6430 @ 1086 Franklin
Pasquerilla Enterprises	DLP Conemaugh Memorial Medical Center, LLC	62106.29663C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	4/1/1986	4/12/2021	Full Time - 1440 Scalp Avenue Lot 11 - Holiday Inn Express Ground Lease
Pasquerilla Enterprises	DLP Conemaugh Memorial Medical Center, LLC	62106.32515C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	9/1/2014	4/12/2021	Memorial Medical Center located at 1086 Franklin Street Lot 12 and 17, Johnstown, PA
Pennsylvania In-Home Partner-I, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.49663C	RE Lease - LifePoint as Landlord - Hospital as LL / JV Entity as Tenant	9/2/2017	9/1/2022	130 W Osborne Street, new FT Lease
Pennsylvania In-Home Partner-I, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.49665C	RE Lease - LifePoint as Landlord - Hospital as LL / JV Entity as Tenant	9/2/2017	8/31/2020	315 Locust Streert, first floor space, FT lease
Pennsylvania In-Home Partner-II, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.45572C	RE Lease - LifePoint as Landlord - Hospital as LL / JV Entity as Tenant	1/1/2017	12/31/2019	FT Lease - Locust Tower located at 315 Locust Street, Johnstown, Pennsylvania 15901
Select Specialty Hospital - Johnstown, INC.	DLP Conemaugh Memorial Medical Center, LLC	62106.29648C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	11/21/2006	10/31/2021	Full Time - 320 Main St
Shared Business Services, LLC	DLP Conemaugh Memorial Medical Center, LLC	62106.37228C	RE Lease - LifePoint as Landlord - Hospital as LL / LPT Other Entity as Tenant	1/1/2016	12/31/2020	Conemaugh Medical Park/MedPark One Tech Drive

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
Snyder Environmental Services, Inc.	DLP Conemaugh Memorial Medical Center, LLC	62106.56120C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	1/15/2019	7/14/2020	Ground Lease-Sherman Street Lot
UPMC Health System	DLP Conemaugh Memorial Medical Center, LLC	62106.29643C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	8/1/2002	7/31/2022	Full Time - Somerset St
DLP -Conemaugh Physician Practices, LLC d/b/a DLP-CPP-Cardiology	DLP Conemaugh Meyersdale Medical Center, LLC	62108.35093C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	9/1/2015	8/31/2021	Part Time- 200 Hospital Drive, Meyersdale , PA 15552 (Cardiology)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Meyersdale Medical Center, LLC	62108.29790C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	7/1/2015	6/30/2020	PT Agreement: 4 rooms in OR department at 200 Hospital Drive
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Meyersdale Medical Center, LLC	62108.49931C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	11/1/2017	10/31/2020	PT Agreement: Rooms 142, 144, 146 & 156 @200 Hospital Drive (OBGYN)
GPH Meyersdale, L.P. d/b/a Golden Living Center - Meyersdale; f/k/a Meyersdale Rehabilitation and Convalescent Center, Inc.	DLP Conemaugh Meyersdale Medical Center, LLC	62108.29780C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	11/1/1980	10/30/2020	Full Time - Golden Living Center - Meyersdale - 201 Hospital Dr
Hill, E. Darryl DPM	DLP Conemaugh Meyersdale Medical Center, LLC	62108.50482C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	12/1/2017	11/30/2020	PT Agreement: Rooms 142, 144, 146 & 156 @ 200 Hospital Drive
Ophthalmic Associates	DLP Conemaugh Meyersdale Medical Center, LLC	62108.49140C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	9/1/2017	8/31/2021	FT Lease: portion of bldg. at 7160 Mason Dixon Hwy
Robert L. Rundorff, M.D., P.C.	DLP Conemaugh Meyersdale Medical Center, LLC	62108.52937C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	8/1/2018	7/31/2020	PT Agreement: Suite LL02 @ 200 Hospital Drive
Sharper Hearing Aid Center, Inc.	DLP Conemaugh Meyersdale Medical Center, LLC	62108.49744C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	10/1/2017	9/30/2020	PT Agreement: Suite LL02 @ 200 Hospital Drive

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
Vantage Physical Therapy & Rehabilitation, Inc.	DLP Conemaugh Meyersdale Medical Center, LLC	62108.52608C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	7/1/2018	6/30/2020	PT Agreement: Suite LL02 @ 200 Hospital Drive
DLP -Conemaugh Physician Practices, LLC d/b/a DLP-CPP-Medical Oncology	DLP Conemaugh Miners Medical Center, LLC	62107.34054C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	7/1/2015	6/30/2020	Part Time- 290 Haida Ave. Hastings, PA 16646
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Miners Medical Center, LLC	62107.29791C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	12/17/2014	12/31/2020	FT Lease- 290 Haida Avenue Suites A091
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Miners Medical Center, LLC	62107.32565C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	7/1/2015	6/30/2020	Part Time- 290 Haida Ave. Hastings, PA 16646 the Cardiology Suite
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Miners Medical Center, LLC	62107.34192C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	8/20/2015	8/31/2021	Part Time- 290 Haida Ave. Hastings, PA 16646 (Surgery & Masciotra)
DLP Conemaugh Physician Practices, LLC	DLP Conemaugh Miners Medical Center, LLC	62107.68729C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	3/1/2019	2/28/2021	PT Agreement-Outpatient Specialty Clinic at Miners (Maranis & Dib)
Indiana Regional Medical Center Physician Group (IPG)	DLP Conemaugh Miners Medical Center, LLC	62107.29796C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	7/1/2015	6/30/2020	Part Time - Miners Medical Center - 290 Haida Avenue - the Special Procedure Unit consisting of an office, Exam Room 1 A084, Exam A083 and Bed 1
Western Pennsylvania Sports Medicine and Rehabilitation Center, Inc.	DLP Conemaugh Physician Practices, LLC	62105.71632C	RE Lease - LifePoint as Landlord - Physician Practice as LL / Third Party as Tenant	10/1/2019	9/30/2024	Sublease: portion of bldg. at 927 Menoher
Central Care, P.A.	Dodge City Healthcare Group, LLC	61128.26853C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	6/1/2014	7/31/2020	FT Lease - 112 Ross BLVD, Suite #D
Wesley Physicians Medical Specialties, LLC	Dodge City Healthcare Group, LLC	61128.71597C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	10/1/2019	9/30/2020	PTOA - 108 Ross Blvd. (former Occ. Health Bldg.)

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
Western Plains Physician Practices, LLC	Dodge City Healthcare Group, LLC	61128.21602C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	7/2/2012	6/30/2022	112 Ross Blvd., Suite C
Western Plains Physician Practices, LLC	Dodge City Healthcare Group, LLC	61128.36172C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	11/1/2015	7/31/2021	FT - 112 Ross Blvd, Suite A
Western Plains Physician Practices, LLC	Dodge City Healthcare Group, LLC	61128.45814C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	2/1/2017	1/31/2020	Lease in Suite B located at 112 Ross Blvd, Dodge City, KS 67801
Western Plains Physician Practices, LLC	Dodge City Healthcare Group, LLC	61128.51115C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	9/1/2017	8/31/2022	Full Time Physician Practice Lease - MOB - 112 Ross Blvd. (Adam)
Western Plains Regional Hospital Auxiliary of Dodge City, Kansas, Inc.	Dodge City Healthcare Group, LLC	61128.41041C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	3/1/2016	2/28/2021	Gift Shop Lease located at 3001 Avenue A, Dodge City, KS
Altoona-Logan Township Mobile Medical Emergency Department Authority, a Pennsylvania corporation f/k/a Roaring Spring Ambulance Service, Inc.	Nason Medical Center, LLC	62140.31961C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	6/1/1992	5/31/2028	
Angel Q. Raposas, M.D., P.C.	Nason Medical Center, LLC	62140.51188C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	2/1/2018	10/31/2020	PT Agreement: Suite 4 @ Cove Medical Bldg (111 Nason)
Bedford Regional Urology, P.C.	Nason Medical Center, LLC	62140.70770C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	8/1/2019	7/31/2020	PT Agreement: Suite 104 @ 111 Nason Drive
Bernard D. Smith	Nason Medical Center, LLC	62140.32380C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	2/1/2015	1/31/2021	FT Lease - Vacant farm land surrounding Nason Medical Center campus at 105 Nason Drive
Cardiology Associates of Altoona	Nason Medical Center, LLC	62140.31963C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	8/1/2015	7/31/2020	Part Time Sublease - Suite/Unit 104 - 111 Nason Dr

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
DLP Conemaugh Physician Practices, LLC	Nason Medical Center, LLC	62140.52338C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	5/1/2018	4/30/2020	FT Lease: Suite 4 @ 111 Nason Drive (CPG-Vascular Surgery)
DLP Conemaugh Physician Practices, LLC	Nason Medical Center, LLC	62140.71395C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	10/1/2019	9/30/2020	PT Agreement-Suite 4 @ 111 Nason Drive (CT Surgery)
Morrisons Cove 1st Federal Credit Union	Nason Medical Center, LLC	62140.48489C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	7/1/2017	6/30/2022	ATM Agreement-105 Nason Drive
Nason Hospital Auxiliary, a Pennsylvania corporation	Nason Medical Center, LLC	62140.31964C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	1/29/2015	1/31/2021	Full Time - Suite/Unit Gift Shop - 105 Nason Dr
Nason Physcian Practices, LLC	Nason Medical Center, LLC	62140.33310C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	6/1/2015	5/31/2021	Full Time Gross Rent Lease located at 105 hillcrest drive, Roaring Springs, PA (Pediatrics)
Nason Physcian Practices, LLC- OB/GYN	Nason Medical Center, LLC	62140.33476C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	6/1/2015	5/31/2021	Full Time Gross Lease 104 hillcrest drive, Roaring Springs, PA (OBGYN)
Pennsylvania In-Home Partner-III, LLC	Nason Medical Center, LLC	62140.51553C	RE Lease - LifePoint as Landlord - Hospital as LL / JV Entity as Tenant	2/2/2018	1/31/2021	FT Lease: 1st floor of 108 Nason Drive
Rhodes, Scott	Nason Medical Center, LLC	62140.66818C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	2/1/2019	1/31/2021	Ground Lease-Vacant farm land surrounding Nason Medical Center campus
Mercy Clinics, Inc.	Ottumwa Health Group, LLC	62461.71197C	RE Lease - LifePoint as Landlord - Physician Practice as LL / Third Party as Tenant	9/1/2019	8/31/2021	PT Agreement: portion of Bldg at 931 Pennsylvania
Akintunde, Oluyemisi MD	Palestine Principal Healthcare Limited Partnership	61117.47755C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	5/1/2017	4/30/2021	126 Medical Center Drive, Suite A - New Full Time Lease
Mt. Enterprise Community Health Clinic	Palestine Principal Healthcare Limited Partnership	61117.52317C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	5/1/2018	4/30/2021	FT Lease, Suite J & K, 4002 South Loop 256, Palestine, TX 75801

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
Nephromed Associates, PA	Palestine Principal Healthcare Limited Partnership	61117.51315C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	3/1/2018	2/29/2020	FT 4002 South Loop 256, Suite F, Palestine, TX 75801
Pulmonary Specialists of Tyler, P.A.	Palestine Principal Healthcare Limited Partnership	61117.67518C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	2/1/2019	1/31/2021	PTOA - 4002 S Loop 256, Suite R
Puvvada, Nandan K. MD and Lakshmi M. Puvvada, MD	Palestine Principal Healthcare Limited Partnership	61117.6210C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	8/1/2014	11/30/2019	4002 S. Loop 256, Suite L
Susan Alison Barrows, M.D.	Palestine Principal Healthcare Limited Partnership	61117.54746C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	9/1/2018	8/31/2020	PT - 4002 S Loop 256, Suite R
Texas Specialty Physicians	Palestine Principal Healthcare Limited Partnership	61117.43096C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	8/1/2016	7/31/2022	FT Lease located in 126 Medical Drive, Palestine, TX 75801
Texas Specialty Physicians	Palestine Principal Healthcare Limited Partnership	61117.53955C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	8/1/2018	7/31/2023	FT Lease - 4002 S Loop 256 - Suite A-A (Dr. Tovar)
Trinity Clinic	Palestine Principal Healthcare Limited Partnership	61117.40904C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	3/7/2016	3/31/2022	Full Time Lease in Suite S located at 4002 South Loop 256, Palestine, Texas 75801
Trinity Clinic	Palestine Principal Healthcare Limited Partnership	61117.7278C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	6/15/2011	11/30/2019	249 South Craig Street (Full Time)
Tyler Nephrology Associates, PA	Palestine Principal Healthcare Limited Partnership	61117.70990C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	9/1/2019	8/31/2021	PTOA - 4002 S Loop 256 - Suite R
William Elfarr, M.D.	Palestine Principal Healthcare Limited Partnership	61117.41045C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	4/1/2016	3/31/2020	PTOA in Suite R at 4002 S Loop 256, Palestine, TX 75801
Burlington Neurology and Sleep Clinic, PLC	RCHP-Ottumwa, LLC	62460.70714C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	7/15/2019	7/31/2020	PT Agreement-portion of Suite D @ 1013 Pennsylvania Avenue (Haas MOB II)

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
Ottumwa Anesthesiologists, P.C.	RCHP-Ottumwa, LLC	62460.68679C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	5/1/2013	4/30/2020	1001 Pennsylvania Ave.
Ottumwa Health Group, LLC	RCHP-Ottumwa, LLC	62460.71194C	RE Lease - LifePoint as Landlord - Hospital as LL / Physician Practice as Tenant	9/1/2019	8/31/2022	FT Lease: Entire bldg. @ 931 Pennsylvania (Women's Health Clinic)
Ottumwa Medical Properties, LLC	RCHP-Ottumwa, LLC	62460.68674C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	11/22/2010	11/21/2060	Ground Lease - MOB at 1011-1013 Pennsylvania Ave, Ottumwa, IA
Fisher, Michael M.D.	Riverton Memorial Hospital, LLC	61121.4095C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	9/1/2010	8/31/2020	Full Time Lease - 1005 Collegeview Drive
Lander Regional Hospital Auxiliary	Riverton Memorial Hospital, LLC	61121.48002C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	11/1/2016	10/31/2021	Gift Shop @ 1320 Bishop Randall
MacGuire, Anne MD	Riverton Memorial Hospital, LLC	61121.28386C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	8/27/2014	12/31/2019	Part Time Lease - 1005 College View Drive, Suite 10
Riverton Physician Practices, LLC	Riverton Memorial Hospital, LLC	61121.43985C	RE Lease - LifePoint as Landlord - Physician Practice as LL / Third Party as Tenant	11/1/2016	12/31/2020	FT Lease: portion of MOB #1 (several employed physicians) at 1005 College View Drive
BRC Family Hearing Solutions	Riverton Memorial Hospital, LLC	61163.54879C	RE Lease - LifePoint as Landlord - Physician Practice as LL / Third Party as Tenant	8/23/2018	8/31/2021	FT Lease - 15 Shrine Club Road - Sublease
Atkinson Medical, PLLC	Southwestern Medical Center, LLC	62475.67440C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	11/1/2012	10/31/2020	Real Estate Lease - 5606 SW Lee Boulevard, Suite 305, Lawton, OK
Kandimala, Geetha MD	Southwestern Medical Center, LLC	62475.67417C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	9/1/2016	8/31/2020	Real Estate Lease - 5606 SW Lee Boulevard, Suite 302, Lawton, OK 73505
Roan, Minda MD	Southwestern Medical Center, LLC	62475.67412C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	3/1/2010	2/29/2020	Real Estate Lease - 5606 SW Lee Blvd., Suite 306, Lawton, OK 73505

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date	Description
Southwestern MOB I, LLC	Southwestern Medical Center, LLC	62475.69235C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	1/7/2008	1/6/2058	Ground lease - hospital as landlord - MOB I - 5604 SW Lee Blvd
Southwestern MOB I, LLC	Southwestern Medical Center, LLC	62475.69237C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	1/7/2008	1/6/2058	Ground lease - hospital as landlord - MOB 2 - 5606 SW Lee Blvd
The Breast Center, Inc.	Southwestern Medical Center, LLC	62475.67185C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	7/1/2012	9/30/2022	Real Estate Lease - 5604 SW Lee Boulevard, Suite 150, Lawton, OK 73505
Wichita Falls Gastroenterology Associates, LLP	Southwestern Medical Center, LLC	62475.68600C	RE Lease - LifePoint as Landlord - Hospital as LL / Third Party as Tenant	11/1/2017	9/30/2020	PT - 5606 SW Lee Blvd, Lawton, OK (MOB II), suite 301

Schedule 4.5(c)(ii)

Collateral Leases

Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - Westwood Plaza Suite/Unit 1 - 1910 Minno Dr.	Address: 1910 Minno Dr. Johnstown, PA 15905 Lease of 60,000 square feet. Per the lease, it appears that this space is leased for use by the Finance Department for billing, collections, financial analysis, etc. Is located approximately 10 minutes away from the hospital.	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - Suite/Unit Parking Lot - 130 Valley Pike	Address: 130 Valley Pike Johnstown, PA 15905 120 parking spaces less than a mile away from the hospital.	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	FT Parking Lot Lease at Somerset Street (DLP CMMC-Spence Custer Lot)	Parking lot on main hospital campus	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time located at 1158 Hunt Street, Cambria County, PA	Parking for the hospital	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - 934 to 960 Franklin Street	Parking for the hospital	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - Franklin Street, Somerset Street and Willow Place	Employee parking	Collateral Assignment

Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Parking license agreement for parking lot at 100-102 Valley Pike	Parking for the hospital	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - Tax Parcel #s: 78-004-401.000; 78-004-400.000; 78-004-315.000 Suite/Unit Parking Lot	Parking license agreement	Collateral Assignment
Conemaugh Nason	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Prime Lease - 111 Nason Dr	MOB on campus.	Collateral Assignment
Ottumwa	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Master Lease of building at 1011-1013 in which hospital entity is the tenant (hospital ground leases as landlord to Ottumwa MOB, LLC in MT 62462.68674)	On-campus MOB where the hospital owns the land but not the building.	Collateral Assignment
Ottumwa	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	FT - 1255 Theater Drive, Suite B. Ottumwa, IA	Ottumwa Walk In Clinic	Collateral Assignment
Palestine	RE Lease - LifePoint as Tenant - Physician Practice as Tenant / Third Party as LL	Full Time Lease - 115 Medical Drive, Condo 1 & 2	On hospital campus; Obstetrics & Gynecology Associates/Pediatric Associates	Collateral Assignment

SageWest Riverton	RE Lease - LifePoint as Tenant - Physician Practice as Tenant / Third Party as LL	15 Shrine Club Road, Suite B	Oncology Center	Collateral Assignment
Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Master Lease for MOB I - hospital as tenant - 5604 SW Lee Blvd.	Master Lease for MOB 1	Collateral Assignment
Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Master Lease for MOB 2 - hospital as tenant - 5606 SW Lee Blvd.	Master Lease for MOB 2	Collateral Assignment
Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Real Estate Lease - 5116 W. Gore Blvd., Suite 1, Lawton, OK 73505	Appears to be MRI about a mile from the hospital in shopping center.	Collateral Assignment

Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Real Estate Lease - 5112 W. Gore Blvd., Suite 1, Lawton, OK 73505	Appears to be MRI about a mile from the hospital in shopping center.	Collateral Assignment
Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Real Estate Lease - 5610 SW Lee Boulevard, Lawton, OK 73505	Southwestern Orthopedics building on the hospital campus	Collateral Assignment
Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	5410 SW Lana Drive, Lawton, OK	Oklahoma P.E.T. Center across the street from the hospital	Collateral Assignment
Western Plains	RE Lease - LifePoint as Tenant - Physician Practice as Tenant / Third Party as LL	Full Time Lease for 106 North Main Street	Primary Care Clinic	Collateral Assignment
Western Plains	RE Lease - LifePoint as Tenant - Physician Practice as Tenant / Third Party as LL	Express Care Lease	Urgent Care Clinic	Collateral Assignment

Schedule 4.5(d)(i)

Matters Relating to Assumed Lima Leases, Tenant Leases and Collateral Leases

1. Ottumwa Regional:
   - Mortgage, Security Agreement, Assignment of Rents and Leases and Fixture Filing, dated September 26, 2016, filed September 30, 2016, in Book 2016, Page 4197, executed by RCHP - Ottumwa, LLC, as mortgagor, to Wilmington Trust, as mortgagee.

2. Southwestern:
   - Mortgage, Security Agreement, Assignment of Rents and Leases and Fixture Filing dated September 26, 2016, executed by Southwestern Medical Center, LLC, in favor of Wilmington Trust, National Association, as trustee, and filed for record September 28, 2016 at 3:18 PM in Book 7686, Page 130, Securing the Principal Sum of $36,870,000.00.

Schedule 4.5(d)(ii)

Matters Relating to Tenant Defaults

Hospital	Tenant	MT#	Charge	Month	Current Owed	0-30 Owed	31-60 Owed	61-90 Owed	Over 90 Owed	Total Owed To 10/31/2019
Conemaugh Memorial	Laurel Cardiology, P.C.	62106.29769C	Late Fee	Oct-19	508.07	508.07	0.00	0.00	0.00	508.07
	Totals				**508.07**	**508.07**	**0.00**	**0.00**	**0.00**	**508.07**
Ottumwa	Mercy Clinics, Inc.	62461.71197C	Base Rent	Jul-19	5.41	0.00	0.00	0.00	5.41	5.41
Ottumwa	Mercy Clinics, Inc.	62461.71197C	Base Rent	Aug-19	108.20	0.00	0.00	0.00	108.20	108.20
Ottumwa	Mercy Clinics, Inc.	62461.71197C	Equip & Furniture	Sep-19	20.90	0.00	20.90	0.00	0.00	20.90
Ottumwa	Mercy Clinics, Inc.	62461.71197C	Base Rent	Sep-19	100.00	0.00	100.00	0.00	0.00	100.00
Ottumwa	Mercy Clinics, Inc.	62461.71197C	Equip & Furniture	Oct-19	20.90	20.90	0.00	0.00	0.00	20.90
Ottumwa	Mercy Clinics, Inc.	62461.71197C	Base Rent	Oct-19	100.00	100.00	0.00	0.00	0.00	100.00
	Totals				**355.41**	**120.90**	**120.90**	**0.00**	**113.61**	**355.41**
Palestine	ETMC Physician Group, Inc.	61117.41045C	Base Rent	Oct-19	316.14	316.14	0.00	0.00	0.00	316.14
	Totals				**316.14**	**316.14**	**0.00**	**0.00**	**0.00**	**316.14**
Palestine	Oluyemisi Akintunde, M.D.	61117.47755C	Base Rent	Oct-19	2.94	2.94	0.00	0.00	0.00	2.94
Palestine	Oluyemisi Akintunde, M.D.	61117.47755C	Late Fee	Oct-19	403.83	403.83	0.00	0.00	0.00	403.83
	Totals				**406.77**	**406.77**	**0.00**	**0.00**	**0.00**	**406.77**

Schedule 4.5(g)

Construction Projects; Construction Documents; Estimated Development Costs

See attached.

1. **Ebensburg Outpatient Center**

    a. Agreement between Owner and Contractor dated 10/17/2018 by and between DLP Conemaugh Memorial Medical Center, LLC and Massaro Corporation.
    b. Agreement between Owner and Architect dated 11/6/2015 by and between DLP Conemaugh Memorial Medical Center, LLC and Stengel Hill Architecture Incorporated.

2. **Somerset New Outpatient Center**

    a. Agreement between Owner and Contractor dated 12/10/2018 by and between DLP Conemaugh Memorial Medical Center, LLC and MBM Contracting, Inc.
    b. Agreement between Owner and Architect dated 6/21/2018 by and between DLP Conemaugh Memorial Medical Center, LLC and Stengel Hill Architecture Incorporated.

LifePoint Health
LIMA Active Construction Projects
10/24/2019

Facility	Description	Status	Architect	General Contractor	Start Date	Target Completion Date	Budget	Notes
Conemaugh Memorial	Ebensburg Outpatient Center - New Building	Approved - Construction	Stengel Hill	Massaro Construction	12/16/2015	11/21/2019	$23,894,776	
Conemaugh Memorial	IR3 Renovation	Approved - Procurement	Stengel Hill	Massaro Construction	9/4/2019	7/31/2020	$2,683,920	
Conemaugh Memorial	Mobile CT (Equipment Only)	Approved - Procurement	N/A	N/A	9/4/2019	12/31/2019	$751,010	
Conemaugh Memorial	Chiller #3 (Soft Start - Phase I)	Approved - Procurement	N/A	N/A	8/1/2019	12/31/2019	$99,950	
Conemaugh Memorial	Steam Converter (P Bldg)	Approved - Procurement	N/A	N/A	7/17/2019	12/31/2019	$13,625	
Conemaugh Memorial	Locust Bldg Roof Replacement (DNC 2018)	Approved - Construction	N/A	N/A	8/22/2019	10/31/2019	$46,390	
Conemaugh Memorial	Replace Fire Dampers	Approved - Procurement	N/A	N/A	8/12/2019	12/31/2019	$29,950	
Conemaugh Memorial	Fire Alarm Panel (South Parking Garage)	Approved - Procurement	N/A	N/A	7/23/2019	12/31/2019	$147,300	
Conemaugh Memorial	Fire Alarm Panel (Good Sam Computer Room)	Approved - Procurement	N/A	N/A	7/22/2019	12/31/2019	$93,800	
Conemaugh Memorial	Door Swing (CP6 Mechanical Room)	Approved - Procurement	N/A	N/A	7/22/2019	12/31/2019	$14,560	
Conemaugh Memorial	Good Sam Exit Door	Approved - Procurement	N/A	N/A	8/22/2019	12/31/2019	$24,159	
Conemaugh Memorial	Sprinkler Head (P 5 Canopy)	Approved - Procurement	N/A	N/A	7/17/2019	12/31/2019	$18,800	
Conemaugh Memorial	Elevator Upgrades (P Bldg - Phase 1)	Approved - Procurement	N/A	N/A	8/9/2019	12/31/2019	$471,000	
Conemaugh Memorial	Upgrade Security Access System	Approved - Construction	N/A	N/A	7/18/2019	11/30/2019	$28,769	
Conemaugh Memorial	ATS (2)	Approved - Construction	N/A	N/A	8/16/2019	11/30/2019	$80,196	
Conemaugh Memorial	Nurse Call System Upgrade	Approved - Procurement	N/A	N/A	8/19/2019	12/31/2019	$199,514	
Conemaugh Memorial	Resurface Roof (85 Mechanical Roof)	Approved - Procurement	N/A	N/A	8/13/2019	12/31/2019	$72,000	
Conemaugh Memorial	Steam Station (C Basement)	Approved - Procurement	N/A	N/A	8/1/2019	12/31/2019	$39,450	
Conemaugh Memorial	Heat Pump Replacement Program (Phase 2)	Approved - Procurement	N/A	N/A	7/22/2019	12/31/2019	$34,900	
Conemaugh Memorial	AHU #6 (P Bldg)	Approved - Procurement	N/A	N/A	8/22/2019	12/31/2019	$207,734	
Conemaugh Memorial	VFD #3	Approved - Procurement	N/A	N/A	7/23/2019	12/31/2019	$36,282	
Conemaugh Memorial	Parking Lots (9,11,19,&30)	Approved - Construction	N/A	N/A	8/15/2019	11/30/2019	$126,181	
Conemaugh Memorial	Cooling Tower Fill (Central Energy Plant)	Approved - Procurement	N/A	N/A	8/22/2019	12/31/2019	$39,495	
Conemaugh Memorial	Outdoor Perimeter Lighting (Lee Campus)	Approved - Procurement	N/A	N/A	9/27/2019	12/31/2019	$20,521	
Conemaugh Memorial	Hot & Cold Water Distribution System	Approved - Procurement	N/A	N/A	8/13/2019	12/31/2019	$26,013	
Conemaugh Memorial	Medical Air Pump Assembly	Approved - Procurement	N/A	N/A	8/15/2019	12/31/2019	$15,950	
Conemaugh Memorial	ATS (2 Good Sam and 1 G Basement)	Approved - Construction	N/A	N/A	8/16/2019	11/30/2019	$84,570	
Conemaugh Memorial	Sidewalk Replacement	Approved - Procurement	N/A	N/A	10/9/2019	12/31/2019	$57,000	
Conemaugh Memorial	Compressor & Air Dryers (Lee Campus)	Approved - Procurement	N/A	N/A	7/23/2019	12/31/2019	$9,396	
Conemaugh Memorial	A/C Systems Medical Arts Bldg (Phase 1 of 3)	Approved - Procurement	N/A	N/A	7/23/2019	12/31/2019	$17,800	
Conemaugh Memorial	Rooftop HVAC Unit (L Bldg)	Approved - Procurement	N/A	N/A	7/22/2019	12/31/2019	$58,430	
Conemaugh Memorial	Instantaneous Domestic Water Heater	Approved - Procurement	N/A	N/A	10/9/2019	12/31/2019	$43,750	
Conemaugh Memorial	Steam Injector System (Phase 2 of 3)	Approved - Procurement	N/A	N/A	8/13/2019	12/31/2019	$9,750	
Conemaugh Memorial	Drain Lines & Containment Pans	Approved - Procurement	N/A	N/A	9/16/2019	12/31/2019	$34,700	
Conemaugh Memorial	HVAC Controls (Lee Campus - Phase I)	Approved - Procurement	N/A	N/A	8/9/2019	12/31/2019	$464,850	
Conemaugh Memorial	Sprinkler Head Replacement (GS 7/8)	Approved - Procurement	N/A	N/A	10/9/2019	12/31/2019	$84,600	
Conemaugh Memorial	Air Compressor (M Bldg Pneumatic)	Approved - Procurement	N/A	N/A	8/15/2019	12/31/2019	$17,392	
Conemaugh Memorial	Drain Line Replacement (P Bldg)	Approved - Procurement	N/A	N/A	7/23/2019	12/31/2019	$25,950	
Conemaugh Memorial	Exterior Handrail Replacement Program (Phase 3-5)	Approved - Procurement	N/A	N/A	9/27/2019	12/31/2019	$4,900	
Conemaugh Memorial	Soffit, Facia, & Rainspouts (123 Mayer Ave.)	Approved - Procurement	N/A	N/A	9/27/2019	12/31/2019	$19,800	
Conemaugh Memorial	Hot/Cold Water Circulating Systems (F Bldg)	Approved - Procurement	N/A	N/A	10/14/2019	12/31/2019	$359,682	
Conemaugh Memorial	Air Compressor (F & G Bldg)	Approved - Procurement	N/A	N/A	8/13/2019	12/31/2019	$10,738	
Conemaugh Memorial	AHU (Pharmacy)	Approved - Procurement	N/A	N/A	10/9/2019	12/31/2019	$486,344	
Conemaugh Memorial	AHU #4 (C Side Pharmacy)	Approved - Procurement	N/A	N/A	9/17/2019	12/31/2019	$479,044	
Conemaugh Memorial	Resurface Helipad	Approved - Procurement	N/A	N/A	8/26/2019	12/31/2019	$149,750	
Conemaugh Memorial	Somerset MOB - New Building	Approved - Construction	Stengel Hill	MBM Contracting	11/26/2018	12/11/2019	$9,737,225	
Conemaugh Memorial	Lab Instrumentation Replacement	Approved - Procurement	N/A	N/A	9/26/2019	12/31/2019	$583,000	
Conemaugh Memorial	Cresson Primary Care Office - New Building	Approved - Design	Stengel Hill	TBD	4/13/2018	12/31/2020	$3,146,065	
Conemaugh Memorial	Patient Room Upgrade Finishes Good Sam 6	Approved - Construction	Stengel Hill	Ridgetop Interiors	9/4/2019	1/31/2020	$1,969,028	
Conemaugh Memorial	Real Estate Swap (Sherman St Lot/110 Mayer Ave)	Approved - In Progress	N/A	N/A	9/4/2019	12/31/2019	$45,000	
Conemaugh Meyersdale	Air Handlers (Phase 1 of 2)	Approved - Procurement	N/A	N/A	9/6/2019	1/31/2020	$397,627	
Conemaugh Meyersdale	Bulk Oxygen System	Approved - Procurement	N/A	N/A	9/27/2019	12/31/2019	$26,215	
Conemaugh Meyersdale	Parking Lot	Approved - Procurement	N/A	N/A	9/23/2019	12/31/2019	$299,793	
Conemaugh Meyersdale	Security Lighting	Approved - Procurement	N/A	N/A	9/27/2019	12/31/2019	$19,500	
Conemaugh Miners	Parking/ADA Access Upgrades	Approved - Construction	Hospital	TBD	8/14/2019	11/30/2019	$247,003	
Conemaugh Miners	Oil Burners (Boilers)	Approved - Procurement	N/A	N/A	10/11/2019	12/31/2019	$75,380	
Conemaugh Miners	Exterior Windows and Doors	Approved - Procurement	N/A	N/A	10/14/2019	12/31/2019	$128,995	
Conemaugh Miners	Parking Lot LED Lighting	Approved - Procurement	N/A	N/A	10/15/2019	12/31/2019	$14,915	
Conemaugh Miners	Dietary Propane Gas Shutoff System	Approved - Procurement	N/A	N/A	10/16/2019	12/31/2019	$4,010	
Conemaugh Miners	AHU #3 Humidifier Replacement	Approved - Procurement	N/A	N/A	10/16/2019	12/31/2019	$34,824	

Conemaugh Miners	AST Modifications	Approved - Procurement	N/A	N/A	10/11/2019	12/31/2019	$11,485	
Nason	Sliding Doors	Approved - Procurement	N/A	N/A	7/13/2019	12/31/2019	$10,206	
Ottumwa	Elevator Upgrades - Service Elevator	Approved - Construction	N/A	N/A	6/25/2019	1/31/2020	$336,702	Phase 2 to complete Q1 2020.
Ottumwa	Ottumwa USP 797/800	Approved - Design	E4H Architecture	TBD	9/15/2019	3/15/2020	$400,000	
Palestine	AHU #1	Approved - Procurement	N/A	N/A	9/17/2019	12/31/2019	$139,859	
SageWest Riverton	Medical Vacuum System (DNC 2018)	Approved - Construction	N/A	N/A	7/18/2019	11/1/2019	$56,315	
SageWest Riverton	Parking Lot	Approved - Construction	N/A	N/A	7/26/2019	11/1/2019	$84,996	
SageWest Lander	PACU Windows	Approved - Construction	N/A	N/A	6/12/2019	11/15/2019	$28,700	
Southwestern	Sprinklers - ORs 1-4, C-Section	Approved - Construction	N/A	N/A	5/30/2019	11/8/2019	$20,426	
Southwestern	West Campus Roof	Approved - Construction	N/A	N/A	7/26/2019	11/30/2019	$256,867	
Southwestern	Southwestern USP 797/800	Approved - Design	E4H Architecture	TBD	8/26/2019	3/15/2020	$350,000	

Schedule 4.5(h)

Noncompliance Matters regarding Real Property

None.

Schedule 4.5(i)

Management Agreements

1.	Managerial and Administrative Support Agreement by and between Palestine Principal Healthcare Limited Partnership and LifePoint Corporate Services, General Partnership, dated 1/1/15.
2.	Managerial and Administrative Support Agreement by and between Riverton Memorial Hospital, LLC and LifePoint Corporate Services, General Partnership, dated 1/1/15.
3.	Managerial and Administrative Support Agreement by and between Dodge City Healthcare Group, LLC and LifePoint Corporate Services, General Partnership, dated 1/1/15.
4.	Support Services Agreement by and among Riverton Memorial Hospital, LLC, Riverton Oncology Practice, LLC, Riverton Physician Practices, LLC, and Lander Valley Physician Practices, LLC, dated 6/1/18.
5.	Support Services Agreement by and between Dodge City Healthcare Group, LLC and Western Plains Physician Practices, LLC, dated 6/1/18.
6.	Support Services Agreement by and between Nason Medical Center, LLC and Nason Physician Practices, LLC, dated 6/1/18.
7.	Hospital Management Agreement by and among Nason Medical Center, LLC, Nason Physician Practices, LLC, and DLP Conemaugh Memorial Medical Center, LLC, dated 2/1/15.
8.	Hospital Management Agreement by and among DLP Conemaugh Memorial Medical Center, LLC, DLP Conemaugh Physician Practices, LLC, and DLP Partner, LLC, dated 8/31/14.
9.	Hospital Management Agreement by and between DLP Conemaugh Meyersdale Medical Center, LLC and DLP Partner, LLC, dated 8/31/14.
10.	Hospital Management Agreement by and between DLP Conemaugh Miners Medical Center, LLC and DLP Partner, LLC, dated 8/31/14.

Schedule 4.5(l)

Notices Regarding Condemnation Proceedings

1. Pennsylvania Department of Transportation is condemning a strip of land in connection with a road widening in front of Conemaugh Memorial Hospital and Good Samaritan.

Schedule 4.6

Environmental Matters

(a)

Conemaugh Memorial Hospital – In July 2014, as part of a Limited Phase II ESA, certain VOCs were identified in groundwater samples at the Lot J (southwest corner of Washington & Walnut Streets, Johnstown, PA) and 320 Main Street properties. In this same time period, two former retail petroleum distribution stations (filling stations) and abandoned USTs were located at the Warehouse property. Groundwater samples in these locations also yielded certain VOCs that were greater than allowable limits. All of these items are to be remediated and USTs property closed as part of a settlement agreement with the Foundation (seller).

(b)

Schedule 4.6(a) is herein incorporated by reference in its entirety.

(c)

Schedule 4.6(a) is herein incorporated by reference in its entirety.

(d)

None.

(e)

None.

(f)

Schedule 4.6(a) is herein incorporated by reference in its entirety.

(g)

Schedule 4.6(a) is herein incorporated by reference in its entirety.

(h)

See attached.

Location Name	Address	City	State	Zip	Tank	AST / UST	Install Date	Retro Date	Capacity	Single/ Double Wall	Monitoring	Date of last Tightness Test	Result Pass/Fail	UST spill/overfill protection?	UST corrosion protection?	Contents	AST secondary containment?	Plans to remove next 3 years?
Dodge City Healthcare Group, LLC dba Western Plains Medical Complex	3001 Avenue A	Dodge City	KS	67801	3	UST	4/27/1993	5/11/1999	3,000	D	Automatic Tank Gauge	9/19/2017	Pass	Yes	Yes	Diesel		
DLP Conemaugh Memorial Medical Center, LLC dba Memorial Medical Center - Lee Campus	320 Main Street	Johnstown	PA	15901	1	UST	6/12/1905	9/1/2014	5,000			8/10/2017	Pass			Diesel		
DLP Conemaugh Memorial Medical Center, LLC dba Memorial Medical Center - Lee Campus	320 Main Street	Johnstown	PA	15901	2	UST	6/11/1905	9/1/2014	2,000			8/10/2017	Pass			Diesel		
DLP Conemaugh Memorial Medical Center, LLC dba Memorial Medical Center	1086 Franklin Street	Johnstown	PA	15905	1	UST	6/28/1905	9/1/2014	20,000			8/10/2017	Pass			Diesel		
DLP Conemaugh Memorial Medical Center, LLC dba Memorial Medical Center	1086 Franklin Street	Johnstown	PA	15905	2	UST	6/19/1905	9/1/2014	2,500			8/10/2017	Pass			Diesel		
DLP Conemaugh Memorial Medical Center, LLC dba Memorial Medical Center	1086 Franklin Street	Johnstown	PA	15905	3	UST	6/20/1905	9/1/2014	2,500			8/10/2017	Pass			Diesel		
DLP Conemaugh Memorial Medical Center, LLC dba Memorial Medical Center	1086 Franklin Street	Johnstown	PA	15905	4	UST	6/28/1905	9/1/2014	3,000			8/10/2017	Pass			Diesel		
DLP Conemaugh Memorial Medical Center, LLC dba Memorial Medical Center (Ebensburg Clinic)	1060 Lloyd Street	Nanty-Glo	PA	15943	1	UST	5/2/1905	9/1/2014	2,000			5/17/2019	Fail			Diesel		Close in place
Ottumwa Regional Health Care	1001 E Pennsylvania Avenue	Ottumwa	IA	52501	23396	UST	1997	5/1/2010	10,000	Fiberglass/Steel Clad	Veeder Root Leak Detection and Monitoring			SO		Diesel		

Schedule 4.7

Litigation

Lima Facility	Date	Description
Conemaugh (CPG)	8/29/2014	Former owners of Conemaugh Physician Group (CPG) disclosed issues involving approximately 2 arrangements with 2 physicians that potentially violated the Stark law and resulted in a potential overpayment to CPG of $2.08 million. Issues disclosed related to payments made to a physician pursuant to a backdated contract and physician occupancy of space under an expired lease. The self-disclosure was submitted to CMS on 8/29/2014, and Hospital is now awaiting a response.
Conemaugh (Meyersdale)	7/28/2014	Former owners of Hospital disclosed issues involving approximately 2 arrangements with 2 physicians that potentially violated the Stark law and resulted in a potential overpayment to the Hospital of $886,542. Issues disclosed related to physician occupancy of space with no written lease and failure to charge or pay rent in a timely manner. The self-disclosure was submitted to CMS on 8/29/2014, and Hospital is now awaiting a response.
Conemaugh (Meyersdale)	8/29/2014	Former owners of Hospital disclosed issues involving approximately 2 arrangements with 2 physicians that potentially violated the Stark law and resulted in a potential overpayment to the Hospital of $862,347. Issues disclosed related to payments made to a physician pursuant to a backdated contract and physician occupancy of space under a lease that was backdated. The self-disclosure was submitted to CMS on 8/29/2014, and Hospital is now awaiting a response.
Conemaugh (Miners)	7/25/2014	Former owners of Hospital disclosed issues involving approximately 19 arrangements with 23 physicians that potentially violated the Stark law and resulted in a potential overpayment to the Hospital of $2.52 million. Issues disclosed related to payments made to physicians with no written contracts and occupancy of space by physicians with no written leases. The self-disclosure was submitted to CMS on 7/25/2014, and Hospital is now awaiting a response.
Conemaugh (Miners)	8/29/2014	Former owners of Hospital disclosed an issue involving an arrangement with a physician that potentially violated the Stark law and resulted in a potential overpayment to the Hospital of $829,325 because Hospital made payments to the physician without a written contract. The self-disclosure was submitted to CMS on 8/29/2014, and Hospital is now awaiting a response.
Conemaugh (MMC)	7/25/2014	Former owners of Hospital disclosed an issue involving an arrangement with approximately 12 physicians that potentially violated the Stark law and resulted in a potential overpayment to the Hospital of $73.26 million because Hospital made payments to the physicians without a written contract. The self-disclosure was submitted to CMS on 7/25/2014, and Hospital is now awaiting a response.

Lima Facility	Date	Description
Conemaugh (MMC)	8/29/2014	Former owners of Hospital disclosed issues involving approximately 14 arrangements with 15 physicians that that potentially violated the Stark law and resulted in a potential overpayment to the Hospital of $7.8 million. Issues disclosed related to payments made to physicians with no written contracts, payments made to physicians pursuant to backdated contracts and forgiveness of physician debt. The self-disclosure was submitted to CMS on 8/29/2014, and Hospital is now awaiting a response.
Conemaugh (MMC)	9/25/2015	Payments were made to 2 physicians in excess of FMV that potentially violated the Stark law and resulted in a potential overpayment to the Hospital of $17.08m. A self-disclosure was submitted to CMS on 9/25/2015, and Hospital is now awaiting a response.

Schedule 4.8(a)

Healthcare Licenses

Facility	Hospital License	Medicare	Medicaid
Conemaugh Memorial Medical Center	Hospital License No. 035601 (exp. 2/28/2020)	CCN (Part A - Acute): 390110 (NPI 1801897038)	PA Medical Assistance: 1029762890001 (Main campus)
Conemaugh Meyersdale Medical Center	Hospital License No. 391101 (exp. 7/31/2021)	CCN (Part A - CAH): 391302 (NPI 1659376358)	PA Medical Assistance: 10297632200001
Conemaugh Miners Medical Center	Hospital License No. 10850100 (exp. 11/30/2021)	CCN (Part A - Acute): 390130 (NPI 1184620486)	PA Medical Assistance: 1029763780001
Conemaugh Nason Medical Center	Hospital License No. 141101 (ex. 4/30/2022)	CCN (Part A - Acute): 390062 (NPI 1497708473)	PA Medical Assistance: 1007464210001
Southwestern Medical Center	Hospital License No. 2231 (exp. 2/28/2020)	CCN (Part A - Acute): 37-0097 (NPI 1952359986)	OK Medicaid: 100697950B
Palestine Regional Medical Center	Hospital License No. 000629 (exp. 9/30/2020)	CCN (Part A - Acute): 450747 (NPI 1164510673)	TX Medicaid: 121816602
Western Plains Medical Center	Hospital License No. H-029-002 (exp. 2/1/2020)	CCN (Part A - Acute): 170175 (NPI 1336231232)	KS Medicaid: 100098790A
Ottumwa Regional Medical Center	Hospital License No. 900055H (exp. 12/31/19)	CCN (Part A - Acute): 16-0089 (NPI 1013233741)	IA Medicaid: 600890
Sage West (Riverton and Lander)	Hospital License No. 15311 (exp. 6/30/2020)	CCN (Part A - Acute): 530008 (NPI 1245337286)	WY Medicaid: 114198800

Schedule 4.8(b)

Noncompliance Matters regarding Healthcare Licenses

None.

Schedule 4.9

Noncompliance with Applicable Laws

None.

Schedule 4.11

Taxes

None.

Schedule 4.12(a)

Benefit Plans

1. Conemaugh Call Pay Plan
2. LifePoint Health, Inc. Retirement Plan
3. RCCH Healthcare Partners 401(k) Plan
4. LifePoint Hospitals, Inc. Welfare Benefits Plan
5. Amended and Restated LifePoint Health Deferred Compensation Plan (the "Deferred Compensation Plan")
6. 2019 Deferred Cash Awards with the following individuals:

Employee Full Name	Legal Entity Name	2019 Award with EBITDA Performance Goal Met	2019 Award without EBITDA Performance Goal met
[redacted]	DLP Conemaugh Memorial Medical Center, LLC	90,000	67,500
	DLP Conemaugh Memorial Medical Center, LLC	90,000	67,500
	DLP Conemaugh Memorial Medical Center, LLC	90,000	67,500
	DLP Conemaugh Memorial Medical Center, LLC	90,000	67,500
	DLP Conemaugh Meyersdale Medical Center, LLC	45,000	33,750
	DLP Conemaugh Meyersdale Medical Center, LLC	15,000	11,250
	DLP Conemaugh Miners Medical Center, LLC	22,500	16,875
	Riverton Memorial Hospital, LLC	45,000	33,750
	Nason Medical Center, LLC	45,000	33,750
	Nason Medical Center, LLC	22,500	16,875
	Nason Medical Center, LLC	22,500	16,875
	Palestine Principal Healthcare L.P.	52,500	39,375
	Dodge City Healthcare Group, LLC	45,000	33,750
Noel, Philip J	RCHP-Ottumwa, LLC	52,500	39,375
Jones, Dewey W	RCHP-Ottumwa, LLC	45,000	33,750
Hunger, Dennis	RCHP-Ottumwa, LLC	45,000	33,750

Bailey, Lori J	RCHP-Ottumwa, LLC	45,000	33,750
[redacted]	Southwestern Medical Center, LLC	45,000	33,750
	Southwestern Medical Center, LLC	45,000	33,750

Schedule 4.12(b)

Funding of Benefit Plans

None.

Schedule 4.12(c)

Other Noncompliance Matters regarding Benefit Plans

None.

Schedule 4.12(d)

Extraordinary Payment Obligations

None.

Schedule 4.12(e)

Benefit Plans Audits

1. The LifePoint Health, Inc. Retirement Plan is currently under a routine audit by the Department of Labor. This appears to be a random audit and no issues have been identified to date.

Schedule 4.13(a)

Collective Bargaining Agreements

Facility	Union	Contract Start Date	Contract End Date	Employees Covered
Conemaugh Miners Medical Center	SEIU Healthcare Pennsylvania CTW CLC	10/18/2018	8/31/2021	FT&PT Maintenance, Technical, RN, LPN, & Clerical

Schedule 4.13(b)

Labor Matters

None.

Schedule 4.13(c)

Labor Complaints and Litigation

Lima Facility	Matter Name	Matter Type	Description
Conemaugh	[redacted]	Demand	Wrongful Termination
Ottumwa		Charge	Discrimination - Race & National Origin
Palestine		OSHA Complaint	Retaliation for submitting complaint about restroom leak
Palestine		Charge	Discrimination - Sex & National Origin; Harassment
Southwestern		Demand	Termination without cause
Southwestern		Demand	Violation of Title VII of the Civil Rights Act of 1964

Schedule 6.5(a)

Requested Tenant Estoppels

MT#	Lessee	Property Street Address 1	Suite	Property City	Property State / Prv	Property Zip
62106.29648C	Select Specialty Hospital-Johnstown, Inc.	320 Main Street	3rd Floor	Johnstown	PA	15905
62106.51431C	Conemaugh Physician Practices, LLC. (CPG)	1450 Scalp Avenue	0200	Johnstown	PA	15905
62106.37228C	Shared Business Services, LLC	1 Tech Drive	Third Floor	Johnstown	PA	15901
62106.71636C	DLP Conemaugh Physician Practices, LLC	927 Menoher Blvd.	Building	Johnstown	PA	15905
62106.54851C	Conemaugh Physician Practices, LLC (OB/GYN)	1450 Scalp Avenue	0303	Johnstown	PA	15905
62106.33740C	Conemaugh Physician Group-Medical Park	1 Tech Drive	Prt. of 1st & 2nd FL	Johnstown	PA	15901
62460.71194C	Ottumwa Health Group, LLC	931 Pennsylvania Avenue	Entire Building	Ottumwa	IA	52501
62106.45243C	Conemaugh Physician Group - Plastic Surgery	1 Tech Drive	1200	Johnstown	PA	15901
61117.53955C	Texas Specialty Physicians	4002 S. Loop 256	A-A & A-B	Palestine	TX	75801
62106.29670C	Conemaugh Physician Practices, LLC	1111 Franklin Street	410	Johnstown	PA	15905
62106.51432C	Conemaugh Physician Practices, LLC (Medwell)	1450 Scalp Avenue	1000	Johnstown	PA	15905
62106.54084C	Conemaugh Physician Practices, LLC	1450 Scalp Avenue	0302	Johnstown	PA	15905
62106.29756C	Medical Oncology	1020 Franklin Street	Ground Floor	Johnstown	PA	15905
62106.29675C	Conemaugh Physician Practices, LLC	1111 Franklin Street	300	Johnstown	PA	15905
62106.29728C	Conemaugh Physician Practices, LLC	1910 Minno Drive	Pt. Unit 1	Johnstown	PA	15905

Schedule 6.5(b)

Requested Collateral Assignments of Leases

Hospital Name	Contract Type	Meditract Descripton	MPT Review	MPT UW Recommendation
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - Westwood Plaza Suite/Unit 1 - 1910 Minno Dr.	Address: 1910 Minno Dr. Johnstown, PA 15905 Lease of 60,000 square feet. Per the lease, it appears that this space is leased for use by the Finance Department for billing, collections, financial analysis, etc. Is located approximately 10 minutes away from the hospital.	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - Suite/Unit Parking Lot - 130 Valley Pike	Address: 130 Valley Pike Johnstown, PA 15905 120 parking spaces less than a mile away from the hospital.	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	FT Parking Lot Lease at Somerset Street (DLP CMMC-Spence Custer Lot)	Parking lot on main hospital campus	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time located at 1158 Hunt Street, Cambria County, PA	Parking for the hospital	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - 934 to 960 Franklin Street	Parking for the hospital	Collateral Assignment

Hospital Name	Contract Type	Meditract Descripton	MPT Review	MPT UW Recommendation
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - Franklin Street, Somerset Street and Willow Place	Employee parking	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Parking license agreement for parking lot at 100-102 Valley Pike	Parking for the hospital	Collateral Assignment
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - Tax Parcel #s: 78-004-401.000; 78-004-400.000; 78-004-315.000 Suite/Unit Parking Lot	Parking license agreement	Collateral Assignment
Conemaugh Nason	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Prime Lease - 111 Nason Dr	MOB on campus.	Collateral Assignment
Ottumwa	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Master Lease of building at 1011-1013 in which hospital entity is the tenant (hospital ground leases as landlord to Ottumwa MOB, LLC in MT 62462.68674)	On-campus MOB where the hospital owns the land but not the building.	Collateral Assignment
Ottumwa	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	FT - 1255 Theater Drive, Suite B. Ottumwa, IA	Ottumwa Walk In Clinic	Collateral Assignment

Hospital Name	Contract Type	Meditract Descripton	MPT Review	MPT UW Recommendation
Palestine	RE Lease - LifePoint as Tenant - Physician Practice as Tenant / Third Party as LL	Full Time Lease - 115 Medical Drive, Condo 1 & 2	On hospital campus; Obstetrics & Gynecology Associates/Pediatric Associates	Collateral Assignment
SageWest Riverton	RE Lease - LifePoint as Tenant - Physician Practice as Tenant / Third Party as LL	15 Shrine Club Road, Suite B	Oncology Center	Collateral Assignment
Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Master Lease for MOB I - hospital as tenant - 5604 SW Lee Blvd.	Master Lease for MOB 1	Collateral Assignment
Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Master Lease for MOB 2 - hospital as tenant - 5606 SW Lee Blvd.	Master Lease for MOB 2	Collateral Assignment

Hospital Name	Contract Type	Meditract Descripton	MPT Review	MPT UW Recommendation
Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Real Estate Lease - 5116 W. Gore Blvd., Suite 1, Lawton, OK 73505	Appears to be MRI about a mile from the hospital in shopping center.	Collateral Assignment
Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Real Estate Lease - 5112 W. Gore Blvd., Suite 1, Lawton, OK 73505	Appears to be MRI about a mile from the hospital in shopping center.	Collateral Assignment
Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Real Estate Lease - 5610 SW Lee Boulevard, Lawton, OK 73505	Southwestern Orthopedics building on the hospital campus	Collateral Assignment
Southwestern	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	5410 SW Lana Drive, Lawton, OK	Oklahoma P.E.T. Center across the street from the hospital	Collateral Assignment
Western Plains	RE Lease - LifePoint as Tenant - Physician Practice as Tenant / Third Party as LL	Full Time Lease for 106 North Main Street	Primary Care Clinic	Collateral Assignment

Hospital Name	Contract Type	Meditract Descripton	MPT Review	MPT UW Recommendation
Western Plains	RE Lease - LifePoint as Tenant - Physician Practice as Tenant / Third Party as LL	Express Care Lease	Urgent Care Clinic	Collateral Assignment

Schedule 6.8

Repayment of Indebtedness and Release of Encumbrances

- Ottumwa Regional:
  - Mortgage, Security Agreement, Assignment of Rents and Leases and Fixture Filing, dated September 26, 2016, filed September 30, 2016, in Book 2016, Page 4197, executed by RCHP - Ottumwa, LLC, as mortgagor, to Wilmington Trust, as mortgagee.
- Southwestern:
  - Mortgage, Security Agreement, Assignment of Rents and Leases and Fixture Filing dated September 26, 2016, executed by Southwestern Medical Center, LLC, in favor of Wilmington Trust, National Association, as trustee, and filed for record September 28, 2016 at 3:18 PM in Book 7686, Page 130, Securing the Principal Sum of $36,870,000.00.

Schedule 6.11

Construction Project Timelines

Project	Estimated Completion Date
Conemaugh Ebensburg Outpatient Center	March 31, 2020
Conemaugh Somerset Outpatient Center	April 30, 2020

Schedule 7.2(e)(ii)

Required Conemaugh Collateral Leases

Hospital Name	Contract Type	Meditract Descripton	MPT Review	MPT UW Recommendation	Counterparty Consent Required
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	FT Parking Lot Lease at Somerset Street (DLP CMMC-Spence Custer Lot)	Parking lot on main hospital campus	Collateral Assignment	None
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - Franklin Street, Somerset Street and Willow Place	Employee parking	Collateral Assignment	None
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Parking license agreement for parking lot at 100-102 Valley Pike	Parking for the hospital	Collateral Assignment	None
Conemaugh Memorial	RE Lease - LifePoint as Tenant - Hospital as Tenant / Third Party as LL	Full Time - Tax Parcel #s: 78-004-401.000; 78-004-400.000; 78-004-315.000 Suite/Unit Parking Lot	Parking license agreement	Collateral Assignment	None

Second Amendment to Professional Services Agreement

This Second Amendment shall modify the Professional Services Agreement ("Agreement") entered into on August 1, 2014, between RCHP Ottumwa, LLC d/b/a Ottumwa Regional Health Center ("Medical Center") and Apogee Medical Management, Inc. ("Company"). Medical Center and Company desire to amend the Agreement as set forth below. The Effective Date of this Amendment shall be the date of last signature as set forth below.

WHEREAS, Medical Center and Company are parties to that certain Professional Services Agreement effective August 1, 2014 and that certain First Amendment (collectively, the "Agreement"); and

WHEREAS, Medical Center and Company desire to amend the Agreement as set forth below.

NOW THEREFORE, in consideration of the mutual covenants and agreements contained herein, the parties agree as follows:

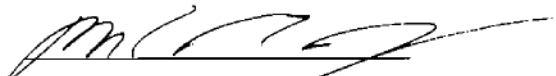
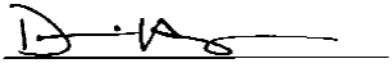
1) Effective September 1, 2022, Subsections a. and b. of Section 8.c.ix.ii shall be deleted in their entirety and replaced with the following:

   a. Thirty-Five Thousand Five Hundred Eighteen Dollars ($35,518.00) per Physician FTE provided by Company under this Agreement. Such amount is based on the sum of the following components divided by 12: Physician's annual base salary, which is Three Hundred Fifty Thousand Dollars ($350,000.00); twenty-two (22) percent of Two Hundred Sixty Thousand Dollars ($260,000.00) (attributed to benefits); and annual medical malpractice insurance coverage of Nineteen Thousand Twenty Dollars ($19,020.00) per Physician FTE.

   b. Eighteen Thousand Five Hundred Eight-Four Dollars ($18,584.00) per Nurse Practitioner or Physician Assistant FTE provided by Company under this Agreement. Such amount is based on the sum of the following components divided by 12: Nurse Practitioner or Physician Assistant's annual base salary, which is One Hundred Seventy-Five Thousand Dollars ($175,000.00); twenty-two (22) percent of Nurse Practitioner or Physician Assistant's annual gross salary (attributed to benefits); and annual medical malpractice insurance coverage of Nine Thousand Five Hundred Ten Dollars ($9,510.00) per Nurse Practitioner or Physician Assistant FTE.

2) All other terms and conditions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have executed this Amendment to be effective on the Effective Date.

COMPANY: Apogee Medical Management, Inc.		**MEDICAL CENTER: RCHP-Ottumwa, LLC d/b/a Ottumwa Regional Health Center**	
By		By	
Title	Michael W. Gregory, MD, President	Title	Dennis Hunger, CEO
Date	10/24/22	Date	21 October 2022

RegionalCare HOSPITAL PARTNERS

CONTRACT CERTIFICATION – PROFESSIONAL SERVICES/OTHER AGREEMENT

Physician Name: Apogee Medical Management, Inc. **Specialty:** Hospitalist Services

Facility: Ottumwa Regional Health Center **Type of Agreement:** Agreement

Agreement Dated: August 1, 2014 **Start Date:** August 1, 2014 **Agreement Term:** Three Years

The undersigned hereby certifies that:

- I have reviewed the above referenced written Agreement, which has been drafted by the RegionalCare Hospital Partners Legal Department in accordance with established guidelines adhering to the applicable Stark and Anti-Kickback Statutes, and subsequently signed by all parties. Any changes to form have been approved by Legal Counsel.
- I am familiar with the Company's policies and procedures related to Contract Approval and have followed these policies in the preparation of this Agreement.
- The compensation is set in advance, and the compensation package represents fair market value for the physician specialty and the specified services provided under this Agreement.
- The Agreement allows the Facility to meet a legitimate community service need.
- The Agreement clearly identifies the services to be provided by physician and represents a commercially reasonable physician-facility arrangement for services.
- There are no agreements or understandings, written or oral, that condition the compensation in any manner on the volume or value of any referrals generated between the Facility and the Physician or Physician's immediate family members.
- The physician is a member in good standing on the facility's active medical staff.
- The physician in not excluded or debarred.

NOTE: Please attach three original executed Agreements. Two will be returned to Facility CEO with final approval for Facility and Physician.

Submitted by:

7/31/14

Facility CEO Date

The undersigned officers of the owner of the Facility hereby certify that:

1. I have review the Agreement described above and hereby approve the terms thereof.
2. I am familiar with the company's policies and procedures related to Contract Approval.
3. Based upon the above certification of the Facility CEO, as well as any personal knowledge I may have of the Facility involved and related market, to the best of my information and belief, the compensation arrangement is established at fair market value for the services to be rendered.

7/30/14

Facility CFO Date

The Agreement and all addenda are hereby approved as to form:

Legal Counsel Date

AGREEMENT

THIS AGREEMENT is made by and between RCHP Ottumwa, LLC d/b/a Ottumwa Regional Health Center ("Medical Center"), and Apogee Medical Management, Inc. ("Company"), (each a "Party" and collectively, the "Parties"), effective as of the 1st day of August, 2014 (the "Effective Date").

WHEREAS, Medical Center provides continuous, twenty-four (24) hour inpatient services to the members of the community who require medical attention and Medical Center service through the Medical Center's departments (the "Departments");

WHEREAS, Medical Center has determined that a community need exists for medical management services and other medical inpatient services from physicians ("Physicians") and other health care providers (each a "Hospitalist" and collectively, the "Hospitalists") dedicated to providing such care ("Hospitalist Services") for patients who require admission to the Medical Center ("Hospitalist Patients");

WHEREAS, Medical Center desires to make complete and integrated Hospitalist Services available to its inpatients from a cohesive group of Hospitalists who strive for excellence in the provision of quality inpatient services;

WHEREAS, Company provides programs developed to offer Hospitalist Services as an aid and assistance to hospitals and to communities in need of Hospitalist Services, through an agreement (the "Management Agreement") with Apogee Medical Group, Iowa, Inc., a medical group that employs or contracts with Hospitalists (the "Medical Group");

WHEREAS, entering into an exclusive agreement with Company will assure Medical Center of the teamwork and resources necessary to provide Hospitalist Services; to offer and maintain physicians skilled in inpatient care and treatment; to develop clinical protocols; to supervise and provide consultations for improved care and treatment in various Medical Center departments; and to attain the specific goals enumerated herein.

NOW, THEREFORE, in consideration of the mutual covenants herein contained, the Parties agree as follows:

1. **Term**. The Parties agree that the provision of Hospitalist Services at full FTE staffing levels (as further described in Section 3.a. below) will require a ramp-up time not to exceed seven (7) months from the Effective Date. As such, Company agrees to begin providing Hospitalist Services at a reduced FTE staffing level on or before December 1, 2014 (the "Commencement Date"), and to provide Hospitalist Services at full FTE staffing levels on or before March 1, 2015. Unless sooner terminated in accordance with the provisions set forth below, the Agreement will continue for a three (3) year period from the Commencement Date; thereafter, it will automatically renew for additional one (1) year periods until terminated (the "Term").

2. **Termination**. This Agreement may be terminated as follows:

a. After the first twelve (12) months of this Agreement, either Party may terminate this Agreement by providing a one hundred eighty (180) days' written notice of termination to the other Party, with or without cause.

b. At any time during this Agreement, if either Party breaches this Agreement and fails to cure such breach to the reasonable satisfaction of the non-breaching Party within thirty (30) days following a written notice from the non-breaching Party specifying the breach, the non-breaching Party may terminate this Agreement by giving written notice of such termination to the other Party; provided, however, if such breach is of such character as to reasonably require more than thirty (30) days to cure, this Agreement may not be terminated by the non-breaching Party if the breaching Party is using reasonable diligence to cure the breach as promptly as feasible as determined by the non-breaching party within its sole discretion.

c. Either Party may terminate this Agreement immediately upon any of the following events:

i. Upon Medical Center's loss of certification as a Medicare provider;

ii. Upon the closure of Medical Center;

iii. Upon Company's failure to ensure that the Medical Group compensates Hospitalists within ten (10) days of when such compensation is due;

iv. Upon either Party's general assignment for the benefit of creditors, Company's petition for relief in bankruptcy or under similar laws for the protection of debtors, or upon the initiation of such proceedings against Company if the same are not dismissed within forty-five (45) days of service;

v. Failure to remove a Hospitalist in accordance with Section 4(d) below within forty-eight (48) hours of conclusion of process in Section 4(d);

vi. The Company or any director or officer becomes debarred, excluded, or suspended, or if any other event occurs that makes it, him, or her an "Ineligible Person," described in Section 21 below;

vii. The Company fails to maintain insurance as required by this Agreement; or

viii. The Company or any Hospitalist engages in conduct that, in the reasonable discretion of Medical Center, could affect the quality of professional care provided to patients or the performance of duties required hereunder or be prejudicial or adverse to the best interest and welfare of the Medical Center or its patients.

3. Services to be provided by Company. Company shall provide or arrange for the provision of the following management and administrative services to the Medical Center (collectively, the "Administrative Services"), either directly, or through the Management Agreement with Medical Group:

a. Staffing Levels. Company shall identify to Medical Center prospective providers to provide Hospitalist Services and ensure the provision of Hospitalist Services twenty-four (24) hours per day, seven (7) days per week. Initial staffing levels will be six (6) full-time equivalent ("FTE") Hospitalists, board certified (or board eligible if permitted in Medical Center's Medical Staff Bylaws) in internal medicine or family practice. One (1) FTE equates to an average of fifteen (15) twelve (12) hour shifts per month. These staffing levels may be changed upon mutual

agreement of the Parties, evidenced by a writing signed by both parties or by an electronic mail transmission reflecting the approval of both parties if sent by Medical Center CEO.

Company shall perform initial interviews, review credentials and references, and provide to the Medical Center a compilation of qualifications and other information useful to assist the Medical Center in determining whether to approve Hospitalists. All physicians presented to the Medical Center as prospective Hospitalists shall have and maintain licenses to practice in the state. Medical Center acknowledges and agrees that all Hospitalists will be employed by or under contract with Medical Group.

b. Program Director. One of the Hospitalists designated by Company and approved by Medical Center shall be the Program Director of the Medical Center's program for delivery of Hospitalist Services (the "Hospitalist Program"). The Program Director shall be responsible for managing the Hospitalist Program on a daily basis, including, but not limited to the following:

i. Recommending policies and procedures;

ii. Handling Hospitalist Patient complaints, in cooperation with Medical Center's Office of Inspector General Compliance Officer;

iii. Acting as liaison between the Hospitalists and Medical Center medical staff and administration;

iv. Handling Hospitalists' staff conflicts, subject to the Medical Center's Medical Staff Bylaws;

v. After receiving appropriate training from Medical Center that is usual and customary for similarly situated hospitalists, facilitate and actively promote the use of CPOE as directed by the Medical Center; and

vi. Any other reasonable duties requested by Medical Center CEO.

Specific duties of the Program Director under this Agreement are delineated on "Schedule A," attached hereto and made a part hereof.

c. Hospitalist Services. The Hospitalists shall provide integrated and comprehensive inpatient Hospitalist Services for all Hospitalist Patients at Medical Center's acute care facility, including Medical Center's acute rehabilitation and psychiatric units, twenty-four (24) hours per day, seven (7) days per week. These Hospitalist Services shall include:

i. Care Management – The Hospitalists shall conduct initial assessments and admission procedures; formulate and implement a treatment plan; schedule and review clinical and diagnostic tests as medically necessary for each Hospitalist Patient; provide timely and regular reports to primary care physicians and family members regarding all aspects of Hospitalist Patients' medical condition and course of treatment; conduct rounds daily and as necessary for the acuity of Hospitalist Patients' conditions; respond to in-house codes for Hospitalist Patients; coordinate and integrate specialty and subspecialty consultations; coordinate Hospitalist Patient transfers to and from the intensive care unit, medical/surgical unit, skilled nursing facility, or home to provide

quality and continuity of care; and discharge the Hospitalist Patient back to the care of the primary care physician as and when appropriate.

ii. Discharge Management – The Hospitalists shall coordinate with discharge planning and social work departments of the Medical Center as appropriate for each Hospitalist Patient and, as requested, shall assist in making arrangements for post-acute care.

iii. Communication – The Hospitalists shall maintain an effective communication process to interface with referring primary care physicians, Hospitalist Patients and family members. This will include a dictated, complete discharge summary within forty-eight (48) hours of discharge. Once admission and discharge billing is entered, PCP is automatically notified via facsimile, as identified. After transcribed by Medical Center, discharge summary is faxed into Company's document processor and filed in patient event; primary care physician is then automatically faxed a draft copy.

iv. Administration – Hospitalists will, from time to time, as requested by the Medical Center's Chief of Medical Staff or Medical Center's Chief Executive Officer, participate on committees of the Medical Staff and provide consultation to Medical Center on the organization and operation of the non-medical aspects of the Departments. These committees may include, without limitation, medicine, pharmacy and therapeutics, and utilization management committees. Company shall assist with the development of clinical protocols for the Hospitalist Services.

v. Patient Information Coordinator - Provide Patient Information Coordinator personnel to assist in the administrative duties of the Hospitalist seven (7) days per week. The Patient Information Coordinators' Duties will include those listed in "Schedule B," attached, and any related duties.

vi. Additional Services – Medical Center may, from time to time, request that Hospitalists perform other services in addition to those outlined above or perform Hospitalist Services at other sites or locations owned and/or operated by the Medical Center. Any such additional services shall be subject to mutual agreement of the Parties, including agreement on any increase in compensation to Company for the provision of such additional services. Any such increase in compensation shall require a written amendment to this Agreement signed by both Parties.

vii. Marketing. Program Director shall assist Medical Center in marketing efforts as reasonably requested by Medical Center CEO.

d. Medical Records. Company will ensure that the Hospitalists are maintaining medical records that adequately reflect the quality of care rendered and the instructions given each Hospitalist Patient. Upon request, Hospitalists will participate in the development and utilization of Medical Center's Health Information System and after receiving appropriate training from Medical Center that is usual and customary for similarly situated hospitalists, will actively participate in Medical Center's CPOE program as directed by Medical Center.

e. Compliance with CMS and Accreditation Standards. Provide assistance to the Medical Center in its efforts to comply with the CMS Conditions of Participation as well as with all applicable standards promulgated by the Joint Commission or other applicable accrediting bodies. Company will require the Hospitalists to comply with applicable accreditation, licensure

and certification standards in the provision of services hereunder. All Services shall be performed in compliance with all applicable standards set forth by law or ordinance or established by the rules and regulations of any federal, state or local agency, department, commission, association or other pertinent governing, accrediting, or advisory body, having authority to set standards for health care facilities, including the Joint Commission on Accreditation of Healthcare Organizations ("Joint Commission"). Also, each Hospitalist shall perform all Services in accordance with all Medical Center rules, regulations, procedures, policies and bylaws and all Medical Center Medical Staff rules, regulations, procedures, policies and bylaws.

f. Compliance Plan. Allow and ensure participation of Hospitalists in the corporate compliance program of the Medical Center, to the extent applicable to the Hospitalists. Company acknowledges that Medical Center has adopted and implemented a code of conduct, compliance program, compliance hotline and related policies (the "Corporate Compliance Program"). Company acknowledges that it has received information about the Corporate Compliance Program, some of which is available at RegionalCare Hospital Partner's website under compliance, and that it and its Hospitalists shall abide by the Corporate Compliance Program policies and procedures to the extent they are relevant and applicable to the services performed under this Agreement. Company further agrees that it shall promptly notify the appropriate individuals set forth in the Corporate Compliance Program of any violations of the code of conduct and the corporate compliance policies of which it becomes aware and attend Corporate Compliance Program meetings as reasonably requested by Medical Center.

g. Hospitalist Service Metrics. Provide to Medical Center the following: daily admission/census reports; dialogue with Medical Center CEO and/or Administrator on call prior to being transferred out of Medical Center for non-life-threatening matters, anticipated discharge date with disposition, updated daily; length of stay by DRG and physician, on a monthly basis; patient perception index, on a monthly basis; and any other reports reasonably requested by Medical Center's CEO.

4. Conditions to Status as Company Hospitalist.

a. Medical Staff Privileges. Before any Hospitalist may practice medicine in the Medical Center, such Hospitalist must first be granted medical staff membership and clinical privileges ("Staff Privileges") by the Medical Staff in accordance with its established rules and regulations as to the granting and removal of such Staff Privileges. Without limiting the foregoing, all Physicians must maintain ICU/CCU privileges and ventilator management privileges, as well as any other privileges necessary to the provision of Hospitalist Services.

Hospitalists who are granted Staff Privileges shall have all rights, privileges and responsibilities of the Medical Center's medical staff. Each Hospitalist's Staff Privileges will be contingent, among other things, upon the Hospitalist's compliance with the Medical Center's medical staff bylaws, rules and regulations (collectively, the "Medical Center Policies").

b. Dispute Resolution. If the Medical Center becomes aware of any questions of professional qualifications or performance of any Hospitalist, the same shall be communicated promptly to Company so that a resolution of the problem can be promptly made. If a clinical or interpersonal problem arises with regard to a Hospitalist, Company will work with the Hospitalist and the Medical Center to correct the problem to the satisfaction of both Parties. If the Medical Center reasonably believes that such problem is of a sufficiently serious nature to warrant suspension, then the Hospitalist in question will be removed from the schedule for a period of two (2) weeks in order to allow Company the time to fairly investigate and evaluate the problem, and

if necessary, consult with the Hospitalist to correct the problem. If the problem cannot be corrected to the satisfaction of the Medical Center, Medical Center shall reserve the right to require Company to terminate said Hospitalist from service at the Medical Center. Such termination shall be administrative in nature and shall not be considered a denial or revocation of Staff Privileges subject to fair hearing and appellate review as may be provided in the Medical Center Policies, Medical Staff Bylaws or otherwise. To the extent permitted by applicable law, any Hospitalist so terminated will be deemed to have resigned voluntarily from the Medical Center's Medical Staff.

c. Medicare/Medicaid Exclusion. Company hereby represents and warrants that neither Company, its officers, directors and owners, nor Medical Group nor any Hospitalist is or has been sanctioned, debarred, or excluded from participation in any federally funded health care program, including Medicare and Medicaid. It is specifically understood and agreed that, in the event any Hospitalist is so sanctioned, debarred or excluded, he/she will be excluded from providing services under this Agreement.

d. Removal. Except as provided below, upon request by Medical Center, Company shall remove from service, under this Agreement, any Hospitalist or Patient Information Coordinator who:

i. Is arrested, indicted, or convicted of a crime other than a minor traffic violation;

ii. Has a guardian or trustee of its person or estate appointed by a court of competent jurisdiction;

iii. Becomes disabled so as to be unable to perform the duties required by this Agreement;

iv. Fails to maintain professional liability insurance required by this Agreement;

v. Has his/her license(s) and/or privileges required to perform the Hospitalist Services suspended, revoked or otherwise limited;

vi. Is suspended, excluded, or debarred from participation in any Federal government payor program;

vii. Fails to comply with any of the terms and conditions of this Agreement or Medical Center Policies; or

viii. Engages in any conduct that, in the reasonable opinion of the Medical Center, would have negative impact on the reputation or business of the Medical Center.

Company will be required to remove a Hospitalist from Medical Center premises immediately in the event that Hospitalist breaches the requirements of subparagraphs vii. and viii. above. Medical Center agrees to reimburse Company for one hundred (100) of excess replacement costs incurred by Company, whether by locum tenens or other Company-affiliated provider who has not previously provided services at Medical Center, for the replacement of such Hospitalist who has been immediately removed from Medical Center premises; provided, however, Medical Center shall not reimburse Company for any costs where such replacement can be reasonably provided and readily available by utilizing existing

Hospitalists. Company will not be required to remove a Hospitalist from service for such breach if the Hospitalist cures the breach to the reasonable satisfaction of Medical Center within ten (10) days after receiving written notice of the breach. If such Hospitalist is unable to cure the breach within ten (10) days, Company shall, within a reasonable period of time, obtain, at its cost and expense, a substitute for the removed Hospitalist or otherwise demonstrate its capabilities for continued coverage and services required by this Agreement. A failure of performance by Company under this section shall be deemed a material breach of this Agreement, and Medical Center may immediately terminate this Agreement.

Upon removal of any Hospitalist from service under this Agreement, Hospitalist will be deemed to have resigned voluntarily from the Medical Center's Medical Staff. Additionally, such removed Hospitalist will not open a medical practice within twenty-five (25) miles of the Medical Center for twenty-four (24) months following termination unless mutually agreed upon by both Parties.

5. Insurance. Company shall arrange for each Hospitalist to be provided with professional liability insurance covering Hospitalist while providing services at Medical Center, which insurance shall have coverage limits of One Million Dollars ($1,000,000.00) per loss event and Three Million Dollars ($3,000,000.00) in the aggregate, annually. Company shall maintain, at its sole expense, professional liability insurance for all Hospitalists who provide Services pursuant to this Agreement, in amounts required to maintain Medical Center Medical Staff membership/clinical privileges in good standing. Company shall obtain this insurance from a carrier and in a form satisfactory to Medical Center. Company shall provide Medical Center with a certificate of such insurance coverage upon execution of this Agreement by Company and thereafter during the term of this Agreement upon Medical Center's request. Further, Company shall provide Medical Center with a statement from the insurance carrier that Medical Center shall be notified at least thirty (30) days prior to any change to or cancellation of such insurance coverage.

6. Coverage. The coverage required by this Section shall be either on an occurrence basis or on a claims-made basis. If the coverage is on a claims-made basis, not less than thirty (30) days prior to the termination of Company's claims-made coverage, Company shall purchase tail or retroactive coverage in the amounts required for all claims arising out of incidents occurring prior to termination of such coverage, and shall provide Medical Center with a certificate evidencing such tail or retroactive coverage. If Company fails to purchase such coverage or fails to provide Medical Center with a certificate of such coverage, Medical Center shall have the right, as hereby acknowledged by Company, to purchase such coverage and notify Company in writing of the total premium costs therefor. Company shall pay to Medical Center the total premium for such coverage immediately upon Company's receipt of such notice.

7. Covenants of the Medical Center.

a. Services Provided by the Medical Center. Medical Center will provide the following to Company and the Hospitalists, as appropriate, at its sole cost and expense.

i. Sufficient office and call room space for the purpose of providing the administrative services set forth in this Agreement. Equipment sufficient to perform the administrative duties relating to the Hospitalist Services, to include: Windows XP Professional or newer workstation with the most up-to-date install of Java; high speed internet connection, telephone and plain paper laser fax/copier/printer system. Workstation must have at least 4 GB of RAM and unrestricted read/write access to a

folder on the local hard drive; no proxy servers; must be local machine; thin clients or Citrix implementations are not acceptable. The Medical Center will provide the Hospitalist Service with a dedicated phone number and dedicated fax line (no VOIP). Hospitalist may not provide care to private patients or conduct private business activities not related to Hospitalist Services in this office space;

ii. Supplies, equipment and materials necessary for the effective delivery of the Hospitalist Services;

iii. Utilities and services including, but not limited to heat, water, electricity, telephone service, long distance fax line, laundry and janitor service; and

iv. Services of nurses and other allied health personnel, as may be needed for the effective operation of the Departments, including case management services.

b. Compliance with CMS Accreditation Standards. The Medical Center will use its best efforts, at all times, to comply with all applicable standards promulgated by CMS, the Joint Commission and any applicable accrediting bodies.

c. Records. Medical records of services provided by Hospitalists hereunder will be made available to Company upon request for any purpose permitted by law. However, any disclosure of such information must comply with all applicable law.

d. Policies and Procedures. Medical Center agrees to provide Company with copies of all of the policies and procedures of Medical Center directly or indirectly applicable to the services provided under this Agreement including, without limitation, Medical Center's:

Hazardous Communication Program; applicable Material Safety Data Sheets; Emergency Evacuation/Disaster Plan; other safety rules, such as the use of proper personal protective equipment to protect against exposure to bloodborne pathogens; labeling and protective features of sharp containers; disposal, packaging and labeling hazardous waste; location of hand washing facilities; location of any asbestos or other hazardous materials; and policies and procedures regarding security, workplace violence, sexual harassment, discrimination, COBRA/EMTALA and corporate compliance.

e. Clothing. Medical Center agrees to (i) provide appropriate, temporary clothing to Hospitalist whose clothes become contaminated with blood or other bodily fluids as a result of services provided at Medical Center, and (ii) clean and return such contaminated clothing to the Hospitalist.

f. Exposure to Fluids. In the event any Hospitalist is exposed to blood/bodily fluids while providing services under this Agreement, Company will be responsible for initial evaluation and follow-up care and testing.

g. Exclusive Nature of the Agreement. So long as Company is not in material breach of Section 3(a) above, Medical Center agrees that it shall not engage any person or entity other than Company to provide or perform the Hospitalist Services and administrative services provided by Program Director, Patient Information Coordinators, and Company contemplated by this Agreement for the Term of this Agreement. Medical Center agrees not to coerce, recruit, employ, contract with, either directly or indirectly, or engage as an independent contractor, any

Hospitalists provided by the Company to provide Hospitalist Services to Medical Center during the Term of this Agreement and for a period of one (1) year thereafter. Excluded from this provision is any Hospitalist candidate provided by Medical Center. In the event that any Hospitalist provided by Company elects to remain at Medical Center following termination of the Agreement, Medical Center shall pay to Company a Retention Fee in the amount of Fifty-Five Thousand Dollars ($55,000.00) per Hospitalist.

If and only if a notice of termination has been provided in accordance with Section 2 above, this Section 7(g) shall not thereafter prohibit, limit or restrain the Medical Center from entering into a contract or agreement with any Hospitalists and/or any Hospitalists, Nurse Practitioners, or Physician Assistants provided by Company, subject to payment of the Retention Fee above. Further, once a notice of termination has been provided in accordance with Section 2 above, the Company agrees not to take any action against any Hospitalists, Nurse Practitioners, or Physician Assistants and/or Medical Center (or any affiliate, parent, or subsidiary thereof) that would prohibit, limit, or restrain the Hospitalists and/or Nurse Practitioners or Physician Assistants from entering into any contract or agreement with the Medical Center for the provision of medical services, subject to payment of the Retention Fee above.

The Parties acknowledge and agree that three (3) breaches of Section 3(a) above within an uninterrupted 180 day period shall constitute a material breach for purposes of this Section 7(g). Medical Center shall provide written notice to Company with ten (10) days of each said breach.

h. Medical Center will maintain a professional service staff sufficient to fulfill duties and responsibilities of Medical Center, as determined by Medical Center in its sole discretion.

i. Medical Center, through its administration and quality review programs, will perform clinical oversight to promote quality medical services by Medical Center and Medical Center personnel.

8. Compensation.

a. Company's Billing for Services. Medical Center acknowledges the right of Company, at Company's expense, to bill Hospitalist Patients and/or their Insurers or other payors for the services rendered by Hospitalists. Any and all such fees shall become and remain the property of Company or Medical Group, and Medical Center shall have no claims for such fees. Company shall give reasonable consideration to any request by Medical Center to refrain from billing for Hospitalist Services provided in cases involving risk management or other sensitive patient-relations issues. If Company receives payment for services provided by Medical Center, Company will promptly deliver such payment to Medical Center. Company acknowledges that the income guarantee provided hereunder is a function of the Company's cash collections. As a consequence, Medical Center will be adversely impacted in the event that the Company's billing performance does not meet industry standards. Therefore, Company agrees to use best practices, in accordance with generally accepted industry standards, to timely bill and collect for Hospitalist services provided hereunder. Company shall provide to Medical Center, at least quarterly, a report of Company's billing and collecting activities for services provided hereunder.

b. Medical Center's Billing for Services. Company acknowledges the right of Medical Center, at Medical Center's expense, to bill Hospitalist Patients and/or their insurers for the use of facilities, personnel, equipment, supplies, and support services provided by Medical Center. Any and all such fees shall become and remain the property of Medical Center under all

circumstances. If Medical Center receives payment for services provided by Hospitalists, Medical Center will promptly deliver such payment to Company.

c. Medical Center Support to Company, Medical Group and Hospitalists.

i. Hospitalist Recruitment Fee. Medical Center recognizes the need for funds to identify and recruit qualified physicians to serve as Hospitalists. Therefore, Medical Center agrees to pay to Company a one-time Hospitalist Recruitment Fee of Twenty Thousand Dollars ($20,000.00) for each Physician FTE identified and recruited by Company and approved by Medical Center to provide Hospitalist Services. Company will waive the Hospitalist Recruitment Fee if Medical Center provides the candidate. If this Agreement is terminated due to a breach by Company prior to the end of the first year of the Term, all money paid to Company as Hospitalist Recruitment Fees will be refunded to Medical Center on a prorated basis based on the number of months of service provided during the first year of the Term.

ii. Reimbursement of Travel Expenses. Medical Center will reimburse the Company for reasonable travel expenses incurred by Hospitalist candidates visiting Medical Center for interviews and community tours.

iii. External Company Provider Expenses. If the parties agree that any of the coverage under this Agreement should be provided by an "External Company Provider," hereinafter defined as an employee of Company whose primary workplace is not Medical Center, then Medical Center shall pay to Company Three Hundred Dollars ($300.00) per shift per External Company Provider, which will be passed directly to the Provider for food, lodging, travel, rental car and any other expenses related to that External Company Provider. The parties expressly agree that Company shall be entitled to bill and collect for the professional fees of the External Company Provider as for any other Company employee serving as a provider at Medical Center, and that the Cash Collections Guarantee outlined in this Agreement shall apply to such External Company Provider.

iv. Locum Tenens Compensation. If the parties agree that any of the coverage under this Agreement should be provided by a locum tenens provider, Company shall provide such locum tenens coverage by contracting for the locum tenens provider. Medical Center shall reimburse Company for the costs of providing such locum tenens coverage, including, but not limited to the compensation payable to the locum tenens provider or service, any expenses for food, lodging, travel, rental car and any other expenses related to that locum tenens provider. In the event that a Hospitalist must be immediately removed from Medical Center premises, such removal shall be in accordance with Section 4(d) above. Any Physician who provides services as a locum tenens under this Agreement will not be considered a Physician FTE for purposes of calculating the "Monthly Guarantee Amount" described in Section 8(c)(x), below.

v. Signing Bonus for Hospitalists. Medical Center agrees to reimburse Company one hundred (100) percent of the amount of any signing bonus approved by Medical Center and paid by Company to a Hospitalist. Any such payment must be approved in advance and in writing by Medical Center, in its sole and absolute discretion. Company shall obligate Hospitalists who receive a signing bonus to:

(i) Agree to provide services at Medical Center for a time period acceptable to the Medical Center; and

(ii) Execute an agreement to repay the full amount of any signing bonus if they fail to provide services for the agreed-upon time period.

vi. Relocation Fee. Medical Center recognizes the need for capital to relocate recruited physicians to the area. Therefore, Medical Center agrees to pay Company Ten Thousand Dollars ($10,000.00) at Medical Center's discretion for each Physician who relocates to the area and becomes a Hospitalist. This amount may be increased by prior written agreement of Medical Center and Company. In the event that a Hospitalist ceases to provide service at Medical Center within six (6) months of such Hospitalist's start date (as determined by the first date the Hospitalist provides services at Medical Center, all money paid to Company as a Relocation Fee for such Hospitalist will be refunded by Company to Medical Center.

vii. Program Director ("PD") Stipend and Patient Information Coordinator ("PIC"). Medical Center recognizes the costs of the PD and PIC services. Therefore, Medical Center agrees to pay to Company Three Thousand Dollars ($3,000.00) per month as a PD stipend. This amount may be increased subject to the mutual agreement of the parties. Additionally, Medical Center agrees to pay to Company Four Thousand Five Hundred Eighty-Three Dollars ($4,583.00) per PIC FTE per month. For purposes of the PIC FTE calculation, one (1) FTE equals forty (40) hour-per-week coverage; weekend coverage may be provided remotely. These stipends shall be paid on or before the fifteenth (15th) day of the month in which services are rendered.

viii. Management Fee. Recognizing that the Company must earn a fair profit in order to continue to provide reliable services to Medical Center, Medical Center agrees to pay Company a management fee (the "Management Fee") equal to fifteen (15) percent of "Cash Collections from Professional Services." "Cash Collections from Professional Services" means ninety-two (92) percent of all cash collections, net of refunds, received by Medical Group for Hospitalists' performance of medical services for Hospitalist Patients at the Medical Center. Company will provide Medical Center with a report reflecting the Cash Collections from Professional Services within five (5) days after the end of each month during which such Cash Collections from Professional Services are received, and Medical Center will pay the Management Fee on or before the twentieth (20th) day of each month. Any Management Fee payable with respect to the final month of the Term will be paid to the Company on or before the twentieth (20th) day of the first month after the Term.

ix. Medical Center Guarantee of Minimum Cash Collections to Company from Professional Services.

(i) During the Term, Medical Center agrees to advance to Company certain amounts of money that Medical Center shall provide as a guarantee of Cash Collections from Professional Services. "Cash Collections from Professional Services" means cash collections, net of refunds, received by Medical Group for Hospitalists' performance of medical services for Hospitalist Patients at the Medical Center less eight (8) percent paid to professional billing service for billing, collections, software licenses, compliance, payor audits, reporting, training, and customer support. Company will provide Medical Center

with a report reflecting the Cash Collections from Professional Services within five (5) days after the end of each month during which such Cash Collections from Professional Services are received, and Medical Center will pay the Management Fee on or before the twentieth (20th) day of each month. Any Management Fee payable with respect to the final month of the Term will be paid to the Company on or before the twentieth (20th) day of the first month after the Term.

(ii) On a monthly basis, Medical Center shall pay to Company the amount by which the Monthly Guarantee Amount, as specified below, exceeds the Company's Cash Collections from Professional Services for the preceding month. Monthly Guarantee Amount means Twenty-Eight Thousand Eighteen Dollars ($28,018.00) per Physician FTE provided by Company under this Agreement. Such amount is based on the sum of the following components divided by 12: Physician's annual base salary, which is Two Hundred Sixty Thousand Dollars ($260,000.00); twenty-two (22) percent of Physician's annual gross salary (attributed to benefits); and annual medical malpractice insurance coverage of Nineteen Thousand Twenty Dollars ($19,020.00) per Physician FTE.

If the first (1st) and last months of the Agreement are less than full calendar months, the Monthly Guarantee Amount shall be prorated accordingly.

x. The amount by which the Monthly Guarantee Amount exceeds the Cash Collections from Professional Services for each month (the "Monthly Guarantee Payment") will be calculated and paid as follows:

(i) On or before the fifth (5th) business day of each month during the Term, and the first (1st) month after the Term, Company shall furnish Medical Center with a statement of Company's Cash Collections from Professional Services for the previous month. Medical Center will calculate the amount by which the Monthly Guarantee Amount exceeds the Company's Cash Collections from Professional Services for the previous month, to determine the Monthly Guarantee Payment, if any, for the current month.

(ii) Monthly Guarantee Payments shall be made within fifteen (15) business days following receipt of Company's statement of Cash Collections from Professional Services. If, however, in any month during the Term, Company's Cash Collections from Professional Services are equal to, or exceed the Monthly Guarantee Amount, Medical Center shall have no obligation hereunder to pay Company a Monthly Guarantee Payment for such month. Further, if during any month during the Term, Company's Cash Collections from Professional Services exceed the Monthly Guarantee Amount, such excess amount ("Excess") shall be subtracted from the Monthly Guarantee Payment that would otherwise be payable for the next month and for any subsequent months until the full amount of the Excess has been deducted from Monthly Guarantee Payments, at which point the Monthly Guarantee Payments shall resume.

(iii) During the Term, and for a period of ninety (90) days thereafter, Medical Center shall have the right to review and audit Company's books and records for whatever period of time is necessary to assure that the Monthly Guarantee Payments have been calculated properly.

(iv) The Monthly Guarantee Payment will be reduced by any amounts not collected by Company due to the failure of Company or any Hospitalist to bill for or document appropriate services provided, or any other failure to comply with any payor's reimbursement requirements. Company will use its best efforts to submit all documentation necessary to credential each Hospitalist with all applicable payors within ninety (90) days of the date on which such Hospitalist begins providing services under this Agreement.

(v) If Company fails to provide the coverage required under this Agreement, Medical Center may, in addition to any other remedies available to it, decrease the Monthly Guarantee Payment in proportion to the shortfall. No such decrease shall be construed as a waiver by Medical Center for Company's obligation to provide required coverage hereunder.

xi. Student Loan Repayment. In the event there is a student loan obligation, Medical Center agrees to reimburse Company for any additional compensation related to the loan obligation, contingent upon mutual agreement of the parties.

xii. Cost-of-Living Increase. At the end of each anniversary date of the Agreement, a Cost-of-Living Increase equal to the lesser of: (i) three (3) percent or (ii) Consumer Price Index for All Urban Consumers ("CPI-U") shall be applied to each Physician's annual base salary, not to exceed three (3) percent per Physician per year. For example, if the Physician's annual base salary is Two Hundred Sixty Thousand Dollars ($260,000.00) and the CPI-U is equal to three (3) percent, the increased amount would be equal to Two Hundred Sixty Thousand Dollars ($260,000.00), multiplied by three (3) percent, for an increase of Seven Thousand Eight Hundred Dollars ($7,800.00) per Physician per year and a total Physician annual base salary of Two Hundred Sixty-Seven Thousand Eight Hundred Dollars ($267,800.00). This amount will be passed directly to the Physician. The Monthly Guarantee Amount will increase, proportionate to the increase in salary. Using the aforementioned example, the Monthly Guarantee Amount will increase by Six Hundred Fifty Dollars ($650.00) per Physician FTE, calculated by dividing Seven Thousand Eight Hundred Dollars ($7,800.00) by twelve (12).

d. Adjustment of Certain Compensation Elements for Non-Physician Hospitalists. If Company provides Hospitalist Services through Nurse Practitioners or Physician Assistants, the compensation payable to Company as a Hospitalist Recruitment Fee, Signing Bonus or Relocation Fee with respect to such Nurse Practitioners or Physician Assistants will be fifty (50) percent of the compensation payable, as specified above, with respect to Physicians.

e. Quality Metrics. Additional compensation is available for the successful performance of "quality metrics," as defined and fully set forth and incorporated herein as "Schedule E." The parties further agree that the criteria contained in Schedule E shall apply after the first anniversary of this Agreement and that the parties hereto may mutually agree to replace, on an annual basis, any of the Quality Metrics with other yet-to-be-defined Quality Metrics, which shall be applicable in future years of this Agreement. Payment or credit compensation for the Quality Metrics shall be on a quarterly basis.

9. Payment Programs with Third Parties. Company agrees to cooperate with Medical Center in its development of relationships with managed care plans, preferred provider organizations, independent provider associations, health insurers and other medical benefit programs (collectively, "Insurers"). With respect to payment for Hospitalist Services only,

Medical Center agrees that Company or Medical Group may negotiate directly with such Insurers. In the event that Company's arrangement with an Insurer is linked to Medical Center's relationship with such Insurer, Medical Center agrees to include a Company management representative in the evaluation and negotiation of such arrangements.

Attached to this Agreement as "Schedule C" is a listing of Insurers with which the Medical Center will require Company or Medical Group to negotiate a contract. Medical Center will work cooperatively with Company to prioritize the negotiations. In addition, Medical Center will provide Company with the following information for each Insurer: the name of the Insurer; its address; the contact person; and his or her electronic mail address and telephone number. Medical Center may revise Schedule C at any time by giving thirty (30) days' notice to Company.

10. Assistance to Company. Medical Center acknowledges that Company requires certain information to be obtained by Medical Center and supplied to Company to enable Company to bill Hospitalist Patients as provided above. Therefore, subject to applicable law, Medical Center shall, at its expense:

a. Use its best efforts to (i) obtain medical insurance information for each patient/patient visit, and (ii) require all Hospitalist Patients and/or guarantors or other legally responsible Parties to sign any forms required by medical insurers;

b. As needed, and upon request, provide to Company legible copies of all Hospitalist Patients' records, including without limitation, physician and nursing notes and continuation sheets;

c. Obtain releases from each Hospitalist Patient authorizing (i) the use of such patient's medical records and other data by Company, for purposes of billing and (ii) payments for services rendered by Hospitalists to be made directly to Company;

d. Provide Company with demographic information on each Hospitalist Patient;

e. Provide Company, monthly, with an accounting of all payments received by Medical Center attributable to services rendered by Hospitalists.

Company agrees not to disclose any of the information provided to it by Medical Center as identified above except as required by Company, its agents, representatives or affiliates for professional liability or risk management purposes or to allow or facilitate Company's billing and/or collecting for services rendered by Hospitalists.

f. Company is a "business associate" of Medical Center, a "covered entity," as those terms are defined in the HIPAA Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rules") and the HIPAA Standards for Security of Electronic Protected Health Information (the "Security Rules"), 45 C.F.R. Part 160 and Part 164, Subparts A, C and E. As a business associate, Company must comply with the Privacy Rules and the Security Rules. The Privacy Rules and the Security Rules require Medical Center to enter into agreements containing certain minimum safeguards with its business associates. As a business associate of Medical Center, Company will comply with the terms and conditions set forth in Schedule D.

11. Relationship of Parties. The Parties agree that (a) they are independent contractors, (b) they will at all times act hereunder as independent contractors, (c) under no

circumstances shall either of them construe this Agreement, or conduct itself in a manner that shall allow it to be construed, as one of agency, partnership, joint venture or employment between them, and (d) neither of them shall or may exercise direction or control over the provision of services by the other of them. Notwithstanding the foregoing, the Hospitalist Services will be performed (a) in accordance with generally accepted professional standards in the medical profession, (b) in compliance with the Medical Center Bylaws, and (c) consistent with applicable Medical Center policies and procedures.

12. Referrals. The Parties acknowledge that none of the benefits granted to either Party hereunder is conditioned on any requirement that either Party or their respective affiliates make referrals to or otherwise generate business for the other Party.

13. Government Regulations. In the event (i) Medicare, Medicaid, any third Party payor or any federal, state or local legislative authority adopts any law, rules, regulation, policy, procedure or interpretation thereof that establishes a material change in the method or amount of reimbursement or payment for services under this Agreement, or if (ii) any or all of such payors or authorities impose requirements that necessitate a material change in the manner of either Party's operations under this Agreement and/or the costs related thereto, then, upon the request of either Party materially affected by any such change in circumstances, the Parties shall enter into good faith negotiations for the purpose of establishing such amendments or modifications as may be appropriate in order to accommodate the new requirements and changes of circumstances while preserving the original intent of this Agreement to the greatest extent possible. If after thirty (30) days of such negotiations, the Parties are unable to reach an agreement as to how or whether this Agreement shall continue, then either Party may terminate this Agreement upon 30 (thirty) days' prior written notice.

14. Liaison. Company and Medical Center shall each designate a liaison to coordinate communications between them. Until notified otherwise in writing, the liaison representative for Company shall be its Chief Executive Officer, and the liaison representative for Medical Center shall be its Chief Executive Officer.

15. Incurring Liabilities. Neither Party shall have the authority to bind the other Party under any contract or agreement or incur any debts or other obligations on behalf of the other Party.

16. Confidentiality. All statistical, financial, personnel, medical records and other data relating to the business of Medical Center is confidential and shall be retained in confidence by Company, its employees and agents; provided, however, the foregoing obligation does not apply to such data, information or materials that (a) Medical Center permits Company to release, (b) Company is required by law to release, or (c) Company is required to use to bill, or collect from, Hospitalist Patients or their Insurers.

17. Authority. Each of Medical Center and Company represent and warrant that it has the right, authority and power to enter into this Agreement.

18. Changes in Bylaws. Medical Center agrees to notify Company in a timely manner of any proposed, anticipated or actual changes to the Medical Staff Bylaws.

19. **Governing Laws**. The laws of the state of Iowa, without regard to the conflicts of law principals thereof, shall govern the validity, construction, enforcement and interpretation of this Agreement.

20. **Entire Agreement; Amendment**. This Agreement embodies the entire agreement between the Parties with respect to the subject matter hereof, and supersedes all prior agreements and understandings, if any, relating to the subject matter hereof. This Agreement may be amended only by an instrument in writing executed jointly by an officer duly authorized by the Board of Directors of the respective Parties.

21. **Binding Effect**. This Agreement shall be binding upon and inure to the benefit of Company and Medical Center, and their respective successors and assigns.

22. **Assignment**. This Agreement may not be assigned by either Party without the prior written consent of the other Party, except that Medical Center may assign this Agreement to any successor to substantially all of Medical Center's operating assets, or to an affiliate of Medical Center.

23. **Waiver of Breach**. The waiver by either Party of a breach of any provision of the Agreement shall not operate or be construed as a waiver of any subsequent breach by such Party.

24. **Use of Words**. Whenever necessary in this Agreement and where the context requires, the gender of words shall include the masculine, feminine, and/or neuter, and the number of all words shall include the singular and the plural.

25. **Descriptive Headings**. The captions and headings used in this Agreement are for convenience only and do not limit or amplify the terms and provisions hereof.

26. **Interpretation**. Nothing in this Agreement shall be construed as authorizing Company to practice medicine or to direct or control the practice of medicine by any Hospitalist providing medical services at Medical Center.

27. **Severability**. If any provision of this Agreement or the application thereof to any person or circumstance, is held to be illegal, invalid or unenforceable for any reason, such illegality, invalidity or unenforceability shall not affect any other provision of this Agreement that can be given effect in the absence of the illegal, invalid or unenforceable provision of application. To this end, all provisions of this Agreement are declared to be severable.

28. **Notices**. All notices, requests, demands and other communications required or permitted hereunder shall be in writing and shall be deemed to have been duly given (a) when received by the Party to whom directed; or (b) when deposited in the United States mail when sent by certified or registered mail, postage prepaid to the following addresses (or at such other addresses as shall be given in writing by either Party to the other):

If to Medical Center:	Ottumwa Regional Health Center 1001 Pennsylvania Avenue Ottumwa, Iowa 52501 Attention: Hospital CEO
And a Copy to:	RegionalCare Hospital Partners, Inc. 103 Continental Place, Suite 200 Brentwood, Tennessee 37027 Attention: Legal Department
If to Company:	Apogee Medical Management, Inc. 2525 East Camelback Road, Suite 1100 Phoenix, Arizona 85016

29. **Government Access**. As and to the extent required by law, upon written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, Company shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If Company carries out any of the duties of this Agreement through a subcontract with a value of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period with a related individual or organization, Company agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of 42 U.S.C. Section 1395x(v)(1) and the regulations thereto. No attorney-client or other legal privilege will be deemed to have been waived by Medical Center, Company or any Hospitalist by virtue of this agreement.

30. **Indemnification.**

a. Company shall indemnify and hold Medical Center harmless from any and all liability, loss (including attorneys' fees and costs) or damages suffered or incurred by Medical Center directly arising out of Company's failure to comply with its obligations under Sections 10(f), 13, 16, 33, 36, and Schedule D of this Agreement. In addition, Company shall indemnify, defend and hold Medical Center harmless from and against any and all claims for wages, salaries, benefits, taxes and all other withholdings and charges payable to, or in respect to, Hospitalists for services provided under this Agreement.

b. Medical Center shall indemnify and hold Company harmless from any and all liability, loss (including attorneys' fees and costs) or damages suffered or incurred by Company directly arising out of Medical Center's failure to comply with its obligations under Sections 10(f), 13, 33, and Schedule D of this Agreement.

c. Each Party specifically reserves any common law right of indemnity and/or contribution that either Party may have against the other.

31. **Counterparts**. This Agreement may be executed in multiple counterparts, each of which shall, for all purposes, be deemed an original, and all of which shall, for all purposes, constitute one and the same instrument.

32. **Approvals**. Neither this Agreement nor any amendment or modification hereto shall be effective or legally binding upon Medical Center, or any officer, director, employee or agent thereof, unless and until it has been approved in writing by an authorized representative of Medical Center.

33. **Compliance with Law**. Notwithstanding any other provision in this Agreement, each Party agrees to comply with all applicable provisions of Federal, state and local statutes, rules and regulations.

34. **Master Contract Database**. As required by 42 C.F.R. § 411.357(d)(1)(ii), all service agreements between Medical Center and a physician organization, physician, or an immediate family member of a physician, are maintained electronically in a master contract database that is maintained and updated centrally and is available for review upon request by an authorized governmental official.

35. **Vendor Promotion/Publication**. Medical Center prohibits the use of Medical Center's name by any vendor or independent contractor, or the use of any name of Medical Center's parent company, subsidiaries, or affiliated facilities in any advertisement, press statement, or release, website, published customer list, or any publication or dissemination similar to the foregoing without receiving in advance the express written permission from Medical Center's Chief Executive Officer. Any request for permission should include the complete text of the publication, statement, or document in which the name usage will appear and be subject to edit by Medical Center.

36. **Representations and Warranties of Company**. Company represents and warrants to Medical Center as follows:

a. Neither Company nor any of the Company's physicians practicing at Medical Center ("Company Physician") is

i. currently excluded, debarred, or otherwise ineligible to participate in any of the federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the "Federal Health Care Programs");

ii. convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible to participate in the Federal Health Care Programs;

iii. under investigation or otherwise aware of any circumstances that may result in Company or any of the Company Physicians' being excluded from participation in the Federal Health Care Programs;

iv. not bound by any Agreement or arrangement that would preclude Company Physician from entering into, or from fully performing the Services required under, this Agreement;

v. No Company Physician's license to practice medicine in Iowa or any other jurisdiction has ever lapsed or been denied, suspended, revoked, terminated, relinquished or made subject to terms of probation or other restriction;

vi. No Company Physician's medical staff privileges at any health care provider have ever been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action or made subject to terms of probation or other restriction;

vii. Each Company Physician holds a valid Drug Enforcement Agency number that has never been revoked, suspended, terminated, relinquished, placed on terms of probation, or restricted in any way;

viii. No Company Physician is currently the subject of a disciplinary or other proceeding or action before any governmental, professional, medical staff or peer review body; or

ix. Each Company Physician has, and shall maintain throughout the term of this Agreement, an unrestricted license to practice medicine in Iowa and staff membership and privileges at Medical Center.

[Signatures on following page]

IN WITNESS WHEREOF, Medical Center and Company have executed this Agreement, in multiple counterparts, each of which shall be deemed an original, effective the day and year first above written.

SIGNATURES AND APPROVALS:

Apogee Medical Management, Inc. **(Company)**	**RCHP Ottumwa, LLC d/b/a Ottumwa Regional Health Center** **(Medical Center)**
By: _____	By: _____
Title: President	Title: CEO
Date: 7/28/14	Date: 7/25/2014

SCHEDULE A

PROGRAM DIRECTOR DUTIES

The Program Director shall:

a) Recommend and implement Hospitalist Services protocols, policies and procedures;

b) Ensure physician coverage for Medical Center by scheduling coverage of Hospitalist Services on a monthly basis;

c) Schedule, coordinate and supervise the provision of Hospitalist Services within Medical Center;

d) Assist Medical Center in the development and implementation of appropriate performance improvement activities and benchmark measures with respect to the quality of Hospitalist Services;

e) Assume primary clinical responsibility for Hospitalist-related performance improvement activities and initiatives as appropriate;

f) Assist Medical Center with the organization and implementation of an effective utilization management program with respect to Hospitalist Services;

g) Assist Medical Center staff regarding the efficiency and effectiveness of Hospitalist Services for specific outcomes and performance indicators;

h) Advise Medical Center regarding budget, both operational and capital, and other items for the proper and efficient operation of Hospitalist Services;

i) Develop, review and provide training programs for Medical Staff and Medical Center regarding Hospitalist Services;

j) Assist Medical Center, as requested, in maintaining compliance with the applicable requirements of The Joint Commission or any other accreditation agency; the applicable licensing requirements; and the applicable requirements promulgated by any federal, state or local agency, as they apply to the Hospitalist Services;

k) Upon request by Medical Center, arrange for Hospitalist coverage at all times to respond or assist in the event of urgent or emergency situations;

l) Ensure that the Hospitalists maintain appropriate physician patient records in a timely fashion in accordance with Medical Center policies and Medical Staff Bylaws and Rules and Regulations;

m) Participate in the educational programs conducted by Medical Center and the Medical Staff necessary to assure Medical Center's overall compliance with accreditation and licensing requirements and perform such other teaching functions as agreed to by the Parties;

n) Monitor, evaluate and work to effect improvements when necessary and appropriate in the clinical abilities and performance of the Hospitalists;

o) Review monthly samples of Hospitalist Patient charts to ensure that complete patient data is being captured in accordance with all applicable requirements and guidelines; and

p) Assist in monitoring the performance of those Hospitalists who are not meeting Medical Center quality, patient satisfaction goals, and/or performance standards, and in disciplining any Hospitalists who continue poor performance, recognizing that the Medical Center Board of Directors is ultimately responsible for maintaining the standards of care provided to Hospitalist Patients;

q) Actively participate in UR committee, if requested by Medical Center CEO or MEC;

r) After receiving appropriate training from Medical Center that is usual and customary for similarly situated hospitalists, promote and utilize CPOE as requested by Medical Center CEO;

s) Support the implementation of all clinical corporate and local medical staff quality initiatives (Safety, Documentation Improvement, ICD-10, etc.).

SCHEDULE B

HOSPITALIST PATIENT INFORMATION COORDINATOR DUTIES

1. Rounding list available by 0700 daily

    a. Accurate billing entered
    b. New Hospitalist Patients entered
    c. Room numbers verified
    d. Discharges verified

2. Enter hospital census

3. Reconciliation reports

    a. Completed daily
    b. Mark as reconciled to confirm accuracy

4. Distribute correct rounding list to floors/nursing stations

5. Hospitalist Patient visits

    a. Verify demographics
    b. Identify Primary Care Physician
    c. Explain Hospitalist and Apogee; leave brochure
    d. Gather clinical pathways and critical care notes
    e. Assist with Primary Care Physician follow-up appointments, if requested

6. Fax documents into ICE for document processing

7. File all documents after entering in ICE

8. Post Scoreboard and High/Low reports in the office

9. Verify insurances, including determining if Medicaid pending

10. PET calls – Bedside visit at discharge or follow-up phone calls to Hospitalist Patient, post-discharge

11. CQIs – Communicate with Program Director if not turned in/completed by physicians

12. Work pending actions report

13. Distribute the mail

14. Create a night rounding list

15. Communicate directly with the Managing Patient Information Coordinator for support and any Patient Information Coordinator schedule changes

16. Keep office tidy

17. Liaison with all Medical Center, Administration, and Apogee

18. After receiving appropriate training from Medical Center that is usual and customary for similarly situated hospitalists, promote and use CPOE as directed by Medical Center

19. After receiving HCAHPS scores from Medical Center, post the scores and individual comments

20. After receiving appropriate training in ORHC Clinical Documentation Improvement as is usual and customary in the hospital industry, participate in the ORHC Clinical Documentation Improvement program to include collaborating with ORHC staff (case managers and clinical managers/directors) and assisting Hospitalists in completion of queries.

Payor	Title/Job Description
Wellmark Blue Cross Blue Shield	Network Engagement Business Partner
Medicare	Customer Service
Medicaid	Senoir Education Coordinator
United Healthcare	Regional Ancillary-Hospital & Facility Advocate
Meridian	Hospital Rep

[redacted]

SCHEDULE D

BUSINESS ASSOCIATE ADDENDUM TO CONTRACT

This Addendum sets out the responsibilities and obligations of the undersigned individual or company ("Associate") as a Business Associate of RCHP-Ottumwa, LLC d/b/a Ottumwa Regional Health Center ("Entity") that is covered by an existing services agreement between Associate and Facility ("Agreement"). Associate and Entity agree to the terms and conditions of this Addendum in order to comply with the use and handling of Protected Health Information ("PHI") which includes Electronic Protected Health Information ("ePHI") under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164, Subparts A and E, as amended from time to time ("Privacy Standards"), the Standards for the Protection of Electronic Protected Health Information, 45 C.F.R. Parts 160 and 164 Subparts A and C, as amended from time to time ("Security Standards"), and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), as incorporated in the American Recovery and Reinvestment Act of 2009. (Collectively, the Privacy Standards, Security Standards, and HITECH Act are referred to as the "Requirements.") Unless otherwise provided, all capitalized terms in this Agreement will have the same meaning as provided under the Requirements. Associate and Entity will comply with the terms of this Addendum for the duration of the Agreement and for such other continuing periods as provided in this Addendum. Unless otherwise indicated in this Addendum, PHI shall include ePHI.

1. **Uses and Disclosures of Protected Health Information**. Associate will use and disclose PHI only for those purposes necessary to perform its duties, obligations and functions under the Agreement, or as otherwise expressly permitted in this Addendum or required by other law. Associate will use or disclose only the Minimum Necessary amount of PHI for each use or disclosure made on behalf of Entity.

2. **Security and Confidentiality Safeguards**. Associate will implement appropriate safeguards to prevent any use or disclosure of PHI not otherwise permitted in this Addendum. Associate will also implement Administrative, Physical and Technical Safeguards to protect the Confidentiality, Integrity, and Availability of the PHI, if any, that Associate creates, receives, maintains, or transmits on behalf of Entity. Associate will comply with all security and privacy requirements applicable to Business Associates as set forth in the Requirements.

3. **Reports of Privacy Breach or Other Impermissible Use or Disclosure**. Associate will report impermissible uses or disclosures to Entity as follows:

    a. **Privacy Breach.**

        (i) Within 72 hours following discovery of a privacy Breach (as defined below), Associate will provide Entity with a brief description of what happened, including the date of the Breach, date of discovery, and an estimate of the number of Patients effected by the Breach. Notice may be made by calling Entity's Privacy Officer or faxing written notice to the Entity's Chief Information Security Officer, as set forth in Section 15.

        (ii) Without unreasonable delay and in no case later than twenty (20) calendar days following discovery of a Breach, Associate will provide Entity's Privacy Officer with:

- the identity, to the extent known, of each Patient whose PHI has been accessed, acquired, used, or disclosed during the Breach;

- A description of the types of PHI that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

- A description of what Associate is doing to investigate the Breach, to mitigate harm to Patients, and to protect against any further Breaches.

"*Breach*" means, for purposes of this Addendum, the acquisition, access, use or disclosure of unencrypted PHI in a manner not permitted under the Requirements or under this Agreement, and that could compromise the privacy or security of the PHI, within the meaning of 45 C.F.R. § 164.402. The unauthorized acquisition, access, use or disclosure of a Patient's Social Security number is automatically deemed to constitute a Breach.

(iii) To the extent any Breach is attributable to a breach of the obligations of Associate under this Addendum or a violation of any of the Requirements, Associate shall bear (a) the costs incurred by Entity in complying with its legal obligations relating to such Breach, and (b) in addition to other damages for which Associate may be liable for under this Addendum, the following expenses incurred by Entity in responding to such Breach: (1) the cost of preparing and distributing notifications to affected Patients, (2) the cost of providing notice to government agencies, credit bureaus, and/or other required entities, (3) the cost of providing affected Patients with credit monitoring services for a specific period not to exceed twenty-four (24) months, or longer if required by law, to the extent the incident could lead to a compromise of the data subject's credit or credit standing, (4) call center support for such affected Patients, and (5) the cost of any other measures required under applicable law.

b. **Security Incident.**

(i) Within 72 hours of a Security Incident (as defined below) that results in access to or disruption of PHI, Associate will provide Entity with a description of the Security Incident, the scope of the Security Incident, the Associate's response, and, if known, the identification of the party responsible for causing the Security Incident. Notice may be made by faxing written notice to the Entity's Director of Information Systems Security as set forth in Section 15.

(ii) Periodically as requested by Entity, Associate will provide Entity with a general description of Security Incidents that were not successful in accessing or disrupting PHI.

(iii) Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a Security Incident.

"*Security Incident*" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

c. **Other Improper Uses or Disclosures**. Associate will report to Entity any other impermissible use or disclosure within 72 hours of discovery of the impermissible use or disclosure.

d. **Mitigation**. Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of PHI by Associate in violation of the requirements of this Addendum or the Requirements, as reasonably directed by Entity.

4. **Agents and Subcontractors**. If Associate provides PHI to a Subcontractor (defined below) for a purpose authorized under the Agreement and this Addendum, Associate will first enter into a written contract with the Subcontractor that complies with the requirements of 45 C.F.R. § 164.504(e)(2) through (e)(4), pursuant to which the Subcontractor agrees to the same restrictions and conditions applicable to Associate's use and disclosure of PHI, as set forth in this Addendum. Associate shall also ensure that any Subcontractor that creates, receives, maintains, or transmits PHI on behalf of Associate agrees to comply with the applicable requirements of the applicable Requirements. Associate will maintain a list of any such disclosures to Subcontractors as provided in Section 8 of this Addendum. "Subcontractor" shall have the same meaning as the term "subcontractor" in 45 C.F.R. § 160.103.

5. **Obligations Regarding Associate Personnel**. Associate will appropriately inform all of its employees, agents, representatives and members of its workforce ("Associate Personnel"), whose services may be used to satisfy Associate's obligations under the Agreement and this Addendum of the terms of this Addendum. Associate represents and warrants that the Associate Personnel have signed confidentiality agreements and are under legal obligation to Associate to enable Associate to fully comply with the provisions of this Addendum. Associate shall maintain copies of such signed confidentiality agreements and shall provide them to Entity upon request.

6. **Access to PHI**.

a. **Entity Request**. Within ten (10) days of a request by Entity for access to PHI held by Associate, Associate will make requested PHI available to Entity.

b. **Patient Request**. If an Individual or his/her Personal Representative as defined by state law (individually or collectively, "Patient") directs the access request to Associate, Associate will within five (5) business days forward such request in writing to Entity. Entity will be responsible for making all determinations regarding the grant or denial of a Patient's request and Associate will make no such determinations.

7. **Amendment of PHI**.

a. **Entity Request**. Within 20 calendar days of receiving a request from Entity to amend a Patient's PHI, Associate will provide such information to Entity for amendment. If the Entity's request includes specific information to be included in the PHI as an amendment, Associate will incorporate such amendment within 10 days of receipt of the Entity's request.

b. **Patient Request**. If a Patient directs the amendment request to Associate, Associate will within 20 days forward such request in writing to Entity. Entity will be responsible for making all determinations regarding the grant or denial of a Patient's request and Associate will make no such determinations.

8. **Accounting of Disclosures; Requests for Disclosure**. Associate will, to the extent required by the Requirements, keep a record of any disclosure made to third parties, including Associate's Subcontractors, and will maintain this disclosure record for the term of the Agreement and for the period prescribed by the Requirements.

   a. **Entity Request**. Associate will provide a copy of its record of such disclosures to Entity within 20 days following the request by Entity.

   b. **Patient Request**. If a Patient directs the accounting request to Associate, Associate will within twenty (20) business days forward such request in writing to Entity. Entity will be responsible for making all determinations regarding the grant or denial of a Patient's request and Associate will make no such determinations.

   c. **Survival**. This Section shall survive termination of this Addendum.

9. **Patient Request for Restrictions**. If a Patient requests Associate to restrict the use or disclosure of PHI, Associate will forward the request to Entity within 20 calendar days of Associate's receipt of the request. Entity will be responsible for making all determinations regarding the grant or denial of a Patient's request for restrictions, and Associate will make no such determinations. Associate will restrict the use or disclosure of PHI consistent with the Entity's instructions, and will further comply with any Patient's request for restrictions that Entity or Associate is required by law to honor, including requested restrictions on payment or health care operations-related disclosures to health plans when the Patient's involved health care provider has been paid out of pocket in full.

10. **Associate Use and Disclosure for Management and Administration**. Associate may use PHI for the proper management and administration of Associate or to carry out its legal responsibilities. Associate may disclose PHI for the proper management and administration of Associate or to carry out its legal responsibilities only if:

   a. The disclosure is required by law; or

   b. Associate secures written assurance from the receiving party that the receiving party will: (i) hold the PHI confidentially; (ii) use or disclose the PHI only as required by law or for the purposes for which it was disclosed to the recipient; and (iii) notify the Associate of any breaches in the confidentiality of the PHI.

11. **Performance of Entity Obligations**. To the extent Associate is to carry out any obligation of Entity under the Privacy Standards, Associate agrees to comply with the same Privacy Standard requirements that apply to Entity in the performance of such obligation.

12. **Responsibilities upon Termination.**

   a. **Return of PHI; Destruction**. Within thirty (30) calendar days of termination of Agreement, Associate will return to Entity all PHI received from Entity or created or received by Associate on behalf of Entity which Associate maintains in any form or format, and Associate will not maintain or keep in any form or format any portion of the PHI. Alternatively, Associate may, upon Entity's written consent, destroy all such PHI and provide written documentation of such destruction. The requirement to return or destroy such PHI will apply to all Subcontractors of Associate. Associate will be responsible for recovering any PHI from such Subcontractors. If Associate cannot obtain

the PHI from any Subcontractor, Agent will so notify Entity and will require that such Subcontractors directly return PHI to Entity or otherwise destroy such PHI, subject to the terms of this Section.

13. **Termination**. Entity may immediately terminate the Agreement upon written notice to Associate if Entity determines that the Associate has breached a material term of this Addendum. Alternatively, Entity may elect to provide Associate with thirty (30) calendar days' advance written notice of Associate's breach of any term or condition of this Addendum, and afford Associate the opportunity to cure the breach to the satisfaction of Entity within twenty (20) calendar days of such notice. If Associate fails to timely cure the breach, as determined by Entity, the Agreement will terminate as provided in Entity's notice.

14. **Associate Books and Records**.

a. **Entity Access**. Entity shall have the right, at its expense, during Associate's normal business hours, to evaluate, test, and review Associate's policies and procedures related to the Requirements, facilities, books, records and systems which contain Entity's PHI in order to ensure compliance with the terms and conditions of this Addendum and the Requirements. Entity shall have the right to conduct such audit by use of its own employees or by use of outside consultants and auditors. Associate agrees to cooperate with Entity, and to otherwise provide any reasonable assistance to Entity necessary for Entity to carry out any audit as permitted herein, at no additional cost to Entity. Upon Entity's written request, Associate agrees to provide an annual written attestation of its compliance to the Requirements in a form and format provided at the discretion of the Entity in order to obtain satisfactory assurances in accordance with the Requirements that the Associate will appropriately safeguard the information with which it is entrusted. Entity shall protect the confidentiality of all confidential and proprietary information of Associate to which Entity or its agents have access during the course of such audit. The fact that Entity inspects, or fails to inspect, or has the right to inspect, Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Associate of its responsibility to comply with this Addendum, nor does Entity's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice of waiver of Entity's enforcement rights under this Addendum. Notwithstanding the foregoing, Entity assumes no obligation to perform any inspection or audit of Associate's practices or policies, and assumes no liability for any violation or breach by Associate, whether an audit is performed or not.

b. **Government Access**. Associate will make its internal practices, books and records on the use and disclosure of PHI available to the Secretary of the Department of Health and Human Services to the extent required for determining compliance with the Requirements. Notwithstanding this provision, no attorney-client, accountant-client or other legal privilege will be deemed waived by Associate or Entity as a result of this Section.

15. **Notices**. Any notices required under this Addendum will be sent to the parties at the following address by first class mail, fax or hand delivery:

Entity:	Associate:
RCHP-Ottumwa, LLC d/b/a Ottumwa Regional Health Center 1001 Pennsylvania Avenue Ottumwa, IA 52501 Attention: Hospital CEO	Apogee Medical Management, Inc. 2525 East Camelback Road Suite 1100 Phoenix, AZ 85016 Attention: Compliance Department

With copy to:

RE: AMENDMENTS or TERMINATION	RE: PRIVACY BREACHES	RE: SECURITY INCIDENTS:
RegionalCare Hospital Partners 103 Continental Place, Suite 200 Brentwood, TN 37027 Attn: Corporate Privacy Officer	RegionalCare Hospital Partners 103 Continental Place, Suite 200 Brentwood, TN 37027 Attn: Corporate Privacy Officer	RegionalCare Hospital Partners 103 Continental Place, Suite 200 Brentwood, TN 37027 Attn: Chief Information Security Officer

16. **Indemnification**. Notwithstanding anything to the contrary in the Agreement, if a Breach or other violation of the Requirements occurs due solely to the acts or omissions of one party, that party shall indemnify, defend and hold the other party harmless from and against any and all losses, liabilities, damages, costs and expenses (including reasonable attorneys' fees) arising solely out of such Breach or other violation of the Requirements. This Section shall survive termination of the Agreement and/or this Addendum and is without regard to any limitation or exclusion of damages provision otherwise set forth in the Agreement.

17. **PHI Disclaimer and Ownership**. PHI IS PROVIDED TO ASSOCIATE SOLELY ON AN "AS IS" BASIS. ENTITY DISCLAIMS ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY, AND FITNESS FOR A PARTICULAR PURPOSE. As between Entity and Associate, any PHI disclosed, delivered or provided to Associate in connection with the Agreement, shall be deemed to be the exclusive property of Entity. In no event shall Associate or its subcontractors claim any rights with respect to such PHI. Neither Associate nor its agents or subcontractors shall transfer or export any PHI provided by Entity outside the United States. Additionally, Associate shall not use, authorize to use or disclose the PHI for the purpose of developing information or statistical compilations for use by third parties or other division or subsidiary of Associate or for any commercial exploitation.

18. **Amendment and Modification**. This Addendum may be amended only as set forth in the Agreement, except that Entity may amend the Addendum to the extent necessary to comply with new regulatory requirements by giving written notice to Associate, and such amendment shall become effective as of the later of 30 days following such notice or the date specified in the notice.

19. **State Privacy Laws**. Associate shall comply with applicable state privacy or state information security laws to the extent that such state privacy or information security laws are not preempted by HIPAA.

20. **Encryption**. Any hard drives on any computers or laptops that are used to access, receive, send, or maintain Entity's PHI must be Encrypted and all communications must be Encrypted if sending PHI. Mobile devices or external or removable media, including, without limitation, backup tapes, used for sending, receiving, or storing PHI must be Encrypted. For the purposes of this Section, "Encryption" shall mean any encryption standards that meet the U.S. Department of Health and Human Services Guidance specifying the Technologies and Methodologies that render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of HITECH Act.

21. **No Exclusion**. None of Associate's officers, directors, employees or agents is an Ineligible Person. An "Ineligible Person" is an individual or entity who: (i) is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs; or (ii) has been convicted of a criminal offense that falls within the range of activities described in 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible. Associate agrees to disclose immediately to Entity if this Section changes and Entity may immediately terminate the Agreement for breach.

22. **Compliance Plan**. Associate acknowledges that Entity has adopted and implemented a code of conduct, compliance program, compliance hotline and related policies (the "Corporate Compliance Program"). Entity acknowledges that it has received information about the Corporate Compliance Program, some of which is available at RegionalCare Hospital Partner's website under compliance, and that it and its employees and agents shall abide by the Corporate Compliance Program policies and procedures to the extent they are relevant and applicable to the services performed under the Agreement. Associate further agrees that it shall promptly notify the appropriate individuals set forth in the Corporate Compliance Program of any violations of the code of conduct and Corporate compliance policies of which it becomes aware and attend Corporate Compliance Program meetings as reasonably requested by Entity.

23. **Obligations of the Entity**. The Entity will notify the Associate of any limitation in the Entity's Notice Of Privacy Practices, as required by the Requirements, that may affect the Associate's use or disclosure of PHI; the Entity will notify the Associate of any changes in or revocation of an individual's permission to use or disclose PHI, to the extent that such change may affect Associate's use or disclosure of PHI; and the Entity will notify the Associate of any restriction regarding the use or disclosure of an individual's PHI that the Entity has agreed to in accordance with 45CFR§ 164.522, to the extent that such restriction may affect Associate's use or disclosure of the PHI.

IN WITNESS WHEREOF, this Addendum is entered into between the parties to be effective as of August 1, 20 14.

ENTITY:

RCHP Ottumwa, LLC
d/b/a Ottumwa Regional Health Center

By: _____
Philip J. Noel, III

Title: Hospital CEO

Date: 7/25/2014

ASSOCIATE:

Apogee Medical Management, Inc.

By: _____

Title: President

Date: 7/28/14

--

SCHEDULE E

QUALITY METRICS

At-Risk Model

Scores shall be earned at Ottumwa Regional Health Center ("Medical Center"). The maximum amount at risk is Sixty-Four Thousand Eight Hundred Dollars ($64,800.00) per year if none of the measures is met at Medical Center. If all measures are met at Medical Center, a maximum additional amount of Sixty-Four Thousand Eight Hundred Dollars ($64,800.00) shall be paid to Company. Such amounts shall be subject to the pro rata performance payout/penalty provision outlined below.

As part of the Management Fee payment calculation, Company may earn or lose an additional amount of up to Sixteen Thousand Two Hundred Dollars ($16,200.00) per quarter for an annual total of Sixty-Four Thousand Eight Hundred Dollars ($64,800.00) as a quality metrics payout amount ("Quality Metrics Payout"). The Quality Metrics Payout shall be earned or lost when the goals outlined in this Schedule E are or are not achieved. To the extent Company has achieved the requisite goals, Medical Center shall make an additional quarterly payment for the Quality Metrics Payout to Company, as outlined below. Results shall be reported within sixty (60) days of the end of each quarter. The Quality Metrics Payout shall be paid within fifteen (15) days of official posting of results. If Medical Center fails to report the results to Company within the aforementioned time frame in any given quarter, the Quality Metrics Payout shall be deemed to have been earned, and Medical Center shall pay Company the quarterly Quality Metrics Payout of Sixteen Thousand Two Hundred Dollars ($16,200.00). If Company does not achieve the goals outlined in this Schedule E, Medical Center shall receive a credit, and Company shall subtract the corresponding amount from the next month's Management Fee.

1. **Clinical Pathways (9.1%) $5,891**

a. Acute Coronary Syndrome/Chest Pain
b. Asthma
c. Cellulitis
d. CHF
e. COPD/Respiratory Failure
f. GI Bleeding
g. Pneumonia
h. Sepsis
i. TIA/Stroke

Result	Performance Payout/Penalty
< 20.0%	-100%
20.0% – < 30.0%	-75%
30.0% – < 40.0%	-50%
40.0% – < 50.0%	-25%
50.0% – < 60.0%	25%
60.0% – < 70.0%	50%
70.0% – < 80.0%	75%
≥ 80.0%	100%

2. **Core Measures, Aggregate (9.1%) $5,891**

a. AMI
b. HF
c. IMM
d. PN
e. STK
f. VTE

Result	Performance Payout/Penalty
< 96.5%	-100%
96.5% – < 97.0%	-75%
97.0% – < 97.5%	-50%
97.5% – < 98.0%	-25%
98.0% – < 98.5%	25%
98.5% – < 99.0%	50%
99.0% – < 99.5%	75%
≥ 99.5%	100%

3. **CPOE Utilization (9.1%) $5,891**

Result	Performance Payout/Penalty
< 65.0%	-100%
65.0% – < 70.0%	-75%
70.0% – < 75.0%	-50%
75.0% – < 80.0%	-25%
80.0% – < 85.0%	25%
85.0% – < 90.0%	50%
90.0% – < 95.0%	75%
≥ 95.0%	100%

4. **Direct Admission Process – PCP Satisfaction (9.1%) $5,891**

Medical Center will survey the referring physicians, to include satisfaction with the direct admission process. Top box scores will be reported.

Result	Performance Payout/Penalty
< 30.0%	-100%
30.0% – < 40.0%	-75%
40.0% – < 50.0%	-50%
50.0% – < 60.0%	-25%
60.0% – < 70.0%	25%
70.0% – < 80.0%	50%
80.0% – < 90.0%	75%
≥ 90.0%	100%

5. **Discharge Summary Completion within 48 Hours of Discharge (9.1%) $5,891**

Result	Performance Payout/Penalty
< 86.0%	-100%
86.0% – < 88.0%	-75%
88.0% – < 90.0%	-50%
90.0% – < 92.0%	-25%
92.0% – < 94.0%	25%
94.0% – < 96.0%	50%
96.0% – < 98.0%	75%
≥ 98.0%	100%

6. **HCAHPS "Communication with Doctors" Average Raw Score for Hospitalists, Top Box: "Always" (9.1%) $5,891**

Medical Center and Company agree to review raw score targets periodically.

Result	Performance Payout/Penalty
< 75.0%	-100%
75.0% – < 76.0%	-75%
76.0% – < 78.0%	-50%
78.0% – < 80.0%	-25%
80.0% – < 82.0%	25%
82.0% – < 84.0%	50%
84.0% – < 85.0%	75%
≥ 85.0%	100%

7. **Marketing Plan Execution (9.1%) $5,891**

Program Director or his or her designee will conduct face-to-face meetings with referring physicians and potential referring physicians to seek feedback on the hospitalist practice and to present the benefits of utilizing the service.

Result	Performance Payout/Penalty
1 Meeting	-100%
2 Meetings	-50%
3 Meetings	50%
4 Meetings	100%

8. **Response to Clinical Documentation Improvement Queries within 48 Hours of Query. (9.1%) $5,891**

Result	Performance Payout/Penalty
< 65.0%	-100%
65.0% – < 70.0%	-75%
70.0% – < 75.0%	-50%
75.0% – < 80.0%	-25%
80.0% – < 85.0%	25%
85.0% – < 90.0%	50%
90.0% – < 95.0%	75%
≥ 95.0%	100%

9. Physician Callbacks to Patients (9.1%) $5,891

An eligible physician is defined as an Apogee provider who has attended Apogee University.

Eligible physician callbacks are triggered by the discharge code and the discharge disposition.

Discharge code:

- 99238
- 99239
- 99315
- 99316
- 99217
- 99234
- 99235
- 99236

Discharge disposition:

- Home/Self Care
- Physician did not specify
- Home Hospice
- Left against medical advice (AMA)
- Home Health Service

Below the chart is a grid outlining the individual performance and volumes in each category.

Eligible – volume of events/patients marked as meeting the requirements for callback.

Called – volume of callbacks marked as called by the provider.

Needs Follow-up – the provider has marked these patients as called and as requiring follow-up.

Not Called – volume of callbacks not completed, either marked by provider or allowed time has expired.

Call Not Needed – marked by the provider as not needing a call. Some valid reasons include:

- Homeless
- Demented
- Hearing-impaired
- Patient readmitted or still in-house
- Non-English-speaking
- Drug-seeking

% Required Called – the formula for determining the overall performance for the period: (Called + Called Needs Follow-up) / (Eligible – Call Not Needed) = **Required Called %**

Result	Performance Payout/Penalty
< 60.0%	-100%
60.0% – < 65.0%	-75%
65.0% – < 70.0%	-50%
70.0% – < 75.0%	-25%
75.0% – < 80.0%	25%
80.0% – < 85.0%	50%
85.0% – < 90.0%	75%
≥ 90.0%	100%

10. Physician Discharge Orders Written before 12:00 P.M., Monthly Average for Measurement Quarter (9.1%) $5,891

Result	Performance Payout/Penalty
< 30.0%	-100%
30.0% – < 35.0%	-75%
35.0% – < 40.0%	-50%
40.0% – < 45.0%	-25%
45.0% – < 50.0%	25%
50.0% – < 55.0%	50%
55.0% – < 60.0%	75%
≥ 60.0%	100%

11. Physician Order Timed, Dated, and Signed within 48 Hours of Order (9.1%) $5,891

Result	Performance Payout/Penalty
< 30.0%	-100%
30.0% – < 40.0%	-75%
40.0% – < 50.0%	-50%
50.0% – < 60.0%	-25%
60.0% – < 70.0%	25%
70.0% – < 80.0%	50%
80.0% – < 90.0%	75%
≥ 90.0%	100%

AMENDED & RESTATED CHARTER
OF THE AUDIT COMMITTEE
OF THE BOARD OF DIRECTORS

I. PURPOSE

The Audit Committee (the *"**Committee**")* is appointed by the Board of Directors (the "***Board**")* of Lifepoint Health, Inc. (the *"**Company**")* to assist the Board in overseeing (i) the integrity of the Company's financial statements, (ii) the independent auditor's qualifications, independence and performance, (iii) the performance of the Company's internal audit function, and (iv) the Company's compliance with legal, ethical and regulatory requirements as it relates to financial reporting matters. In performing its duties, the Committee shall seek to maintain an open avenue of communication among the Board, the independent auditor, the internal auditors and the management of the Company.

While the Committee has the responsibilities and authority set forth in this Charter, management and the independent auditor are responsible for planning or conducting audits and determining that the Company's financial statements are complete and accurate and are in accordance with generally accepted accounting principles. Nothing contained in this Charter is intended to expand applicable standards of liability under legal or regulatory requirements for the directors of the Company or members of the Committee.

The independent auditor is ultimately accountable to the Committee, which has the sole authority to appoint, oversee and, where appropriate, replace the independent auditor. The Committee has direct responsibility for the compensation and oversight of the work of the independent auditor (including resolution of disagreements between management and the independent auditor regarding financial reporting) in connection with preparing or issuing an audit report or performing other audit, review or attest services for the Company. The independent auditor shall report directly to the Committee.

II. RESPONSIBILITIES

In carrying out its responsibilities, the Committee's policies and procedures should remain flexible to enable the Committee to react to changes in circumstances and conditions so that it can fulfill its oversight responsibilities. In addition to such other duties as the Board may from time to time assign, the Committee shall:

Financial Statements

- Review and discuss with management and the independent auditor the Company's annual audited financial statements. In the event the Company is required to (i) deliver an annual report pursuant to any relevant debt document or (ii) file an annual report on Form 10-K (any such annual report referred to in clause (i) or (ii), an "***Annual Report**"),* such review and discussion shall be completed prior to the delivery or filing, as applicable, of the Company's Annual Report and shall include disclosures made in Management's Discussion and Analysis of Financial Condition and Results of Operations, and the Committee shall recommend to the Board whether the audited financial statements should be included in the Annual Report.

- Review and discuss with management the Company's quarterly financial statements. In the event the Company is required to (i) deliver a quarterly report pursuant to any relevant debt document or (ii) file a quarterly report on Form 10-Q (any such quarterly report referred to in clause (i) or (ii), a *"**Quarterly Report**"),* such review and discussion shall be completed prior to the delivery or filing, as applicable, of the Company's Quarterly Report and shall include disclosures made in Management's Discussion and Analysis of Financial Condition and Results of Operations.

- Discuss with management and the independent auditor significant financial reporting issues and judgments made in connection with the preparation of the Company's financial statements, including any significant changes in the Company's selection or application of accounting principles, and the judgments of each of management and the independent auditor as to the quality and appropriateness of the Company's accounting principles as applied in its financial reporting.

- In the event the Company becomes subject to the Securities and Exchange Commission (the "SEC") filing requirement with respect to management's report on internal control over financial reporting and the independent auditor's attestation of the Company's internal control over financial reporting, review and discuss with management and the independent auditor such report and the independent auditor's attestation of the Company's internal control over financial reporting prior to the delivery or filing, as applicable, of the Company's Annual Report.

- If applicable, review and discuss the reports required to be delivered by the independent auditor pursuant to Section 10A(k) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") regarding:

    - all critical accounting policies and practices to be used;

    - all alternative treatments of financial information within generally accepted accounting principles that have been discussed with management, ramifications of the use of such alternative disclosures and treatments, and the treatment preferred by the independent auditor; and

    - other material written communications between the independent auditor and management, such as any management letter or schedule of unadjusted differences.

- Discuss with management the Company's earnings press releases, if any, including the use of "pro forma" or "adjusted" non-GAAP information, as well as financial information and earnings guidance provided to analysts and rating agencies. Such discussion may be done generally (consisting of discussing the types of information to be disclosed and the types of presentations to be made) and the Committee need not discuss in advance each earnings release or each instance in which the Company may provide earnings guidance.

- Discuss with management and the independent auditor the effect of regulatory and accounting initiatives, as well as off balance sheet structures, on the Company's financial statements.

- Discuss with the independent auditor the matters required to be discussed by the independent auditor with the Audit Committee under applicable auditing standards, and under the rules and regulations of the SEC and other applicable authorities (as such standards and rules and regulations may be established or amended from time to time). In particular, the Committee and independent auditor shall discuss, among other things, matters that arise during the audit, including

any difficulties encountered in the course of the audit work, any restrictions on the scope of activities or access to requested information, and any significant disagreements with management.

- Review and discuss with management and the independent auditor any major issues as to the adequacy of the Company's internal controls, any special audit steps adopted in light of material control deficiencies and the adequacy of disclosures about changes in internal control over financial reporting.

- To the extent applicable, review disclosures made to the Committee by the Company's CEO and CFO during their certification process for the Annual Report and Quarterly Report about any significant deficiencies in the design or operation of internal control over financial reporting or material weaknesses therein and any fraud involving management or other employees who have a significant role in the Company's internal control over financial reporting.

- Keep the independent auditor informed of the Committee's understanding of the Company's relationships and transactions with related parties that are significant to the Company; and review and discuss with the independent auditor the auditor's evaluation of the Company's identification of, accounting for, and disclosure of its relationships and transactions with related parties, including any significant matters arising from the audit regarding the Company's relationships and transactions with related parties.

Oversight of the Company's Relationship with the Independent Auditor

- Select, oversee and, if appropriate, replace the Company's independent auditor, considering qualifications, independence and performance; approve the scope of the proposed audit for each fiscal year and the fees and other compensation to be paid to the independent auditor therefor.

  In evaluating the independent auditor's qualifications, performance and independence, the Committee should discuss with the independent auditor the independent auditor's independence, take into account the opinions of management and the internal auditors and consider whether the independent auditor's quality controls are sufficient and whether the provision of permitted non-audit services is compatible with maintaining the auditor's independence. The Committee shall present its conclusions with respect to the independent auditor to the Board.

- Review and evaluate the lead partner of the independent auditor's audit team for the Company.

- Obtain and review a report from the independent auditor at least annually regarding:

  - the independent auditor's internal quality-control procedures;

  - any material issues raised by the most recent internal quality control review, or peer review, of the independent auditor, or by any inquiry or investigation by governmental or professional authorities within the preceding five years respecting one or more independent audits carried out by the independent auditor;

  - any steps taken to deal with any such issues; and

- all relationships between the independent auditor and the Company, including the matters set forth in any letter from independent auditors required by applicable auditing standards.

- Ensure the rotation of the lead audit partner having primary responsibility for the Company's audit and the audit partner responsible for reviewing the audit as required by law.

- Establish policies for the Company's hiring of employees or former employees of the independent auditor.

- Consider whether there should be regular rotation of the Company's independent auditor.

- Discuss with the independent auditor material issues on which the national office of the independent auditor was consulted by the Company's audit team.

- Preapprove (or adopt appropriate procedures to pre-approve) all auditing services, internal control-related services and permitted non-audit services (including the fees and terms thereof) to be performed for the Company by the independent auditor, subject to such exceptions for non-audit services as permitted by applicable laws and regulations. The Committee may when it deems appropriate form and delegate this authority to a subcommittee consisting of one or more Committee members, including the authority to grant preapprovals of audit and permitted non-audit services, provided that decisions of such subcommittee to grant preapprovals shall be presented to the full Committee at its next meeting.

Oversight of the Company's Internal Audit Function

- Review and approve the internal audit department charter at least bi-annually, or in the event of significant changes.

- Participate in discussions and decisions regarding the appointment and removal of the senior officer responsible for the internal audit function.

- Ensure the senior officer responsible for the internal audit function has unrestricted access to directly interact with the committee, without management present, during routine committee meetings and otherwise as circumstances warranting such discussions arise.

- Affirm the internal audit function's unrestricted access to any and all company records, physical properties, and personnel.

- Review and discuss with management and the senior officer responsible for the internal audit function the annual audit plan and its alignment with risks identified as part of the Company's enterprise risk management program, the adequacy of the internal audit function's budget and staffing to carry out the annual audit plan, and the organizational structure and qualifications of the persons performing the internal audit function.

- Receive and review communications from the senior officer responsible for internal audit regarding the department's performance relative to its plan and other matters.

- Review and discuss with management and the senior officer responsible for the internal audit function significant reports to management prepared by the internal audit function and management's responses thereto.

- Review with the senior officer responsible for the internal audit function any difficulties encountered by the internal audit function in the course of its audits, including any restrictions on the scope of its work or access to required information.

Oversight of Other Compliance and Regulatory Matters Related to Financial Reporting

- Review and approve any related person transactions in which the Company is a participant and for which disclosure would be required under Item 404(a) of Regulation S-K.

- Review and approve any waivers of the Company's Code of Ethics for Senior Financial Officers and Chief Executive Officer requested by the Company's Chief Executive Officer, Chief Financial Officer or Controller (or persons performing similar functions) and recommend to the Board whether a particular waiver requested by any of such officers should be granted.

- Review and approve procedures for the receipt, retention and treatment of complaints received by the Company regarding accounting, internal accounting controls or auditing matters, and the confidential, anonymous submission by employees of concerns regarding questionable accounting or auditing matters.

- Discuss with management and the independent auditor any published reports or correspondence with regulators or governmental agencies that raise material issues regarding the Company's financial statements or accounting policies.

- Discuss with the Company's Chief Legal Officer and/or outside counsel legal matters that may have a material impact on the financial statements.

- Discuss and review the Company's policies and guidelines with respect to risk assessment and risk management, and discuss with management the Company's major financial and other risk exposures and the steps management has taken to monitor and control such exposures.

- Through the Committee’s Chairperson, coordinate with the Compliance and Enterprise Risk Committee as necessary or appropriate with respect to material financial risks.

- If applicable, obtain from the independent auditor assurance that Section 10A(b) of the Exchange Act has not been implicated.

Other

- Regularly report Committee activities to the Board and make such recommendations to the Board as the Committee deems appropriate.

- Prepare for the Board an annual performance evaluation of the Committee.

- Annually review and reassess the adequacy of this Charter (recommending any appropriate changes to the Board).

- To the extent required by applicable SEC rules and regulations, provide or approve a report for inclusion in the Company's proxy statement for its annual meeting of shareholders.

- Oversee the Related Person Transactions Policies and Procedures and perform any responsibilities delegated to the Committee therein.

- Oversee and periodically review management's processes and procedures for assessing, identifying and managing material risks from cybersecurity threats to the Company and the effectiveness of the Company's information security processes and procedures; periodically evaluate the knowledge, experience and capabilities of the members of the Committee and management with respect to cyber security risk and information security processes and procedures; and evaluate the nature, scope, timing and impact to the Company of any material cybersecurity incidents.

III. COMPOSITION

The Committee shall be comprised of three or more members (including a Chairperson). The members of the Committee and the Chairperson shall be appointed by the Board and serve at the pleasure of the Board. A Committee member (including the Chairperson) may be removed at any time, with or without cause, by the Board. The Board shall have the power to change the members of the Committee and fill any vacancies occurring on the Committee for any reason.

All Committee members shall be financially literate, as determined by the Board. Committee members may enhance their familiarity with finance and accounting by participating in educational programs conducted by the Company or an outside consultant. The Chairperson shall maintain regular communication with the chief executive officer, chief financial officer, the lead partner of the independent auditor and the senior officer responsible for the internal audit function.

The Committee may have, but is not required to have, one or more members that (i) meet the independence requirements of the New York Stock Exchange (the "NYSE") and Rule 10A-3(b)(1) under the Exchange Act, or (ii) qualify as an "audit committee financial expert" as defined by the SEC. In the event that the Company is required to deliver or file, as applicable, an Annual Report, the Company shall disclose in the Annual Report (a) whether or not the Committee has at least one member who is an audit committee financial expert, (b) if there is an audit committee financial expert, whether such audit committee financial expert is "independent" in accordance with the requirements established by the NYSE, and (c) if there is no audit committee financial expert, the reasons why there is none.

IV. MEETINGS

The Committee shall meet as often as it determines necessary, but at least quarterly, to enable it to fulfill its responsibilities. The Committee shall meet at the call of its Chairperson and shall be governed by the same rules regarding notice of meetings and waiver of notice as are applicable to the Board. The Committee may meet by telephone conference call or by any other means permitted by law or the Company's Bylaws. A majority of the members of the Committee shall constitute a quorum. The Committee shall act on the affirmative vote of a majority of members present at a meeting at which a quorum is present. Subject to the Company's Bylaws, the Committee may act by unanimous written

consent of all members in lieu of a meeting. The Committee shall determine its own rules and procedures, including designation of a chairperson pro tempore in the absence of the Chairperson, and designation of a secretary. The secretary need not be a member of the Committee and shall attend Committee meetings and prepare minutes. The Committee shall keep written minutes of its meetings, which shall be recorded or filed with the books and records of the Company. Any member of the Board shall be provided with copies of such Committee minutes if requested.

The Committee may ask members of management, employees, outside counsel, the independent auditors, internal auditors or others whose advice and counsel are relevant to the issues then being considered by the Committee, to attend any meetings and to provide such pertinent information as the Committee may request.

The Chairperson of the Committee shall be responsible for leadership of the Committee, including preparing the agenda, presiding over Committee meetings, making Committee assignments and regularly reporting the Committee's actions, including any significant issues or concerns that arise at meetings, to the Board.

As part of its responsibility to foster free and open communication, the Committee shall meet periodically with management, the internal auditors and the independent auditor in separate executive sessions.

V. AUTHORITY

In discharging its responsibilities, the Committee shall have the authority to engage and determine funding for independent legal, accounting or other advisors (without seeking Board approval) as the Committee determines necessary or appropriate to carry out its duties and responsibilities under this Charter. The Committee may conduct or authorize investigations into or studies of matters within the Committee's scope of responsibilities as described herein. The Company shall provide appropriate funding, as determined by the Committee, for the payment of (i) compensation to the independent auditor, and legal, accounting or other advisors engaged by the Committee and (ii) ordinary administrative expenses of the Committee that are necessary or appropriate in carrying out its duties.

Adopted and approved by the Board of Directors on September 27, 2023 and supersedes the charters approved and adopted on March 12, 2019, March 14, 2017 and September 22, 2016.

CHARTER OF THE
COMPENSATION COMMITTEE
OF THE BOARD OF DIRECTORS

I. PURPOSES

The Compensation Committee (the ***"Committee")*** is appointed by the Board of Directors (the ***"Board")*** of LifePoint Health, Inc. (the ***"Company"),*** for the purposes of (a) discharging the Board's responsibilities relating to the compensation of the Company's chief executive officer (the ***"CEO")***, (b) approving the compensation of the Company's and its subsidiaries' other executive officers, other officers, directors and Key Employees (as defined below), (c) making recommendations with respect to equity-based and other compensation to Compensation Committee of the board of managers of DSB Parent L.P. ***("Parent"),*** administering the Company's equity-based compensation plans, (d) if the Company is required to (i) deliver an annual report pursuant to any relevant debt document, (ii) file an annual report on Form 10-K (any such annual report referred to in clause (i) or (ii), an ***"Annual Report")*** or (iii) deliver or file an annual proxy statement, reviewing the disclosures in Compensation Discussion and Analysis and producing an annual compensation committee report for inclusion in the Company's Annual Report or in the Company's annual proxy statement and (e) overseeing the Board's evaluation of the Company's and its subsidiaries' senior management. For purposes hereof, the term ***"Key Employee"*** means any employee of the Company and its subsidiaries (other than non-executive physicians) whose annual cash compensation is at or greater than $1,000,000 (including base salary and bonus).

II. RESPONSIBILITIES

In addition to such other duties as the Board may from time to time assign, the Committee shall:

- in consultation with senior management, review, evaluate and recommend to the Board for approval the Company's general compensation philosophy and objectives and establish performance-based incentives that support the Company's long-term goals, objectives and interests:

- in consultation with the Compliance Committee, review and evaluate whether the Company's compensation policies are aligned with the Company's compliance obligations;

- review and approve the Company's goals and objectives relevant to the compensation of the CEO, annually evaluate the CEO's performance in light of those goals and objectives and based on this evaluation (i) determine the CEO's compensation level, including salary, bonus targets and non-equity incentive compensation and (ii) make recommendations to the Compensation Committee of the board of managers of Parent with respect to the CEO's equity compensation. In determining the long-term incentive component of the CEO's compensation, the Committee shall consider, among other factors, the Company's performance and relative shareholder return, the value of similar incentive awards to CEOs at comparable companies, and the awards given to the Company's CEO in past years;

- review and approve all non-equity based compensation for the Company's non-CEO executive officers, officers and other Key Employees of the Company and its subsidiaries, and review and make recommendations to the Compensation Committee of Parent with respect to all equity-based compensation for the Company's non-CEO executive officers, officers and other Key Employees of the Company and its subsidiaries;

- review and approve (i) all employment agreements, severance agreements, consulting agreements, change of control provisions and agreements and similar arrangements providing for severance, termination, change of control or similar payments to any current or former executive officer, officer or other Key Employee of the Company and its subsidiaries and (ii) any special supplemental benefits applicable to any current or former executive officer, officer or other Key Employee of the Company and its subsidiaries;

- review and make recommendations to the Board with respect to non-equity incentive compensation plans, policies and benefit programs for employees of the Company and its subsidiaries generally, and oversee the activities of the individuals and committees responsible for administering these plans, and review and make recommendations to the Compensation Committee of the board of managers of Parent with respect to equity-based compensation plans;

- together with the Compensation Committee of the board of managers of Parent, administer the Company's equity-based compensation plans and oversee the activities of the individuals and committees responsible for administering such plans; provided that the adoption of any such plan and the grant of any equity awards under any such plan shall be approved by the Compensation Committee of the board of managers of Parent;

- review and make recommendations to the Board with respect to the non-equity components of compensation for the members of the Board, and review and make recommendations to the Compensation Committee of the board of managers of Parent with respect to all equity-based components of compensation for the members of the Board;

- oversee the risk assessment of the Company's and its subsidiaries' compensation arrangements applicable to the Company's and its subsidiaries' executive officers and other employees and review and discuss the relationship between risk management policies and practices and compensation;

- review and make recommendations to the Board with respect to stock ownership guidelines for the Company's CEO and other executive officers and members of the Board and monitor compliance with such guidelines;

- provide oversight concerning the selection of officers, management succession planning (including developing a succession plan for the Company's CEO and other members of senior management), expense accounts, indemnification of officers, directors or employees, insurance policies for the benefit of officers, directors or employees or that cover the actions or omissions of officers, directors or employees, and separation packages;

- review and approve any recognition and/or neutrality agreement, collective bargaining agreement or other agreement arrangement or understanding with any labor organization purporting to represent any employees of the Company Group other than at individual hospital facilities;

- if the Company becomes subject to, or otherwise determines to comply with, the disclosure requirements of the Securities and Exchange Commission ***("SEC")*** regarding Compensation Discussion and Analysis, review and discuss with management the disclosures made in Compensation Discussion and Analysis prior to the delivery or filing, as applicable, of the Company's Annual Report and/or proxy statement for the annual meeting of stockholders, and recommend to the Board whether the Compensation Discussion and Analysis should be included in the Annual Report and/or proxy statement;

- if the Company becomes subject to, or otherwise determines to comply with, the SEC disclosure requirements regarding a compensation committee report, prepare an annual compensation committee report for inclusion in the Company's Annual Report and/or proxy statement for the annual meeting of stockholders in accordance with the applicable rules of the SEC;

- conduct an annual performance evaluation of the Committee; and

- review and reassess the adequacy of this charter and recommend any proposed changes to the Board for approval.

III. COMPOSITION

The Committee shall be comprised of two or more members (including a Chairperson) and, as and when required in accordance with the New York Stock Exchange rules, all of such members shall be "independent directors," as such term is defined in the New York Stock Exchange rules. The members of the Committee and the Chairperson shall be appointed by the Board and serve at the pleasure of the Board. A Committee member (including the Chairperson) may be removed at any time, with or without cause, by the Board. The Board shall have the power to change the members of the Committee and fill any vacancies occurring on the Committee for any reason.

IV. MEETINGS

The Committee shall meet as often as it determines necessary, but at least once each year, to enable it to fulfill its responsibilities. The Committee shall meet at the call of its Chairperson. The Committee may meet by telephone conference call or by any other means permitted by law or the Company's Bylaws. A majority of the members of the Committee shall constitute a quorum. The Committee shall act on the affirmative vote of a majority of members present at a meeting at which a quorum is present. Subject to the Company's Bylaws, the Committee may act by unanimous written consent of all members in lieu of a meeting. The Committee shall determine its own rules and procedures, including designation of a chairperson pro tempore in the absence of the Chairperson, and designation of a secretary. The secretary need not be a member of the Committee and shall attend Committee meetings and prepare minutes. The Secretary of the Company shall be the Secretary of the Compensation Committee unless the Committee designates otherwise. The Committee shall keep written minutes of its meetings, which shall be recorded or

filed with the books and records of the Company. Any member of the Board shall be provided with copies of such Committee minutes if requested.

The Committee may ask members of management, employees, outside counsel, or others whose advice and counsel are relevant to the issues then being considered by the Committee to attend any meetings and to provide such pertinent information as the Committee may request. The CEO should not attend any meeting where the CEO's performance or compensation is discussed, unless specifically invited by the Committee. The Committee shall have the authority to delegate any of its responsibilities to one or more subcommittees as the Committee may from time to time deem appropriate.

The Chairperson of the Committee shall be responsible for leadership of the Committee, including preparing the agenda, presiding over Committee meetings, making Committee assignments and reporting the Committee's actions to the Board from time to time as requested by the Board.

V. AUTHORITY

In discharging its responsibilities, the Committee shall have the authority, to the extent it deems appropriate, to retain one or more compensation consultants to assist in the evaluation of director, CEO, executive or other key employee compensation. The Committee shall have the sole authority to retain and terminate any such consulting firm, and to approve the firm's fees and other retention terms. The Committee shall also have the authority to retain and determine the funding for such other advisors (without seeking Board approval) as the Committee determines necessary or appropriate to carry out its duties and responsibilities under this Charter. The Company will provide for appropriate funding, as determined by the Committee, for payment of compensation to any consulting firm or other advisor employed by the Committee.

Adopted and approved by the Board of Directors on March 12, 2019, and supersedes the charter adopted and approved on September 22, 2016.

AMENDED AND RESTATED CHARTER
OF THE COMPLIANCE AND ENTERPRISE RISK COMMITTEE
OF THE BOARD OF DIRECTORS

I. PURPOSES

The Compliance and Enterprise Risk Committee (the ***"Committee")*** is appointed by the Board of Directors (the ***"Board")*** of Lifepoint Health, Inc. (the ***"Company")*** to assist the Board in its oversight of the Company's and its subsidiaries' compliance with the legal and regulatory requirements of their respective business operations and the Company's ethics and compliance policies and procedures, and its oversight of the Company's enterprise risk management program. The Committee's primary purposes are to: (1) oversee matters relating to the Company's compliance with all applicable state and federal laws and regulations; (2) oversee matters relating to the Company's compliance with federal health care program ***("FHCP")*** requirements; (3) oversee the performance and effectiveness of the Company's compliance program, the Health Support Center ("HSC") Compliance Committee and other internal compliance functions; (4) work in concert with the Company's Chief Compliance Officer and the Company's HSC Compliance Committee; (5) review matters concerning or relating to the Company's code of conduct, the Company's compliance programs, and compliance with the requirements of FHCPs; (6) oversee management's implementation of an enterprise risk management program and its efforts to identify risks and mitigate identified risks; and (7) make regular reports to the Board regarding these responsibilities.

II. RESPONSIBILITIES

In addition to such other duties as the Board may from time to time delegate, the Committee shall:

- Review and oversee significant compliance risk areas, including, but not limited to:
    - regulatory compliance;
    - coding and reimbursement;
    - physician recruitment, employment, and contracting compliance with state and federal fraud and abuse and self-referral laws;
    - privacy of company, employee, and patient information;
    - employee relations and workplace conduct; and
    - risks identified to have material enterprise impact on the Company.

  The Committee shall also review the steps management has taken to assess, monitor, control, mitigate and report such compliance and enterprise risk exposures.

- Review the appointment, performance and replacement, as necessary of the Company's Chief Compliance Officer.

- Meet at least quarterly with the Company's General Counsel and Chief Compliance Officer for a report on the Company's ethics and compliance programs, including a review of any issues that may pose a material financial, reputational or enterprise risk to the Company.

- Review, oversee, and take any such other action as the Committee deems necessary with respect to the Company's compliance and enterprise risk management programs, including but not limited to:

    - Developing and updating the Company's compliance program and the Company's code of conduct, either itself or by delegation to the appropriate officers or employees of the Company.

    - Overseeing management's development and implementation of an enterprise risk management program that is designed to assist management with identifying, monitoring and mitigating compliance, legal, regulatory, operational, reputational and other risks related to the Company's and its subsidiaries' business.

    - Reviewing reports submitted to the Committee by the Chief Compliance Officer regarding the activities undertaken pursuant to the Company's compliance programs, any actual or potential issues identified, and actions taken.

    - Monitoring and evaluating the effectiveness of the compliance programs and resource allocation to the compliance department.

    - Monitoring and evaluating the effectiveness of the enterprise risk management program to properly identify risk and progress towards the stated goals of risk mitigation within a reasonable timeframe.

- Review the status of the Company's compliance with relevant laws, regulations, and internal procedures, including without limitation compliance with FHCP requirements and the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations *(**"HIPAA"**)*.

- As deemed appropriate by the Committee in its discretion, review compliance related policies and procedures, which shall be approved from time to time by the HSC Compliance Committee, including those regarding compliance with applicable federal, state, and local laws and regulations and with the Company's code of conduct. In connection with this responsibility, the Committee may require changes to any such policy or procedure.

- Review the Company's implementation of appropriate lines and means of communication to report suspected non-compliance with legal or regulatory requirements or the Company's polices, including procedures for the receipt, retention, and treatment of complaints regarding compliance with applicable legal and regulatory requirements and Company's code of conduct.

- In consultation with the Compensation Committee, discuss with management an evaluation of whether compensation practices are aligned with the Company's compliance obligations. Any compensation practices evaluation prepared as a result may

either be reported first to the Committee, or the Compensation Committee, which will then report the results to the Committee.

- Oversee the implementation of the Company's compliance program with respect to any hospitals, health systems, or other health care providers acquired by the Company.

- Discuss with the Company's Chief Compliance Officer, Executive Compliance Committee, General Counsel and other members of management (as deemed appropriate by the Committee in its discretion) or at the Committee's option, with outside counsel, any legal, compliance, or regulatory matters, including employee complaints and published reports or correspondence with regulators or government agencies, that may have a material impact on the Company's business or the Company's compliance policies.

- Ensure proper communication of significant compliance and enterprise risk issues to the Board, including the reporting of such issues that may have significant financial implications to the Company.

- Prepare for the Board an annual performance evaluation of the Committee.

- As frequently as deemed appropriate by the Committee in its discretion but at least annually, report to the Board on: (1) the state of the Company's compliance functions and enterprise risk program; (2) relevant compliance issues involving the Company of which the Committee has been made aware, including, as deemed appropriate by the Committee in its discretion, a summary of the results of any significant compliance investigations conducted by the Company; (3) any potential patterns of non-compliance presenting substantial compliance risk identified with the Company; (4) any significant disciplinary actions against any compliance personnel; and (5) any other issues that may reflect any systemic or widespread problems in compliance or regulatory matters exposing the Company to substantial compliance and/or enterprise risks.

- Annually review and reassess the adequacy of this Charter (recommending any appropriate changes to the Board).

Oversight of certain risk areas shall be retained by the Board's other committees as outlined in their respective charters, including charters of the Audit Committee and the Compensation Committee. Through the Committee Chairperson, the Committee shall coordinate with the Audit Committee and Compensation Committee as necessary or appropriate with respect to material financial and compensation risks.

III. COMPOSITION

The Committee shall be comprised of two or more members. The Committee may have, but is not required to have, one or more members that meet the independence requirements in accordance with New York Stock Exchange Listing Standards. Members of the Committee may, in the judgment of the Board, have relevant experience in healthcare, law, corporate compliance, regulatory or governmental affairs, or service on the Board of a healthcare institution or highly regulated company. The Chairperson of the Committee shall be designated by the Board.

The members of the Committee, including the Chairperson, shall be appointed by the Board and serve at the pleasure of the Board. A Committee member (including the Chairperson) may be removed at any time, with or without cause, by the Board. The Board shall have the power to change the members of the Committee and fill any vacancies occurring on the Committee for any reason. The Committee will provide its members with periodic continuing education opportunities and customized training focusing on topics such as leading practices with regard to compliance, oversight, and other legal and regulatory healthcare topics.

IV. MEETINGS AND OPERATIONS

The Committee shall meet as often as it determines necessary to fulfill its responsibilities, but not less frequently than quarterly. The Committee shall meet at the call of its Chairperson. The Committee may meet by telephone conference call or by any other means permitted by law or the Company's Third Amended and Restated Bylaws (as amended from time to time, the ***"Bylaws"***).

A majority of the members of the Committee shall constitute a quorum. The Committee shall act on the affirmative vote of a majority of members present at a meeting at which a quorum is present. Subject to the Company's Bylaws, the Committee may act by unanimous written consent of all members in lieu of a meeting. The Committee shall determine its own rules and procedures, including designation of a chairperson pro tempore in the absence of the Chairperson, and designation of a secretary. The secretary need not be a member of the Committee and shall attend Committee meetings and prepare minutes. The Secretary of the Company shall be the Secretary of the Committee unless the Committee designates otherwise. The Committee shall keep written minutes of its meetings, which shall be recorded or filed with the books and records of the Company. Any member of the Board shall be provided with copies of such Committee minutes if requested.

The Committee may ask members of management, employees, outside counsel, independent auditor or others whose advice and counsel are relevant to the issues then being considered by the Committee to attend any meetings, to meet with any member of, or advisors to, the Committee, or to provide such pertinent information as the Committee may request. The Committee shall have authority to delegate any of its responsibilities to one or more subcommittees as the Committee may from time to time deem appropriate.

The Chairperson of the Committee shall be responsible for leadership of the Committee, including preparing the agenda, presiding over Committee meetings, making Committee assignments, and reporting the Committee's actions to the Board.

V. AUTHORITY

The Committee is authorized to investigate any matter within the scope of its duties and responsibilities or as otherwise delegated by the Board, with full access to all books, records, facilities, and personnel of the Company. The Committee shall have the resources and the authority to discharge its duties and responsibilities, including, to the extent it deems appropriate, the authority to select, retain, terminate, and approve the fees or other retention terms of one or more independent consultant(s), expert(s), auditor(s), or outside legal advisor(s). The Committee shall have authority to obtain advice and assistance from internal or external legal, accounting or other advisors at the Company's expense.

Adopted and approved by the Board of Directors on September 21, 2016, amended on August 8, 2018; amended and restated on December 13, 2018**;** amended on March 12, 2019; amended and restated on December 7, 2020; and amended and restated on June 15, 2023.

CHARTER OF
THE EXECUTIVE COMMITTEE
OF THE BOARD OF DIRECTORS

I. PURPOSE

The purpose of the Executive Committee (the "***Committee***") of the Board of Directors (the "***Board***") is to facilitate the effective management of the business and affairs of Lifepoint Health, Inc. (the "***Company***") by the delegation (to the extent permitted by applicable law, the Company's Certificate of Incorporation (as amended from time to time, the "***Certificate of Incorporation***"), the Company's Amended and Restated Bylaws (as amended from time to time, the "***Bylaws***"), this Charter and action of the Board) to the Committee of certain of the powers and authority of the Board.

II. RESPONSIBILITIES

When, as determined by the Chairperson of the Committee, (a) it is both (i) necessary due to urgent or highly confidential situations, and (ii) impracticable to convene in-person, telephonic, or electronic meetings of the Board or (b) it is otherwise advisable, the Committee may, subject to the restrictions of applicable law and the Certificate of Incorporation and Bylaws, exercise the full powers and authority of the Board in the management of the business and affairs of the Company; provided, that, the Committee shall not have any power or authority to do any of the following actions, except pursuant to an express action of the Board from time to time:

- amend the Certificate of Incorporation or Bylaws or any organizational document of the Company;

- enter into or authorize any mergers, amalgamation, consolidation, reorganization, recapitalization or other business combination involving the Company (other than any merger, amalgamation, consolidation or other business combination solely involving the Company and another member of the Company Group (as defined below) that is wholly-owned by the Company);

- enter into any joint venture (or series of related joint ventures) involving an aggregate enterprise value in excess of $250,000,000 or any binding agreement to form such a joint venture (or series of related joint ventures);

- enter into or authorize any acquisition or divestiture (or series of related acquisitions or divestitures) involving an aggregate enterprise value in excess of $250,000,000 or any binding agreement to consummate any such acquisition or divestiture (or series of related acquisitions or divestitures);

- declare any dividend in respect of the Company's securities (other than (i) declaring and authorizing the payment of one or more cash dividends or distributions to the holders of the Company's common stock in such amount as determined by the Committee, solely to the extent used directly or indirectly in connection with the repurchase of equity from employees, consultants, managers, officers and directors of

any member of the Company Group in connection with a termination of employment, consulting relationship or service as a manager, officer or director, as applicable, following the date hereof (the "***Future Repurchase Distributions***"); (ii) determining the record dates for such Future Repurchase Distributions; and (iii) authorizing, approving, ratifying and confirming any and all such other agreements and documents, in each case, that the Committee deems necessary, desirable or appropriate in furtherance of such Future Repurchase Distributions);

- issue or authorize the issuance of any equity security of the Company;

- commence the termination, liquidation or dissolution of the Company, or enter into any agreement or arrangement relating thereto;

- propose or institute proceedings to adjudicate the Company or any of the Company's subsidiaries (such subsidiaries collectively with the Company, the "***Company Group***") as bankrupt, or consent to the filing of a bankruptcy proceeding against any member of the Company Group, or file a petition or answer or consent seeking reorganization of any member of the Company Group under any applicable bankruptcy or insolvency laws, or consent to the filing of any such petition against any member of the Company Group, or consent to the appointment of a receiver or liquidator or trustee or assignee in bankruptcy or insolvency of any member of the Company Group, or make an assignment for the benefit of creditors of any member of the Company Group or admit in writing any member of the Company Group's inability to pay its debts generally as they become due;

- propose that the Company be wound up or that any liquidation proceedings be commenced;

- form or dissolve standing or director-only committees of the Board;

- amend the charter of any committee of the Board;

- take any actions that have been expressly, by charter or resolutions, delegated to any other committee of the Board; and

- amend or repeal any resolution of the Board.

The Committee's authority shall be subject at all times to control by the Board, which has the power to revise or alter any action taken by the Committee acting in such capacity so long as no rights of third parties are adversely affected thereby. Any action taken by the Committee pursuant to its authority hereunder shall be communicated to the entire Board as promptly as the Committee deems reasonably practicable.

In addition to the duties and responsibilities set forth in this Charter, the Committee shall:

- advise and counsel the Chief Executive Officer of the Company (the "***CEO***") regarding Company matters;

- report regularly to the Board upon its activities and recommendations, and prepare special reports at the request of the Board (which reports may take the form of an oral report by the Chairperson or any other person designated by the Committee to make such report); and

- periodically review and assess the adequacy of this Charter and recommend any proposed changes to the Board.

III. COMPOSITION

The Committee shall be comprised of one or more members (including a Chairperson). The members of the Committee and the Chairperson shall be appointed by the Board and serve at the pleasure of the Board. A Committee member (including the Chairperson) may be removed at any time, with or without cause, by the Board. The Board shall have the power to change the members of the Committee and fill any vacancies occurring on the Committee for any reason.

If the CEO is not otherwise on the Committee, then the CEO shall serve ex officio as a non-voting advisor to the Committee.

IV. MEETINGS

The Committee shall meet as often as it determines necessary, but at least once each year, to enable it to fulfill its responsibilities. The Committee shall meet at the call of its Chairperson. The Committee may meet by telephone conference call or by any other means permitted by law or the Company's Bylaws. A majority of the members of the Committee shall constitute a quorum. The Committee shall act on the affirmative vote of a majority of members present at a meeting at which a quorum is present. Subject to the Company's Bylaws, the Committee may act by unanimous written consent of all members in lieu of a meeting. The Committee shall determine its own rules and procedures, including designation of a chairperson pro tempore in the absence of the Chairperson, and designation of a secretary. The secretary need not be a member of the Committee and shall attend Committee meetings and prepare minutes. The Committee shall keep written minutes of its meetings, which shall be recorded or filed with the books and records of the Company. Any member of the Board shall be provided with copies of such Committee minutes if requested.

The Committee shall have the authority to delegate any of its responsibilities to one or more subcommittees as the Committee may from time to time deem appropriate.

The Committee and any subcommittee may ask members of management, employees, outside counsel, the independent auditors, internal auditors or others whose advice and counsel are relevant to the issues then being considered by the Committee or subcommittee, to attend any meetings and to provide such pertinent information as the Committee or subcommittee may request. The Committee or subcommittee may also exclude from its meetings any person it deems appropriate in order to enable it to carry out its duties (including a member of the Committee or subcommittee if the matter at hand involves such person or the person's presence presents an appearance of a conflict of interest).

The Chairperson of the Committee shall be responsible for leadership of the Committee, including preparing the agenda, presiding over Committee meetings, making Committee assignments and reporting the Committee's actions to the Board from time to time as requested by the Board.

V. AUTHORITY

In discharging its responsibilities, the Committee shall have the authority to retain and determine funding for independent counsel and other advisors and experts (without seeking Board approval) as the Committee determines necessary or appropriate to carry out its duties and responsibilities under this Charter. The Company shall provide appropriate funding, as determined by the Committee, for the payment of (i) compensation any such persons employed by the Committee pursuant to its authority under the immediately preceding sentence and (ii) ordinary administrative expenses of the Committee that are necessary or appropriate in carrying out its duties.

In carrying out its duties, the Committee may act in reliance on management, independent public accountants, internal auditors, internal and outside counsel and such other outside advisors and experts, as it deems necessary or appropriate.

The Committee has the power, in its discretion, to conduct any investigation it deems necessary or appropriate to enable it to carry out its duties.

The Committee will have unrestricted access to the independent public accountants, the internal auditors, internal and outside counsel, and anyone else in the Company, and may require any officer or employee of the Company or the Company's outside counsel or independent public accountants to attend any meeting of the Committee or to meet with any members of, or consultants or advisors to, the Committee.

Adopted and approved by the Board of Directors on December 6, 2023, and supersedes the charter previously adopted and approved on March 12, 2019 and September 22, 2016.

CHARTER OF THE
NOMINATING AND CORPORATE GOVERNANCE COMMITTEE
OF THE BOARD OF DIRECTORS

I. PURPOSES

The Nominating and Corporate Governance Committee (the ***"Committee")*** is appointed by the Board of Directors ***("Board")*** of LifePoint Health, Inc. (the ***"Company")*** for the purposes of (a) assisting the Board in identifying individuals qualified to serve as members of the Board and/or committees thereof, (b) developing and recommending to the Board a set of corporate governance guidelines for the Company to the extent it determines adopting such corporate governance guidelines are required or otherwise appropriate and (c) overseeing the self-evaluation process of the Board.

II. RESPONSIBILITIES

In addition to such other duties as the Board may from time to time assign, the Committee shall:

- identify individuals qualified to become Board members, consistent with criteria approved by the Board;
- recommend to the Board the director nominees for election by the stockholders at each meeting of stockholders at which directors will be elected and recommend to the Board nominees to fill any vacancies and newly created directorships on the Board;
- if it deems appropriate or required by applicable stock exchange rules, develop and recommend to the Board a set of corporate governance guidelines applicable to the Company and review and reassess the adequacy of such guidelines and recommend any proposed changes to the Board for approval;
- develop and recommend to the Board for its approval an annual evaluation process, which should include evaluations completed by each member and committee of the Board;
- oversee the self-evaluation process of the Board, the standing committees of the Board and the individual members of the Board and solicit and receive comments from all directors and report annually to the Board with an assessment of the performance of the Board, its members and its standing committees;
- periodically review the criteria for the selection of new directors to serve on the Board and recommend any proposed changes to the Board for approval;
- evaluate candidates for Board membership, including those recommended by stockholders in compliance with the Company's Amended and Restated Bylaws, as such may be amended from time to time (the "Bylaws");
- periodically review and make recommendations regarding the composition and size of the Board;

- periodically review and make recommendations regarding the composition, size, purpose, structure, operations and charter of each of the Board's committees, including the creation of additional committees or elimination of existing committees;

- recommend to the Board the chairpersons and members of each of the Board's committees;

- recommend to the Board proposals submitted by the stockholders;

- establish a process for the design of continuing education for current directors, which shall be periodically updated as necessary;

- review and reassess the adequacy of the Certificate of Incorporation, Bylaws and this charter, periodically, and at least annually, as conditions dictate, and recommend any proposed amendments to the Board for approval;

- oversee the Insider Trading Policy and perform any responsibilities delegated to the Committee therein; and

- oversee director orientation and continuing education programs.

III. COMPOSITION

The Committee shall be comprised of two or more members (including a Chairperson) and, as and when required in accordance with corporate governance guidelines corporate governance guidelines, all of such members shall be "independent directors," as such term is defined in such applicable stock exchange rules. The members of the Committee and the Chairperson shall be selected by the Board and serve at the pleasure of the Board. A Committee member (including the Chairperson) may be removed at any time, with or without cause, by the Board. The Board shall have the power to change the members of the Committee and fill any vacancies occurring on the Committee for any reason.

IV. MEETINGS AND OPERATIONS

The Committee shall meet as often as necessary to enable it to fulfill its responsibilities. The Committee shall meet at the call of its Chairperson. The Committee may meet by telephone conference call or by any other means permitted by law or the Company's Bylaws. A majority of the members of the Committee shall constitute a quorum. The Committee shall act on the affirmative vote of a majority of members present at a meeting at which a quorum is present. Subject to the Company's Bylaws, the Committee may act by unanimous written consent of all members in lieu of a meeting. The Committee shall determine its own rules and procedures, including designation of a chairperson pro tempore in the absence of the Chairperson, and designation of a secretary. The secretary need not be a member of the Committee and shall attend Committee meetings and prepare minutes. The Secretary of the Company shall be the Secretary of the Committee unless the Committee designates otherwise. The Committee shall keep written minutes of its meetings, which shall be recorded or filed with the books and records of the Company. Any member of the Board shall be provided with copies of such Committee minutes if requested.

The Committee may ask members of management, employees, outside counsel, or others whose advice and counsel are relevant to the issues then being considered by the Committee to attend

any meetings and to provide such pertinent information as the Committee may request. The Committee shall have authority to delegate any of its responsibilities to one or more subcommittees as the Committee may from time to time deem appropriate.

The Chairperson of the Committee shall be responsible for leadership of the Committee, including preparing the agenda, presiding over Committee meetings, making Committee assignments and reporting the Committee's actions to the Board from time to time as requested by the Board.

V. AUTHORITY

The Committee has the authority, to the extent it deems appropriate, to retain one or more search firms to be used to identify director candidates. The Committee shall have the sole authority to retain and terminate any such consulting firm, and to approve the firm's fees and other retention terms. The Committee shall also have the authority, to the extent it deems necessary or appropriate, to retain other advisors. The Company will provide for appropriate funding, as determined by the Committee, for payment of compensation to any search firm or other advisors employed by the Committee.

Adopted and approved by the Board of Directors on March 12, 2019 and supersedes the charter adopted and approved on September 22, 2016.

CHARTER OF THE
QUALITY COMMITTEE
OF THE BOARD OF DIRECTORS

ARTICLE I. PURPOSE

The purpose of the Quality Committee (the "Committee") of the Board of Directors (the "Board") of LifePoint Health, Inc. (the "Company") shall be to assist the Board in its efforts to monitor and provide leadership with respect to the quality of care, patient safety and the appropriate environment for care provided at hospitals or other healthcare facilities owned or leased by subsidiaries of the Company.

ARTICLE II. COMPOSITION

The Committee shall be comprised of two or more members (including a Chairperson). The Committee may have, but is not required to have, one or more members that meet the independence requirements in accordance with New York Stock Exchange Listing Standards. Members of the Committee may, in the judgment of the Board, have relevant experience in healthcare, patient safety and quality or service on the Board of a healthcare institution. The members of the Committee and the Chairperson shall be appointed by the Board and serve at the pleasure of the Board. A Committee member (including the Chairperson) may be removed at any time, with or without cause, by the Board. The Board shall have the power to change the members of the Committee and fill any vacancies occurring on the Committee for any reason.

The Committee will provide its members with periodic continuing education opportunities and customized training focusing on topics such as leading practices with regard to compliance, oversight, patient quality and safety and other legal and regulatory healthcare topics.

ARTICLE III. AUTHORITY AND RESPONSIBILITIES

In carrying out its responsibilities, the Committee's policies and procedures should remain flexible to enable the Committee to react to changes in circumstances and conditions so that it can fulfill its oversight responsibilities. In addition to such other duties as the Board may from time to time assign, the Committee shall have the authority and responsibility, with respect to hospitals or other healthcare facilities owned or leased by subsidiaries of the Company, to:

(1) Monitor and evaluate the Company's quality of care and patient safety programs and initiatives.

(2) Review and discuss with senior management the adequacy and effectiveness of the Company's quality of care and patient safety programs initiatives and consider recommendations for improvement thereof.

(3) Receive reports from senior management as frequently as appropriate summarizing significant: (a) deviations from the Company's quality of care and patient safety standards; (b) corrective and preventative actions and (c) other matters deemed relevant by the Committee.

(4) Receive reports from senior management as frequently as appropriate summarizing significant quality assurance related activities undertaken by the Company and the results of internal quality compliance audits conducted.

(5) Meet at least quarterly with the Company's Chief Medical Officer for a report on the Company's Patient Safety and Quality Programs,

(6) Receive summaries of reports prepared by third party consultants or auditors retained to evaluate the Company's quality of care and patient safety programs and initiatives.

(7) Prepare for the Board an annual performance evaluation of the Committee.

(8) Report at least annually to the Board on any significant failure to maintain quality and/or patient safety standards at any of the Company's facilities that poses a material financial or reputational risk to the Company.

ARTICLE IV. MEETINGS AND OPERATIONS

The Committee shall meet as often as it determines necessary, but at least quarterly, to enable it to fulfill its responsibilities. The Committee shall meet at the call of its Chairperson and shall be governed by the same rules regarding notice of meetings and waiver of notice as are applicable to the Board. The Committee may meet by telephone conference call or by any other means permitted by law or the Company's Second Amended and Restated Bylaws (as amended from time to time, the "Bylaws").

A majority of the members of the Committee shall constitute a quorum. The Committee shall act on the affirmative vote of a majority of members present at a meeting at which a quorum is present. Subject to the Company's Bylaws, the Committee may act by unanimous written consent of all members in lieu of a meeting. The Committee shall determine its own rules and procedures, including designation of a chairperson pro tempore in the absence of the Chairperson, and designation of a secretary. The secretary need not be a member of the Committee and shall attend Committee meetings and prepare minutes. The Secretary of the Company shall be the Secretary of the Committee unless the Committee designates otherwise. The Committee shall keep written minutes of its meetings, which shall be recorded or filed with the books and records of the Company. Any member of the Board shall be provided with copies of such Committee minutes if requested.

The Committee may ask members of management, employees, outside counsel or others whose advice and counsel are relevant to the issues then being considered by the Committee, to attend any meetings and to provide such pertinent information as the Committee may request. The Committee may also exclude from its meetings any persons it deems appropriate in order to discharge its responsibilities.

The Chairperson of the Committee shall be responsible for leadership of the Committee, including preparing the agenda, presiding over Committee meetings, making Committee assignments and regularly reporting the Committee's actions, including any significant issues or concerns that arise at meetings, to the Board.

ARTICLE V. ADDITIONAL AUTHORITY, RESPONSIBILITIES AND DUTIES

The Committee is authorized to investigate any matter within the scope of its duties and responsibilities or as otherwise delegated by the Board, with full access to all books, records, facilities, and personnel of the Company. The Committee shall have the resources and the authority to discharge its duties and responsibilities, including, to the extent it deems appropriate, the authority to select, retain, terminate, and approve the fees or other retention terms of one or more independent

consultant(s), expert(s), auditor(s), or outside legal advisor(s). The Committee shall have authority to obtain advice and assistance from internal or external legal, accounting or other advisors at the Company's expense.

Adopted and approved by the Board of Directors on March 12, 2019 and supersedes the charter adopted and approved on December 13, 2018;

DSB Parent L.P.

Delegation of Authority and Corporate Policy
(Adopted as of November 21, 2019)

Purpose:

This Delegation of Authority and Corporate Policy (this "Policy") is established to define the limits of authority designated to specified positions of responsibility within DSB Parent L.P. (the "Company") and its Subsidiaries (including LifePoint, Legacy LifePoint and each of their respective Subsidiaries) (collectively, the "Company Group") and to set forth certain types of commitments, transactions and other actions requiring (i) the approval of the Board and/or (ii) the approval of one or more individuals holding certain specified positions within the Company Group. The approval of any commitment, transaction or other action outlined in this Policy must always be made by the parties that have been designated in this Policy as having authority to approve such commitment, transaction or other action.

All officers and employees of the Company Group should be aware that conduct that violates this Policy is always considered outside the scope of their employment and may result in personal liability. Individuals who violate these policies are subject to appropriate disciplinary action by the Company Group, including possible termination of employment. In addition, violating this Policy could significantly damage the Company Group and expose it to unintended legal and commercial liabilities.

All managers should periodically consult with their staff members to determine that appropriate procedures for the implementation of this Policy have been developed and are being followed.

Scope:

This Policy is applicable to (i) each of the members of the Company Group, (ii) any joint ventures or investments that are controlled by any member of the Company Group and (iii) each of the officers, employees, consultants and agents of any of the foregoing.

Statement of Policy:

The Company Group is required to implement appropriate approval procedures and controls to ensure compliance with this Policy, which procedures and controls shall be consistent with this Policy and shall be approved by at least two of the following officers: the Chief Executive Officer, the Chief Financial Officer, the Executive Vice President, Hospital Operations, the Executive Vice President, Integrated Operations, the Executive Vice President, Human Resources and the Executive Vice President, General Counsel.

The Company Group shall adopt policies and procedures requiring each officer and employee of any member of the Company Group to consult with the Legal Department and/or senior management of the Company if such officer, employee, consultant or agent knows or has reason to know that any prospective action could violate: (i) any law, rule or regulation; (ii) any order, judgment or decree of any court or arbitral body; or (ii) in any material respect any Contract.

Procedures:

1. Combining Transactions:

This Policy shall be interpreted broadly so that a series of reasonably related transactions shall be considered as a single transaction for purposes of determining approval and authority levels required by this Policy.

2. Delegation of Authority to Subordinates:

a. It is emphasized that any commitment, transaction or other action that is the subject of this Policy cannot be approved by individuals having a lower level of approval authority than the level specified in this Policy for such commitment, transaction or other action, except pursuant to a delegation of temporary authority that has been approved in accordance with this Policy.

b. If any person (an "Authorized Person") having approval authority under this Policy will be out of the office for a prolonged period of time or is temporarily unavailable during exigent circumstances, such Authorized Person shall inform the General Counsel of such absence or exigent circumstances and may recommend that another employee of the Company Group (the "Temporarily Authorized Person") be granted a delegation of temporary authority to approve all commitments, transactions and other actions that such Authorized Person has the authority to approve under this Policy for such time as the applicable Authorized Person is out of the office or temporarily unavailable. Any such delegation of temporary authority shall be in writing, shall specify the effective length of time that such Temporarily Authorized Person shall have such authority and shall be approved by the applicable Authorized Person and two of the following individuals: the Chief Executive Officer, the Chief Financial Officer, the Executive Vice President, Hospital Operations, the Executive Vice President, Integrated Operations, the Executive Vice President, Human Resources and the Executive Vice President, General Counsel. Any such delegation so approved shall be permitted under this Policy.

3. Compliance Documentation

Employees executing Contracts and approving transactions are required to ensure that all appropriate approvals and reviews required by this Policy and the Company Group's other policies and procedures have been obtained, and to ensure that appropriate documentation of these approvals is maintained. Appropriate documentation can take various forms, including, without limitation, the initialing of final Contracts, approval forms, or memorandums. All Contracts subject to legal review and approval of the corporate legal department under policies and procedures adopted by the Company Group shall be maintained with documentation of the appropriate approvals and a copy of the documentation shall be maintained in the Company's electronic contract management database.

4. Policy Interpretations and Amendments

a. Inevitably, it will be necessary for the Company to issue interpretations of various provisions of this Policy as unanticipated facts and circumstances occur that are not specifically addressed in this Policy. The ability of the Board, and where an interpretation by the Board is impractical, the Chief Executive Officer, the Chief Financial Officer, the Executive Vice President, Hospital Operations, the Executive Vice President, Integrated

Operations, the Executive Vice President, Human Resources and the Executive Vice President, General Counsel to make interpretations of this Policy shall be interpreted broadly. Any such formal interpretation shall be in writing and, if not approved by the Board, shall be approved by any two of the following individuals: the Chief Executive Officer, the Chief Financial Officer, Executive Vice President, Hospital Operations, the Executive Vice President, Integrated Operations, the Executive Vice President, Human Resources and the Executive Vice President, General Counsel.

b. The Board reserves the right to revise the terms and conditions of this Policy at any time. Officers and employees are responsible for understanding or seeking clarification of any rules outlined in this document and for familiarizing themselves with the most current version of this Policy.

Definitions:

Unless the context suggests otherwise, capitalized terms as used and not otherwise defined herein are defined as follows:

"Affiliate" means: (a) with respect to any Person, any other Person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, such first Person, and (b) with respect to a Person who is a natural person, (i) any member of the immediate family of an individual, including parents, siblings, spouse and children (including those by adoption); the parents, siblings, spouse, or children (including those by adoption) of such immediate family member, and in any such case any trust whose primary beneficiary is such individual or one or more members of such immediate family and/or such individual's lineal descendants; and (ii) the legal representative or guardian of such individual or of any such immediate family member in the event such individual or any such immediate family member becomes mentally incompetent.

"Apollo" means Apollo Global Management, LLC or any of its Affiliates, investments funds, alternative investment vehicles or portfolio companies (other than the Company Group).

"Board" means the board of managers of DSB Parent L.P., or the board of directors of LifePoint or any Duly Authorized Committee of either such board.

"Chief Executive Officer" means the individual then serving as the Chief Executive Officer of LifePoint or any successor entity thereto.

"Chief Financial Officer" means the individual then serving as the Chief Financial Officer of LifePoint or any successor entity thereto.

"Contract" means any written or oral contract, agreement, letter of intent, memorandum of understanding, subcontract, license, sublicense, lease, sublease, sales order, purchase order, insurance policy, instrument, obligation, commitment or understanding.

"Duly Authorized Committee" means a duly authorized committee of the Board.

"Encumbrances" means any direct or indirect encumbrance, lien, pledge, security interest, claim, charges, option, right of first refusal or offer, mortgage, deed of trust,

easement, or any other restriction or third party right, including restrictions on the right to vote equity interests.

"Executive Committee" means the Executive Committee of the board of directors of LifePoint.

"Executive Officer" means those Officers of any member of the Company Group designated as such by the Board (or the board of directors of the applicable Subsidiary) from time to time, including the Chief Executive Officer, , Chief Financial Officer, , General Counsel, Chief Medical Officer, Chief Information Officer, President and anyone elected by the Board or duly appointed by another Officer in accordance with applicable organization documents as an Executive Vice President, or any Officer of a Subsidiary with the corresponding authority and powers.

"Executive Vice President" means any individual then serving as an Executive Vice President of LifePoint or any successor entity thereto.

"Financing Agreements" means (A) the Asset-Based Revolving Credit Agreement, dated as of November 16, 2018, by and among DSB Acquisition LLC, LifePoint, Legend Merger Sub, Inc. ("Merger Sub"), the lenders party thereto from time to time, and Citibank, N.A., as administrative agent and collateral agent, (B) the First Lien Credit Agreement, dated as of November 16, 2018, by and among DSB Acquisition LLC, LifePoint, Merger Sub, the lenders party thereto from time to time, and Citibank, N.A., as administrative agent and collateral agent, (C) the Indenture, dated as of November 16, 2018, by and among LifePoint, Merger Sub, the Subsidiary Guarantors (as defined therein) party thereto from time to time, and Wilmington Trust, National Association, as trustee, and (D) the Indenture, dated as of April 29, 2016, by and among LifePoint, the Subsidiary Guarantors (as defined therein) party thereto from time to time, and Wilmington Trust, National Association, as trustee and (E) the Indenture, dated as of April 29, 2016, by and among LifePoint, the Subsidiary Guarantors (as defined therein) party thereto from time to time, and Wilmington Trust, National Association, as trustee, in each case, as amended, restated, supplemented or otherwise modified from time to time and including any financing agreements entered into in exchange for, or the net proceeds of which are used to extend, refinance, renew, replace, defease or refund any of the foregoing agreements, provided that any such action is approved by the Board or a Duly Authorized Committee. "GAAP" means, with respect to any date of determination, generally accepted accounting principles as used by the Financial Accounting Standards Board and/or the American Institute of Certified Public Accountants consistently applied and maintained throughout the periods indicated.

"General Counsel" means the individual then serving as the General Counsel of LifePoint or any successor entity thereto.

"HealthCare Services Contractor" means any Person under an arrangement to provide healthcare services on behalf of the Company or any of its Subsidiaries and whose annual aggregate compensation is at or greater than $2,000,000.

"Indebtedness" means, with respect to any Person, (a) all indebtedness of such Person, whether or not contingent, for borrowed money, and (b) all obligations of such Person evidenced by notes, bonds, debentures or other similar debt instruments.

"Insurance Captive" means Point of Life Indemnity LTD.

"Key Contractor" any Person subject to an arrangement to provide professional advisory or consulting services to any member of the Company Group whose annual cash compensation is at or greater than $1,000,000 and either (x) the primary individual(s) associated with such Person delivering services to the Company Group is a former employee of the Company Group and/or (y) such Person was formed for the purpose of such individual avoiding being designated as a Key Employee.

"Key Employee" means any employee of the Company Group (other than non-executive physician employees) whose annual cash compensation is at or greater than $1,000,000 (including base salary and bonus).

"Lease Agreements" means the lease agreements of the Company and its Subsidiaries in effect as of the date of this Policy and any related ancillary agreements entered into in connection therewith, including without limitation (i) the Amended & Restated Master Lease dated as of March 21, 2016 among affiliates of LifePoint and affiliates of MPT Camaro Opco, LLC, (ii) the Amended & Restated Lease Agreement dated as of March 21, 2016 between Hot Springs National Park Hospital Holdings, LLC and MPT of Hot Springs—Capella, LLC, (iii) the Amended and Restated Lease Agreement dated as of October 31, 2016 between Columbia Capital Medical Center Limited Partnership and MPT of Olympia-Capella, LLC and (iv) any other lease in effect as of the date of this Policy that is treated as a capital lease under GAAP, in each case as amended, restated, supplemented or otherwise modified from time to time and any lease or financing agreements entered into in exchange for, or the net proceeds of which are used to extend, refinance, renew, replace, defease or refund any of the foregoing agreements, provided that any such action is approved by the Board or a Duly Authorized Committee. "Legacy LifePoint" means Legacy LifePoint, Inc. (f/k/a LifePoint Health, Inc.).

"LifePoint" means LifePoint Health, Inc..

"Management Consulting Agreement" means the Management Consulting Agreement, dated as of November 16, 2018, by and among LifePoint and Apollo Management Holdings, L.P.

"Material Consultant" means any Person (i) under an arrangement to provide audit, investment banking or financial advisory services to the Company or any of its Subsidiaries, or (ii) under an arrangement to provide any other professional advisory or consulting services to the Company or any of its Subsidiaries and in the case of clause (ii) whose annual aggregate compensation is at or greater than $1,000,000; provided that Healthcare Services Contractors, any physicians or groups of physicians and any providers of audit services to individual hospitals or subsidiaries (other than by the independent auditor(s) of the Company Group) that are not used for the audits of the Company Group completed in connection with financial reporting required under the Financing Agreements or financial reporting required by the Securities and Exchange Commission shall be excluded from the definition of Material Consultant.

"Officer" means any Person who would be an officer under Section 142 of the General Corporation Law of the State of Delaware or any term of similar import under the laws under the which the applicable Person was formed or any other natural Person with the power or authority to bind, obligate or otherwise act on behalf of the Person with respect to which such natural Person is appointed. For the avoidance of doubt an Officer shall not include an individual with a nominal title of "Vice President" with no actual or apparent

authority to bind, obligate or act of behalf of the Company or any Subsidiary or act in any of the capacities contemplated to be taken by an "officer," "manager," "partner" or similar position by the laws under which such Person is organized or its organizational documents.

"Partnership Agreement" means the Amended and Restated Limited Partnership Agreement, dated as of December 3, 2015, by and between DSB Parent L.P. and the limited and general partners party thereto, as amended, modified or supplemented from time to time.

"Person" shall be construed broadly and shall include, without limitation, an individual, a partnership, a limited liability company, a corporation, an association, a joint stock company, a trust, a joint venture, an unincorporated organization and a governmental entity or any department, agency or political subdivision thereof.

"Registration Rights Agreement" means the Registration Rights Agreement by and among DSB Holdings Inc. and the Persons party thereto, as amended, modified or supplemented from time to time.

"Securities" means, with respect to any Person, such Person's "securities" as defined in Section 2(1) of the Securities Act of 1933, as amended, and includes such Person's capital stock or other equity interests or any options, warrants or other securities that are directly or indirectly convertible into, or exercisable or exchangeable for, such Person's capital stock or other equity or equity-linked interests, including phantom stock and stock appreciation rights.

"Subsidiary" means, with respect to any Person, any corporation, association, partnership, limited liability company, business entity or other Person of which 50% or more of the total voting power of equity interests (including partnership interests) entitled (without regard to the occurrence of any contingency) to vote in the election of directors, managers, representatives or trustees thereof is at the time owned or controlled, directly or indirectly, by (a) such Person, (b) such Person and one or more Subsidiaries of such Person, or (c) one or more Subsidiaries of such Person.

"Transaction Fee Agreement" means the Transaction Fee Agreement, dated as of November 16, 2018, by and among LifePoint and Apollo Global Securities, LLC.

"Vice President" means any individual then serving as a Vice President of LifePoint or any of its Subsidiaries or any successor entity thereto.

Actions Requiring Special Approvals and Related Procedures:

1. Annual Budget and Business Plan

a. Any annual business plans (including any annual budgets) for LifePoint shall require the approval of the Board.

b. Any strategic plan for LifePoint, to the extent such plan supplements, modifies or deviates from a business plan previously approved by the Board, shall require the approval of the Board.

c. All business plans (including any annual budgets) for any subsidiary of LifePoint which are materially inconsistent with the most recent plan adopted for LifePoint shall require the approval of the Board.

2. Securities and Dividends, Use of Cash and Repayment of Indebtedness

The following actions shall require the approval of the Board:

a. acquiring, repurchasing, redeeming, canceling, selling, issuing or otherwise transferring or disposing of any Indebtedness or equity interest of any member of the Company Group (or any successor entity holding all or substantially all of the assets of any member of the Company Group), or any other Securities convertible into or exchangeable for, or any rights, warrants or options to acquire any equity interests of any member of the Company Group (or any successor entity holding all or substantially all of the assets of any member of the Company Group); provided, that, regularly scheduled payments of any previously approved Indebtedness may be made without approval of the Board if such payments are approved by the Executive Committee, Chief Executive Officer or the Chief Financial Officer;

b. declaring, setting aside, making or paying any dividend or other distribution in respect of any member of the Company Group's Securities (or the Securities of any successor entity holding all or substantially all of the assets of the Company Group), or purchasing or redeeming, directly or indirectly, such Securities, other than dividends or other distributions to the Company or another Subsidiary of the Company (or any successor entity holding all or substantially all of the assets of such member of the Company Group) that (i) are approved by the Executive Committee, Chief Executive Officer or Chief Financial Officer and (ii) would not use or otherwise adversely impact any "baskets" specified in the covenants in the Financing Agreements. Notwithstanding the foregoing, (i) intercompany cash transfers between and among DSB Holdings Inc. and its Subsidiaries in connection with cash management in the ordinary course of business and consistent with past practice and (ii) distributions of cash by any joint ventures with third parties that are in the ordinary course of business and permitted by the operating agreement of such joint venture, shall be permitted without approval of the Board if such payments are approved by the Executive Committee, Chief Executive Officer, the Chief Financial Officer or the Chief Financial Officer, Hospital Operations;

c. amending, modifying or waiving any material term of any outstanding Security or Indebtedness of any member of the Company Group (or any successor entity holding all or substantially all of the assets of any member of the Company Group); and

d. commencing or consummating an initial public offering or a public offering of the Securities of any member of the Company Group (or any successor entity holding all or substantially all of the assets of any member of the Company Group) (other than on Forms S-4 or S-8 or their equivalent).

3. Investments

The following actions shall require the approval of the Board:

a.(i) making any acquisition or divestiture of any corporation, partnership, limited liability company, joint venture or other business organization, or any line of business or division thereof, or other significant assets, in each case with a value in excess

of $10,000,000 or that materially changes the nature of the business of the Company Group, (ii) entering into any joint venture, or any agreements or commitments relating to any such acquisition, divestiture or joint venture, or (iii) making, committing to or entering into any such transaction or series of related transactions that would use or adversely impact any "baskets" specified in the covenants in the Financing Agreements or would require the satisfaction of financial tests under the Financing Agreements (the limitations in this clause (iii) being referred to as the "Financing Restriction"); other than, to the extent approved by the Executive Committee, Chief Executive Officer or Chief Financial Officer, acquisitions and dispositions of assets involving a transaction or series of related transactions that do not conflict with the Financing Restriction and are either (A) between the Company and any subsidiary or between any Subsidiaries or (B) (i) in the ordinary course of business with an unaffiliated third party for which the consideration paid or received (including assumed Indebtedness) does not exceed $1,000,000 in the aggregate or (ii) for which the consideration paid or received (including assumed Indebtedness) is more than $1,000,000 and less than $10,000,000 in the aggregate and the Board has received prior notice (including through any budget or business plan);

b. entering into any new line of business materially different than the current lines of business conducted by the Company Group;

c. making, modifying or disposing of any investment in another Person other than cash management activities conducted (i) in accordance with an investment policy or Contract approved by the Board, (ii) by the Insurance Captives established by the Company Group and (iii) any affiliated physician practices of the Company Group; and

d. casting any votes or giving written consent as an equity holder (excluding for the avoidance of doubt acting in the capacity as a board member or manager by virtue of such equity holdings), with respect to investments, joint ventures or Subsidiaries or granting any proxy with respect to the voting of any shares or other equity interests directly or indirectly held as to an action or transaction that would require approval of the Board if such action were to be taken by a member of the Company Group.

4. Capital Expenditures and Other Expenses

a. Capital Expenditures: Approving, authorizing or incurring, or committing to make or pay any capital expenditures having a value of greater than $2,000,000, based on aggregate expenditures for one project or series of related projects, shall require the approval of the Board.

b. Operating & Other Expenses: Approving, authorizing or incurring, or committing to make or pay any operating expenses or other non-capital expenditures shall require the following approvals, measured based on annual and aggregate expenditures for each such commitment or series of related commitments:

Title	***Authority Level***	
	Annual Expenses	*Aggregate Expenses*
Board	Above $2,000,000	Above $5,000,000
Any Executive Officer	Up to $2,000,000	Up to $5,000,000

c. Exceptions for Actions Requiring Board Approval: Notwithstanding anything to the contrary set forth in this Section 4, the approval of the Board shall not be required for (i) purchases of equipment and supplies and maintenance expenditures at existing properties in the ordinary course of business consistent with past practice, (ii) purchases of equipment and supplies in accordance with a Contract that has been previously approved in accordance with this Policy, (iii) as expressly set forth in the then in effect annual business plan and/or annual budget (as the same may be amended or modified by the Board from time to time), (iv) operating expenses and other non-capital expenditures that are within the then in effect annual business plan and/or annual budget (as the same may be amended or modified by the Board from time to time) that are incurred in the ordinary course of business or (v) any capital expenditure or any other expense expressly described in any project, plan or budget approved by the Board.

d. Processing Payments: No commitment, transaction or other action will be processed by the purchasing, accounting, or treasury departments unless such commitment, transaction or other action is approved in accordance with this Policy and only when the underlying commitment, transaction, agreement (including purchase order) or arrangement has been properly approved and satisfactory evidence is available that the obligation is due, shall disbursement of the Company Group funds be permitted.

e. Expense Reports: Expense reports covering reimbursement of expenses incurred on behalf of the Company Group shall be approved in accordance with Company Group's policies and procedures for such expenses.

5. Business Combination Transactions: Reorganizations; Liquidations; Dissolutions

a. The following actions shall require the approval of the Board:

i. agreeing to enter into or consummate any merger, amalgamation, consolidation, reorganization, recapitalization or other business combination involving any member of the Company Group and third parties;

ii. creating any holding companies or any Subsidiaries that are not Guarantor Subsidiaries (as defined below);

iii. withdrawing from, terminating, or making any material change to the investment in or rights under any joint venture or partnership;

iv. commencing the termination, liquidation or dissolution of any member of the Company Group other than an Immaterial Subsidiary (as defined below), or entering into any agreement or arrangement relating thereto;

v. proposing or instituting proceedings to adjudicate any member of the Company Group as bankrupt, or consenting to the filing of a bankruptcy proceeding against any member of the Company Group, or filing a petition or answer or consent seeking reorganization of any member of the Company Group under any applicable bankruptcy or insolvency laws, or consenting to the filing of any such petition against any member of the Company Group, or consenting to the appointment of a receiver or liquidator or trustee or assignee in bankruptcy or insolvency of any member of the Company Group, or making an assignment for the benefit

of creditors of any member of the Company Group or admitting in writing any member of the Company Group's inability to pay its debts generally as they become due; and

vi. subject to applicable insolvency law, proposing that DSB Holdings, Inc. (or any successor entity holding all or substantially all of the assets of DSB Holdings Inc.) be wound up or that any liquidation proceedings be commenced.

b. The Company or LifePoint shall notify the Board at the next regularly scheduled quarterly board meeting by delivering a report in form and substance acceptable to the board (a "Quarterly Board Report") if any member of the Company Group takes the following actions and such actions shall not require the approval of the Board:

i. agreeing to enter into, or consummate, any merger, amalgamation, consolidation, reorganization, recapitalization or other business combination solely involving members of the Company Group and no third parties;

ii. creating direct or indirect subsidiaries of LifePoint that are (x) wholly-owned (y) guarantors under the Financing Agreements and (z) that comply with all the requirements applicable to becoming a guarantor under the Financing Agreements ("Guarantor Subsidiaries"); and

iii. commencing the termination, liquidation or dissolution of any Subsidiary of LifePoint that does not have any ongoing operations or material liabilities (contingent or otherwise), in each case, in compliance with the applicable requirements of the Financing Agreements and the Lease Agreements (each such Subsidiary, an "Immaterial Subsidiary"), or entering into any agreement or arrangement relating thereto

6. Dispositions of Assets

Except for sales of assets pursuant to a Contract previously approved in accordance with this Policy (including, without limitation, sales of equipment pursuant to equipment assumption provisions in such Contracts), disposing (whether by sale, transfer or otherwise) of any assets of the Company Group having a value of greater than $2,000,000 (based on the book value of such assets), in a single transaction or a series of related transactions, shall require the approval of the Board.

7. Indebtedness and Encumbrances

a. *Encumbrances:* Except as required by the Financing Agreements or the Lease Agreements, making, facilitating or approving any new lien or mortgage or otherwise encumbering or subjecting to any new Encumbrance any properties or other assets of any member of the Company Group, shall require the approval of the Board. *Making Loans:* Except (i) pursuant to a Contract previously approved in accordance with this Policy, (ii) having an aggregate value of less than $1,000,000, or (iii) income guarantees and other financial assistance to non-executive physicians in the ordinary course, lending or agreeing to lend any money or assets of the Company Group to any other Person (including any loans (regardless of amount) made to directors, Officers, employees, Key Contractors or

Material Consultants of any member of the Company Group) shall require the approval of the Board.

b. Letters of Credit and Similar Instruments: Entering into or causing to be issued on behalf of any member of the Company Group any letter of credit, performance bond, bid bond, surety bond, bank guarantee, bankers acceptance or similar instrument greater than $500,000 in value, shall require the approval of the Board; provided that letters of credit issued under the ABL Facility in the ordinary course of business consistent with past practice shall not require Board approval but the Company Group shall promptly notify the Board of any such issuances.

c. Incurrence of Indebtedness: Except for the existing Financing Agreements and Lease Agreements (or any financing arrangement or lease subsequently approved in accordance with this Policy), incurring any of the following types of indebtedness shall require the approval of the Board:

i. Indebtedness for money borrowed from others or purchase money indebtedness (other than accounts payable in the ordinary course consistent with past practice to the extent that such accounts payable are not more than thirty (30) days past due) shall require the approval of the Board;

ii. Indebtedness of the type described in clause (i) above guaranteed in any manner by any member of the Company Group or in effect guaranteed, directly or indirectly, in any manner by any member of the Company Group through an agreement, contingent or otherwise, to supply funds to, or in any other manner invest in, the debtor, or to purchase indebtedness, or to purchase and pay for property if not delivered or pay for services if not performed, primarily or exclusively, for the purpose of enabling the debtor to make payment of the indebtedness or to insure the owners of the indebtedness against loss (any such arrangement being hereinafter referred to as a "Guaranty"), but excluding endorsements of checks and other instruments in the ordinary course consistent with past practice;

iii. Indebtedness of the type described in clauses (i) and (ii) above secured by any Encumbrance upon property owned by any member of the Company Group, even though it has not in any manner become liable for the payment of such indebtedness;

iv. Obligations of any member of the Company Group under any lease of (or other arrangement covering the right to use) real or personal property, which obligations are expected to be required to be classified and accounted for as capital leases on a balance sheet of the Company Group and for which the capitalized lease obligation reflected on such balance sheet is expected to be greater than $2,000,000, computed in accordance with GAAP as of the date of incurrence; and

v. Any indebtedness at each of DSB Parent L.P., DSB Holdings, Inc. and DSB Acquisition LLC.

e. Borrowing Under Existing Facilities: Borrowing funds under the Financing Agreements or any of the Company Group's credit facilities existing at such time shall require the authorization of the Chief Financial Officer and any of the Executive

Committee, Chief Executive Officer or the General Counsel, and shall be in a manner consistent with any budgets or plans approved by the Board; provided, that the Board's approval shall be required for the drawdown of the Company's existing revolving facility under the ABL Facility in an aggregate amount greater than $25,000,000 following November 16, 2018 and any additional drawdown in an amount greater than $10,000,000 thereafter.

f. Cash Management: Notwithstanding the foregoing, the Board's approval is required for any distribution, contribution or any other use of cash at each of DSB Parent L.P., DSB Holdings Inc. and DSB Acquisition LLC.

8. Material Agreements and Transactions with Affiliates

a. Contracts Generally: Entering into any Contracts that require payments or liabilities of greater than $20,000,000 in the aggregate shall require the approval of the Board.

The above referenced approval authority shall also apply to (i) the submission of any request for proposal, bid proposal or similar document ("Bids"), (ii) any amendment, modification or supplement to any Contract or Bid, (iii) any renewal of any Contract or Bid, (iv) any termination of any Contract or Bid and (v) any waiver of any material rights under any Contract or Bid.

b. Additional Required Board Approvals: In addition to the approvals set forth in Section 8(a), entering into any of the following Contracts shall require the approval of the Board:

i. any Contract providing for the indemnification of any Officer, director, employee, Key Contractor, Material Consultant, agent or representative of any member of the Company Group or indemnification of another Person, other than agreements with customers, third party payors, vendors or other suppliers containing customary indemnification provisions entered in the ordinary course of business consistent with past practice; any Contract providing insurance for the benefit of any Officer, director, employee, Key Contractor, Material Consultant, agent or representative of any member of the Company Group or another Person, unless such action is approved by the relevant Company Group compensation committee;

ii. any Contract that would restrict or otherwise limit the operations of (A) Apollo in any respect or (B) any affiliate of LifePoint except for the Company or its Subsidiaries, including, in the case of clauses (A) or (B), Contracts that limit or purport to limit the ability of the Company Group to compete in any line of business or with any entity or Person or in any geographic area; and

iii. any Contracts or transactions that would require Board approval under the Financing Agreements or any similar agreements.

c. Existing Non-Competes. Approving of, or otherwise taking, any action that would expand the scope of any existing restrictive covenant in any Contract that restricts or otherwise limits the operations of Apollo or any other affiliates of the Company other than the Company Group shall require the approval of the Board.

d. Additional Required Management Approvals: In addition to the approvals set forth in Section 8(a), the Company Group shall adopt policies and procedures regarding prior approvals of Executive Officers or their designees for any member of the Company Group to enter into any of the following Contracts:

i. any Contract with a physician or group of physicians or Healthcare Services Contractor;

ii. any Contract with any third party payor managed care organization, provider of health insurance coverage or employer, in each case, with respect to setting rates at which a Company Group member may be reimbursed for the provision of health care services or goods;

iii. any Contract that limits or purports to limit the ability of the Company Group to compete in any line of business or with any entity or person or in any geographic area;

iv. any Contract granting a customer or other third party a "most favored nation" status or other type of special discount;

v. any Contract pursuant to which any member of the Company Group grants any third party the right to be the exclusive provider of any material good or service to such member of the Company Group; and

vi. Any management agreement for the operation of a hospital or other facility.

e. Review of General Terms and Conditions: Without limiting the foregoing, the terms and conditions of any Contract or Bid shall also be reviewed and approved by the General Counsel, which approval may be delegated as the General Counsel deems appropriate.

9. Employee and Consultant Related Matters

a. *General Board Approvals and Notification:* The following actions shall require the approval of the Board:

i. entering into any recognition and/or neutrality agreement, collective bargaining agreement or other agreement, arrangement or understanding with any labor organization purporting to represent any employees of the Company Group other than at individual hospital facilities;

ii. recognizing any labor organization purporting to represent any employees of the Company Group other than at individual hospital facilities;

iii. participating in, contributing to or otherwise endorsing or adopting any welfare or benefit plan or arrangement involving any labor organization (including without limitation any multi-employer trust providing retirement benefits) other than at individual hospital facilities;

iv. participating in, contributing to or otherwise endorsing or adopting any pension plan or arrangement involving any labor organization (including without limitation any multi-employer trust providing retirement benefits);

v. creating new Executive Officer positions or appointing new Executive Officers of any member of the Company Group other than pursuant to written delegated authority from the Board; provided, that, the Executive Committee shall be delegated the authority to appoint Officers with a title of vice president (excluding executive vice president) or lesser position with powers and duties commensurate with such position and not inconsistent with the limits on authority set forth in this Policy and any other action of the Board and no greater than the Executive Officer to whom such lesser Officer reports;

vi. creating new director positions or appoint new members of the Board or the board of directors of any member of the Company Group other than pursuant to a vote or written consent as an equity holder (which vote or consent was properly authorized under Section 3(d)); and

vii. (x) other than pursuant to authority delegated, in writing, by the Board to a duly authorized administrative committee composed of Executive Officers and/or other employees of the Company Group, enter into, adopt, amend, approve or terminate any compensation or benefit plans, programs and policies of any member of the Company Group or Parent, including, without limitation, health, welfare and retirement benefit plans, cash bonus plans, equity-based or profit sharing plans, (y) or approve any grant under any equity-based or profit sharing plan or (z) change the compensation of any Executive Officer, Key Employee or Key Contractor of any member of the Company Group.

The Company or LifePoint shall notify the Board at the next regularly scheduled quarterly board meeting by delivering a Quarterly Board Report if any member of the Company Group takes the following actions and such actions shall not require the approval of the Board:

i. entering into any recognition and/or neutrality agreement, collective bargaining agreement or other agreement, arrangement or understanding with any labor organization purporting to represent any employees of the Company Group at an individual hospital facility;

ii. recognizing any labor organization purporting to represent any employees of the Company Group at an individual hospital facility;

iii. participating in, contributing to or otherwise endorsing or adopting any welfare or benefit plan or arrangement involving any labor organization (including without limitation any multi-employer trust providing retirement benefits) at an individual hospital facility consistent with the Company Group's overall compensation philosophy and objectives and policies established by the compensation committee of the Board or the Board;

b. *Hiring and Firing Employees:*

i. Hiring or firing any Executive Officer, Key Employee or Key Contractor of any member of the Company Group shall require the approval of the Board.

ii. Hiring or firing any other employee (other than non-executive physician employees) whose annual cash compensation (including salary and bonus) is in excess of $750,000 (each, a "Second Tier Employee") shall require the approval of the compensation committee of the Board.

iii. Hiring or firing any other employees (other than non-executive physicians) shall be conducted in accordance with the policies and procedures adopted by the Company Group.

iv. All employment agreements, offer letters or similar agreements for any Key Employee or Second Tier Employee shall be reviewed and approved by (A) the Senior Vice President for Human Resources and (B) one of the Executive Committee, the Chief Executive Officer or any Executive Vice President and, if related to the employment of any Executive Officer or Key Employee, the Board. All other employment agreements, offer letters or similar agreements shall be reviewed and approved in accordance with the policies and procedures adopted by the Company Group.

c. Non-Equity Compensation:

i. Increasing or agreeing to increase the compensation, of (i) any Executive Officer, Key Employee, or Key Contractor or (ii) any other employee or consultant (other than non-executive physicians) if the result of such increase would result in such employee becoming a Key Employee, or Key Contractor shall require the approval of the Board.

ii. Increasing or agreeing to increase the compensation of (i) any Second Tier Employee or (ii) any other employee if the result of such increase would result in such employee becoming a Second Tier Employee shall require the approval of the Executive Committee or Chief Executive Officer.

iii. All non-equity bonuses (including, but not limited to, bonuses under defined incentive plans, statutory bonus, special bonuses and discretionary or one-time bonuses) payable to (A) any Executive Officer, Key Employee or Key Contractor or any such non-equity bonus in excess of $500,000 in the aggregate to any other employee (other than non-executive physicians) shall require the approval of the Board and (B) any other employee or consultant shall require the approval of the Executive Committee or Chief Executive Officer (provided such approval shall be consistent with the compensation philosophy and objectives established by the Board (including any bonus targets) and within the aggregate amounts approved by the Board for non-equity incentive compensation in the annual budget or otherwise.

d. *Equity Compensation:* Making any grants of equity-based compensation or any payments or distributions to any (i) Executive Officer, (ii) Key Employee or Key Contractor, (iii) Material Consultant, (iv) director, or (v) any of their respective Affiliates shall require the approval of the Board, except for the following payments:

i. fees, expenses and other payments required to be paid or reimbursed under the Transaction Fee Agreement, Management Consulting Agreement, the Partnership Agreement or the Registration Rights Agreement;

ii. regular salary payments and other payments arising under any member of the Company Group's or Parent's employee benefit plans which are generally applicable to all employees of the Company Group and which plans have been previously approved by the Board;

iii. expense reimbursement (A) in the ordinary course of business consistent with past practice and (B) generally applicable to the directors and Officers of the Company Group, in accordance with policies approved by the Board;

iv. payments pursuant to any Contract previously approved in accordance with this Policy; and

v. director fees and expenses paid in accordance with a policy or agreement previously approved by the Board.

e. *Severance:* Entering into or approving any severance agreement or other severance arrangement with, or paying any severance to, or determining severance eligibility with respect to, any person shall require the following approvals:

Title	***Authority Level*** (based on the aggregate payments and benefits to be provided to such person)
Board	Above $500,000
Chief Executive Officer	Up to $500,000

f. *Material Consultants:* Engaging, determining the compensation of, or terminating any Material Consultant shall require the approval of the Board, other than the termination of Material Consultants without cause and without material incremental liability once the engagement of any such consultant is substantially complete.

10. Litigation; Settling Claims

a. *General Approval Authority:* Commencing or settling any litigation, regulatory proceeding, or otherwise paying, settling, discharging, waiving or satisfying any claim, liability, dispute or obligation greater than $2,000,000) other than medical malpractice claims within the retention limits of the Company's self-insurance and third party insurance programs) shall require the approval of the Board.

b. *Special Board Approval:* Notwithstanding the foregoing, no litigation, dispute or other claim may be commenced or settled without the approval of the Board if such litigation, dispute or claim involves (i) the imposition of a consent order, injunction or decree affecting any member of the Company Group, (ii) a finding or admission of a violation of law by any member of the Company Group or any of their respective employees or agents, (iii) a finding or admission of guilt by any member of the Company

Group or any of their respective employees or agents or (iv) any other material non-monetary terms.

c. *Legal Department Review:* In addition to the above approvals, all litigation claims and other disputes (including commercial disputes) shall be reviewed and approved by the General Counsel, which review and approval may be delegated to one or more members of the Legal Department or the Risk Management Department, as the General Counsel deems appropriate.

d. *Insurance Claims:* All insurance claims filed by any member of the Company Group shall require the approval of the Vice President for Risk Management and either the Chief Financial Officer or General Counsel.

11. Miscellaneous

a. *Regulatory:* Making any filing with or any report to any regulatory agency relating to, or referring to, (x) Apollo or the Company Group's capital structure that has not been previously disclosed in accordance with this policy or otherwise approved by representatives of Apollo ("Approved Apollo Disclosure") or (y) if publicly filed or otherwise reasonably expected to become publicly available, any other Investor Disclosure Matters (defined below) other than to the extent disclosed in accordance with the Disclosure Policy, shall require the approval of the Board.

b. *Tax and Financial Reporting Matters:* The following tax and financial reporting related actions shall require the approval of the Audit Committee of the Board in accordance with the Audit Committee Charter:

i. materially change any of the tax, accounting, bookkeeping or record-keeping principles, elections or positions;

ii. electing, terminating or replacing an independent auditor of the Company Group; provided engagement of independent auditors that are not the auditor of LifePoint by a member of the Company Group with respect to audits of such Person for purposes other than financial reporting shall not require board approval and

iii. reviewing, accepting, approving or changing the Company Group's independent auditors' reports.

c. *Investor Relations:* Issuing any press release or other public announcement, or giving any media interview relating to or referring to (x) Apollo, or (y) the Company's or any of its Subsidiaries' earnings, results of operations, financial condition or capital structure (the "Investor Disclosure Matters") shall be made in accordance with the Disclosure Policy adopted by LifePoint.

d. *Amending Organizational Documents:* Materially amending, modifying or waiving the terms of any organizational document of any joint venture or any other material member of the Company Group shall require the approval of the Board.

e. *Governance Policies:* Modifying or approving policies established by the Board relating to the Company Group's operations or governance or making, modifying or

approving any plans, practices or procedures inconsistent with those policies adopted by the Board shall require the approval of the Board.

f. *Corporate Headquarters:* Changing the corporate headquarters of the Company Group shall require the approval of the Board.

g. Bank Accounts: Opening and closing bank accounts shall require the authorization of the Chief Financial Officer and the Vice President and Treasurer of LifePoint and shall be in a manner consistent with any budgets or plans approved by the Board.

h. Powers of Attorney: Approval of the General Counsel and the Chief Executive Officer is required prior to the execution of any power of attorney. Only the Chief Executive Officer or Chief Financial Officer may execute a power of attorney unless otherwise required by the constituent documents of the relevant member of the Company Group, in which case, the appropriate corporate officer of such member of the Company Group will execute the power of attorney and the Chief Executive Officer will approve the power of attorney.

i. Political Contributions: No political contributions may be made on behalf of any member of the Company Group without the prior written approval of the Board other than (i) corporate contributions not in excess of $10,000 in any fiscal year made in compliance with applicable law and applicable policies and procedures adopted by the Company Group and (ii) any contributions made by political actions committees established or sponsored by a member of the Company Group acting in compliance with applicable law.

Chief Executive Officer
JOB DESCRIPTION

Job Summary

The CEO provides leadership and direction for the overall operation of the hospital. Plans, directs and coordinates the development of short and long range objectives; is responsible for achieving the organization's financial and non-financial goals.

General Responsibilities

- Coordinates the activities of senior executives and works with them to develop short and long range objectives, policies, and procedures.
- Ensures that policies are uniformly understood and consistently interpreted and administered.
- Establishes the organization hierarchy and delegates limits of authority to subordinates executives; prescribes the specific limitations of the authority of subordinates regarding policies, contractual commitments, expenditures and personal actions.
- Reviews and approves all financial reports, budgets, managed care contracts and major expenditures; directs, establishes, reviews, and adjusts charges for services; and maintains accreditation and licensure standards of the Joint Commission on Accreditation of Hospital Organizations, Medicare, Medicaid, state licensure, regulatory agencies, and similar organizations.
- Analyzes operating results of the organization and its principal components relative to established objectives and ensures that appropriate steps are taken to correct unsatisfactory conditions.

Minimum Qualifications (Experience, Education and Special Certifications…)

- Master's Degree in Hospital Administration (MHA), Business Administration (MBA), Management or related field is required.
- A minimum of 3-5 years experience at the CEO level in a similar sized for-profit, acute-care hospital is required; however, may also consider 3-5 years of COO experience in a larger, for-profit, acute-care hospital.
- Exceptional physician recruitment and relations skills are required.
- Exceptional community and board relations skills are required.
- Exceptional leadership skills and a hands-on visible approach to staff management and interaction are required.
- Exceptional financial acumen and operations management expertise are required.

03.01.2013

PHYSICAL DEMANDS/WORKING CONDITIONS - The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of

this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Requires prolonged sitting and some bending, stooping, and stretching. Requires eye-hand coordination and manual dexterity sufficient to operate a keyboard, photocopier, telephone, calculator, and other office equipment. Requires normal range of hearing and eyesight to record, prepare, and communicate appropriate reports. Requires lifting papers or boxes up to 50 pounds occasionally. Work is performed in an office environment and involves frequent contact with staff and the public.

LifePoint Health is an Equal Opportunity Employer
EOE Minorities/Females/Protected Veterans/Disabled

LifePoint Health and all of our facilities are committed to providing Equal Employment Opportunity for all applicants and employees and complies with all applicable laws prohibiting discrimination against any employee or applicant for employment because of color, race, sex, age, religion, national origin, disability, genetic information, gender identity, sexual orientation, veterans' status, or any other basis protected by applicable federal, state, or local law.

This job description in no way states or implies that the key accountabilities above are the only ones being performed by the individual(s) with this job description. The individual(s) may be called upon and required to follow or perform other duties and tasks requested by his or her supervisor, consistent with the purpose of the position, department and/or company objectives.

Signature: _____ **Date:** 1/26/23

Competencies:

Is this a leadership position (i.e., significant management/influencing skills required)?

[x] Yes [ ] No

If yes, please identify the most important characteristics for the position under each aspect of the leadership model:

Core Values
[x] Honor
[x] Trustworthiness
[x] Legal & Ethical Compliance
[x] Compassion

Business Mastery
Business Acumen:
[x] Grows the Business
[x] Financial Intelligence
Accountability:
[x] Results Oriented
[x] Planning & Decision Making

Relationship Mastery
Managing Relationships:
[x] Organizational Savvy
[x] Collaboration/Relationship Management
[x] Conflict Management
[x] Interpersonal Skills
Leading/Developing People:
[x] Manages Vision & Purpose
[x] Influences Others
[x] Motivates Others
[x] Identifies, Develops & Retains Talent

Personal Mastery
Personal & Professional Self Management:
[x] Demonstrate Dependability, Adaptability and Bias for Learning
[x] Effective Communication
[x] Cognitive Thinking
[x] Stress Tolerance

AMENDED AND RESTATED EXCLUSIVE EMERGENCY DEPARTMENT, HOSPITALIST SERVICES, AND ANESTHESIA SERVICES MASTER AGREEMENT

This Amended and Restated Exclusive Emergency Department, Hospitalist Services and Anesthesia Services Master Agreement (the "Agreement") is hereby entered into and effective as the date of the last signature (the "Effective Date"), by and between LifePoint Corporate Services, General Partnership ("Company") and Southeastern Emergency Physicians, LLC, a Tennessee limited liability company and TeamHealth subsidiary ("Contractor"). Company and Contractor may hereafter be referred to individually as a "Party" and collectively as tire "Parties".

RECITALS

WHEREAS, Company and Contractor are parties to that certain Exclusive Emergency Department and Hospitalist Services Master Agreement and certain Addenda thereto, dated January 1, 2018 (the "Previous Agreement");

WHEREAS, the Parties which to amend the Previous Agreement for the purposes of memorializing all the current services under one agreement, to add Anesthesia Services to the Previous Agreement, and to restate the Previous Agreement in its entirety;

WHEREAS, Company is an affiliate of those health care facilities more particularly identified in Exhibit 1 and subsequent Attachments, as defined below each attached hereto and incorporated by reference into this Agreement (individually referred to as the "Hospital" and collectively referred to as the "Hospitals"); and

WHEREAS, as a result of operational efficiencies achieved by combining emergency medicine and hospital medicine service offerings into a single, combined service offering, Company desires for Contractor to supply combined professional and administrative services in the applicable Hospitals' emergency departments, hospital medicine programs and/or anesthesia departments (collectively "Services") in exchange for consolidated payments that fully recognize the economies of scale created by a single combined service offering; and

WHEREAS, Company desires to manage the financial relationship of affiliated Hospitals and Contractor upon the terms and conditions stated below; and

WHEREAS, Contractor will, at its expense, arrange coverage for each of the Hospitals through licensed physicians and advanced practice clinicians (individually and collectively referred to as "Contractor's Representatives") authorized and licensed to practice under the laws of the stales in which the Hospitals are located and qualified to practice the professional services as defined in this Agreement; and

WHEREAS, Company desires to contract with Contractor as set forth herein to obtain the opportunity for Hospitals to contract with Contractor as the exclusive provider for emergency department and/or hospitalist services for Hospitals; and

WHEREAS, this Agreement is entered into for the purpose of defining the Parties' respective rights and responsibilities.

NOW, THEREFORE, in consideration of the premises and mutual covenants and agreements herein set forth, the Parties hereto agree as follows:

I. OBLIGATIONS OF CONTRACTOR

A. Organization. Contractor represents and warrants that it is a limited liability company that is duly organized and validly existing under the laws of its state of incorporation and has the corporate power and authority to execute and deliver this Agreement, and to carry out its provisions.

B. Emergency Department, Hospitalist Services and Anesthesia Services. Contractor shall provide to Hospitals professional and administrative services needed at the Hospitals, as reflected in separate arrangements (each an "Attachment") with each Hospital and the Services provided at each such Hospital identified in Exhibit 1 of the Agreement, as may be updated from time to time by the Parties without executing a written amendment to this Agreement. An example of the Attachment each Hospital will enter into with Contractor is attached hereto as Exhibit 4 for reference. Parties agree that only Hospitals with executed Attachments will be added to Exhibit 1. All Attachments previously set forth in that Previous Agreement are hereby incorporated into this Agreement by reference and repeated verbatim, unless such any such Attachments are otherwise amended, terminated, or replaced. In the event of any conflict between the terms of this Agreement and the terms of any Attachment, the terms of this Agreement shall control unless specifically stated otherwise.

C. Compliance. Contractor represents and warrants that as of the date of this Agreement: (i) neither it nor any Contractor's Representative providing Services at a Hospital is excluded, debarred or otherwise ineligible to participate in Medicare, Medicaid or any other federal or state healthcare programs or in any federal or state procurement or non-procurement programs; and (ii) neither Contractor nor any Contractor's Representative has been convicted of a criminal offense that could lead to such debarment or exclusion. Contractor shall immediately remove from Sendee at the applicable Hospital any Contractor's Representative for whom this representation and warranty is no longer true and shall so inform the Company and Hospital to which Contractor's Representative is assigned. Contractor acknowledges and agrees that this is a material term of this Agreement and the Attachments, and in the event this representation and warranty becomes untrue as to Contractor, Company may (i) deem this Agreement immediately terminated if such representation becomes untrue regarding this Agreement; or (ii) deem the applicable Attachment immediately terminated if such representation and warranty becomes untrue pursuant to Section I.E of the applicable Attachment. Contractor agrees this is an ongoing representation and will immediately notify Company in the event the foregoing representation and warranty is no longer completely accurate as it pertains to this Agreement or the applicable Attachment.

II. **OBLIGATIONS OF COMPANY**

A. Organization. Company represents and warrants that it is a corporation or limited liability company duly organized and validly existing under the laws of its state of incorporation and has the corporate power and authority to execute and deliver this Agreement, and to carry out its provisions.

B. Additional Hospitals. For purposes of this Master Agreement, an "Additional Hospital" or "Additional Hospitals" shall be defined as any hospital or service line at any hospital owned or operated by RCCH, Capella, Company or any subsidiary of RCCH, Capella or Company that is not currently included in Exhibit 1 as of the Effective Date. The parties agree that Additional Hospitals may be added to Exhibit 1 from time to time pursuant to the terms of this Master Agreement. As Additional Hospitals are added to this Master Agreement, the terms "Hospital" and "Hospitals" as used herein shall include any Additional Hospitals, unless otherwise noted."

C. Contractor's Right to Participate in Future Requests for Proposal. Should Company plan to request proposals for or terminate services at any Hospital at which Contractor is then providing any services to a Company Hospital, as applicable, Company agrees to: (i) include Contractor in the request for proposal process, and (ii) use its best efforts to meet with Contractor face to face to develop a precise pro-forma for the opportunity, with such face to face meeting scheduled on a mutually agreeable date no less than thirty (30) days prior to the deadline for submission of the response to the request for proposal.

III. **PARTNERSHIP GOVERNANCE**. Company and Contractor, through the Party's respective senior leadership teams, hereby acknowledge and agree to work cooperatively together to lead and administer the governance expectations set forth under this Agreement, which will include, but not be limited to, carrying out the following:

A. The Parties shall mutually agree upon any Attachment start-ups or terminations, unless otherwise terminated, as allowed in Section VI. The Parties agree that the applicable Hospital CEO(s) will not have unilateral termination authority for the applicable Attachment(s). This sentence shall supersede any conflicting termination provisions contained in the applicable Attachment(s).

B. Hold, at a minimum, monthly operations reviews of financial and operational performance that include the involvement of both Parties' senior leadership teams.

C. Each Party will appoint one or more senior leadership team members to manage the day-to-day operations of the Agreement, with such day-to-day management including the following:

1. Conducting bi-monthly and quarterly reviews in conjunction with Company's Group Chief Operating Officers.

2. Conducting monthly operation reviews with Company and Contractor leadership teams.

3. Conducting monthly operation reviews with the respective Hospital CEOs for those Hospitals that Company and Contractor mutually agree upon in advance.

4. Conduct monthly and weekly physician recruitment reviews with the applicable Hospital CEOs, the applicable Company service line leaders, and Contractor's leadership team to create more accountability and resolution to staffing, recruitment, premium labor, and other operational issues as identified.

IV. EXCLUSIVITY

A. Company concludes that an exclusive relationship with Contractor for Services at Hospitals and Additional Hospitals will best facilitate the delivery of efficient, effective and quality patient care. Such a relationship is expected to enhance patient services provided by Contractor and the Hospitals, improve the relationships between Contractor, the Hospitals' Medical Staffs and each Hospital, afford effective utilization of the Hospitals' equipment, provide consistent service and quality control, provide prompt availability of professional services, simplify scheduling of patients and physician coverage, enhance the efficient and effective administration of the service — all of which enhance the quality of patient care.

B. During the Term of this Agreement, Contractor shall be the exclusive provider of Services described in this Agreement at participating Hospitals, and therefore, Hospitals will not extend medical staff privileges for the practice of the Services at those Hospitals to any provider not employed by or under contract with Contractor. However, nothing in the preceding sentence shall be construed to limit the rights of community based physicians with medical staff privileges at the Hospitals to provide care for their patients while they are admitted to the same.

V. RESTRICTIVE COVENANT

A. During the Term of the Agreement, Contractor agrees that, prior to performing emergency department, hospitalist, or anesthesia services at any facility within the Hospitals' primary service areas, Contractor will notify Company in writing of its desire to provide such services. Following Contractor's delivery of such written notice to Company, Contractor and Company shall discuss and agree upon the opportunity, which agreement by Company will not be unreasonably withheld, prior to Contractor performing such services. Notwithstanding the foregoing, Company acknowledges and agrees that as of the Effective Date of this Agreement, Contractor or an affiliate of Contractor maintains existing relationships with those facilities identified in Exhibit 2-A of the Previous Agreement (as defined in the Recitals, above). Company agrees that no such notice requirement or restriction shall apply with respect to any such aforementioned facility.

B. If it shall be determined that the duration of any restriction contained in this section is unenforceable, it is the intention of the Parties that such restrictive covenant set forth herein shall not thereby be terminated or void but shall be deemed amended to the extent required to render it valid and enforceable to the greatest extent permissible by the applicable law and public policy, such amendment shall apply only with respect to the operation of this Article V.

C. Contractor shall not, by contract or otherwise, prohibit Contractor's Representatives from providing Services at the Hospitals in the event that this Agreement or an Attachment is terminated. In the event that this Agreement or an Attachment is terminated for any reason, the Company and Hospitals shall have the right to continue to engage or to employ (either directly or indirectly, including through a successor contracting entity to Contractor) the Contractor's Representatives who were engaged on the date of termination by Contractor to provide Services hereunder for any of the Hospitals (the "Existing Providers"); provided, however, that in the event this Agreement or an Attachment is terminated for any reason by Company or a Hospital, or upon expiration of this Agreement, the right of the Company and/or the Hospitals to continue to engage or to employ any such Existing Providers shall be contingent upon Company or the applicable Hospital first paying Contractor the following amounts for each Existing Provider engaged or employed by Company, Hospitals or any third party succeeding Contractor as the provider of similar services at Hospitals, as liquidated damages (collectively, the "Existing Provider Buyout Fee"):

i. the sum of Fifteen Thousand Dollars ($15,000.00), plus the amount of any repayments due to Contractor from Existing Providers for unamortized sign-on bonuses, workforce in place payments, or similar amounts, due to Contractor for each Existing Provider who is a physician; and

ii. the sum of Seven Thousand Five Hundred Dollars ($7,500.00), plus the amount of any repayments due to Contractor from Existing Providers unamortized sign-on bonuses or similar amounts, due to Contractor for each Existing Provider who is an advanced practice clinician;

Notwithstanding the foregoing, in the event this Agreement is terminated by Contractor for any reason, the Parties hereby acknowledge and agree that neither Company nor any Hospital shall be obligated to pay Contractor the aforementioned Existing Provider Buyout Fee for those Existing Providers engaged by Company and/or a Hospital after such termination. In addition, with the exception of any Facility Medical Director (to whom the Existing Provider Buyout Fee shall apply), no Existing Provider Buyout Fee will be applicable to any Existing Providers who provided services at the applicable Hospital prior to the first date Contractor began servicing the Hospital under this or any prior agreement. Such

amounts shall be payable to Contractor within thirty (30) days of the date of termination or expiration of this Agreement.

VI. TERM AND TERMINATION

A. This Agreement shall commence on October 1, 2022 (the "Effective Date"), beginning at 12:00 a.m. in the applicable time zones of the Hospitals, and shall continue for three (3) years thereafter through October 1, 2025 (the "Initial Term"), unless sooner terminated by either Party as further described herein. Notwithstanding the foregoing, upon expiration of the Initial Term, this Agreement will automatically renew for an additional three (3) year period (the "First Renewal Term"), and following the expiration of the First Renewal Term, two additional periods of one (1) year each (each an "Additional Term") until (i) such time as a new Agreement is executed by the Parties, or (ii) this Agreement is otherwise terminated as provided herein. As used herein, "Term" shall mean the Initial Term, the First Renewal Term, and any Additional Terms.

B. Termination Without Cause.

(i) Termination Without Cause by Company. Company may at any time give notice to terminate this Master Agreement in its entirety, but not any individual Hospitals or Attachments (unless otherwise mutually agreed to in writing by the Parties or subject to Section C below), without cause by providing not less than one hundred eighty (180) days prior written notice stating Company's intended date of termination. In such event, this Master Agreement and all Hospitals under this Master Agreement shall terminate at the end of such one hundred eighty (180) day notice period provided by Company and Contractor shall have no further obligation to provide services to the Hospitals.

(ii) Termination Without Cause by Contractor. Contractor may at any time give notice to terminate this Master Agreement in its entirety, but not any individual Hospitals or Attachments (unless otherwise mutually agreed to in writing by the Parties), without cause by providing not less than one hundred eighty (180) days prior written notice stating Contractor's intended date of termination. Upon receipt of such notice from Contractor, Company shall have the option of: (i) accepting Contractor's notice of without cause termination and allowing this Master Agreement and all Hospitals under this Master Agreement to terminate at the end of such one hundred eighty (180) day period, or (ii) notifying Contractor in writing that Company elects a staged termination approach, in which case Contractor will terminate no more than twenty-five percent (25%) of the then remaining Hospitals under this Agreement every one hundred eighty (180) thereafter (each a "Termination Staging Period"), until all Hospitals and the Master Agreement itself have terminated at the end of the final one hundred eighty (180) Termination Staging Period.

(iii) In the event Company: (i) terminates the Master Agreement for any reason prior to or during the Offset Period, or (ii) Contractor fails to achieve sufficient Additional Hospital growth to offset the Covid Adjustment. Amount prior to the termination of this Agreement for any reason, as evidenced by Contractor's financial documentation presented to and agreed upon by Company, Company agrees to pay Contractor, within sixty (60) days following final termination of the Master Agreement, a liquidated damage amount equal to the unpaid Covid Adjustment Amount. This amount shall be calculated by Contractor in accordance with Section 1.a and its routine accounting practices.

C. In the event of Company's sale or divestiture of any Hospital(s) covered by this Agreement, Company agrees to provide Contractor with no less than sixty (60) days prior written notice in advance of the closing, or promptly after full execution of a definitive sale agreement if closing takes place within less than sixty (60) days of such execution.. Such notice shall include, at a minimum, (i) the anticipated closing date, (ii) the name of the buyer, and (iii) contact information for buyer's representative(s) responsible for negotiating with Contractor for ongoing services at the site. Following Company's delivery of such written notice, Company agrees to provide reasonable transition assistance to Contractor during the sixty (60) days prior to closing in order to facilitate communications with Buyer regarding post-closing service opportunities..

D. Notwithstanding anything herein to the contrary, should either Party terminate this Agreement for any reason, all separate Attachments and arrangements identified in Exhibit 1 with each Hospital shall also terminate on the same Termination Date as this Agreement.

E. Either Party may terminate this Agreement at any time in the event the other Party engages in an act or omission constituting a material breach of any Term or condition of this Agreement. The Party electing to terminate this Agreement shall provide the breaching Party with written notice specifying the nature of the breach. If a dispute arises regarding the materiality of a breach, then both Parties shall submit the issue to a mutually agreed upon arbitrator pursuant to Section VIII of this Agreement for resolution of the dispute. The breaching Party shall then have thirty (30) days from the date of the notice or thirty (30) days from the date of the arbitrator's decision in which to remedy the breach and conform its conduct to this Agreement. If such corrective action is not taken within the time specified, this Agreement shall terminate at the end of the thirty (30) day period without further notice or demand, provided, however, that Company may not terminate this Agreement if Contractor is diligently pursuing the remedy of the breach.

F. Either Party may terminate this Agreement immediately if either Party makes a general assignment for the benefit of creditors, or files a petition for relief in bankruptcy or under similar laws for the protection of debtors, or upon the initiation of such proceedings against either Party if the same are not dismissed within forty-five (45) days of service.

G. No later than June 30, 2023, Company and Contractor shall mutually agree upon the "Amended and Restated Consolidated ED Scorecard" applicable to the Hospitals' emergency departments. Further, no later than June 30, 2023, Company and Contractor shall agree upon a "Consolidated Hospitalist Physician Scorecard" applicable to the Hospital's hospital medicine program. Existing scorecards shall remain in effect until the amended and restated versions set forth above are mutually agreed upon. Company and Contractor hereby agree that Contractor's actual performance against the Consolidated ED Scorecard and the Consolidated Hospitalist Physician Scorecard shall be measured against Contractor data at all TeamHealth contracted Hospitals from the then-current year to the immediately preceding year, subject to Company and the Hospitals providing Contractor with timely and accurate data to allow for such measuring. Company may terminate this Agreement upon ninety (90) days' prior written notice to Contractor with respect to an individual Hospital, but not with respect to this entire Agreement, if Contractor fails to achieve an overall minimum score of sixty (60) points on the "Consolidated ED Physician Scorecard" or "Consolidated Hospitalist Physician Scorecard" (defined in any of the Attachments to this Agreement) that specific Hospital for any two consecutive quarters during the term of this Agreement or any renewal period thereof. In the event Company and/or Hospitals fail or refuse to provide the necessary data for Contractor to measure its performance against the applicable scorecard, Contractor's performance relative to such missing data shall be deemed fully achieved. Contractor, however, shall have the right, at its own expense, to review and audit any quality metric contained in the ED Physician Scorecard or Hospitalist Physician Scorecard, including all underlying data. Company agrees to resolve any discrepancy found during an audit performed by Contractor to the Parties' mutual satisfaction. If a dispute arises or the Parties are unable to resolve the discrepancy to their mutual satisfaction, then both Parties shall submit the issue to a mutually agreed upon arbitrator pursuant to Section VIII of this Agreement for resolution of the dispute.

H. Except as provided herein, upon any termination of this Agreement, neither Party shall have further rights against, or obligations to, the other Party except with respect to any rights or obligations accruing prior to the date and time of termination and any obligations, promises or agreements which expressly extend beyond the termination, including but not limited to the terms herein related to insurance coverage, restrictive covenants, dispute resolution and confidentiality provisions. Contractor shall have reasonable access to any Hospital's information and records pursuant to this Agreement for a period of six months after termination of this Agreement for Contractor's billing, risk management and/or quality/peer review purposes.

VII. PAYMENT

A. GUARANTEE PAYMENTS

1. CONTRACTOR BILLING RESPONSIBILITY. Contractor shall be responsible for, and solely entitled to, billing and collection of the charges for all Services provided by any Contractor's Representatives at the Hospitals, unless indicated otherwise in the individual Attachments.

2. COST-PLUS SUBSIDY PAYMENTS. Company shall pay to Contractor, in monthly installments each year commencing on the Effective Date, a cost-plus subsidy amount (the "Cost-Plus Subsidy Payment") for services provided by Contractor to the Hospitals equal to the total of (i) the Total Estimated Semi-Annual Practice Expense Amount (as hereinafter defined) incurred by Contractor in fulfilling its obligations hereunder, plus (ii) a Management Fee equal to ten percent (10%) of the Total Estimated Semi-Annual Practice Expense Amount (the "Management Fee") covering administrative services provided by Contractor including, without limitation, legal, accounting, education and ongoing training, travel, performance improvement, satisfaction surveys, recruiting costs, billing administration, malpractice administration,

operation and clinical management, and other administrative services, less (iii) Contractor's Semi-Annual Professional Service Revenue, as that term is defined below. Notwithstanding the above, for those Additional Hospitals (i) scheduled in Exhibit 1, or (ii) added to Exhibit 1 effective after the Effective Date, the Management Fee shall equal five percent (5%) of the Total Estimated Semi-Annual Practice Expense Amount during the initial twelve (12) months of services, after which the Management Fee for such sites shall increase to the standard ten percent (10%) of the Total Estimated Semi-Annual Practice Expense Amount. Exhibit 2 attached to this Agreement sets forth the calculation of the Cost-Plus Subsidy Payment for a sample semi-annual period and shall serve as an example for all future Cost-Plus Subsidy Payment calculations unless otherwise mutually agreed between the parties. In the event there is any conflict or inconsistency between the terms and conditions of this Section VII(A)(2) and the manner of calculation of the Semi-Annual Practice Subsidy Amount set forth in Exhibit 2, the manner of calculation of the Cost-Plus Subsidy Payment set forth in Exhibit 2 shall govern and control the rights and obligations of the parties.

(a) For purposes of the Cost-Plus calculation occurring under the Agreement, the compensation methodology for the following facilities receiving anesthesia services from Contractor: (Northeastern Nevada Regional Hospital and Paris Regional Medical Center) will commence calculation of the Management Fee at ten percent (10%) pursuant to the Agreement as of the Effective Date, notwithstanding the fact that Anesthesia services commenced on an earlier date. Additional Anesthesia sites will be supplemented to Exhibit 1, as necessary.

(b) Notwithstanding the foregoing, for purposes of the Cost-Plus Compensation calculations, the parties reserve the right to mutually agree in writing to variations in the Year 1 and/or Year 2 Management Fee for Anesthesia Services if necessary based on prevailing market factors.

(c) With regard to anesthesia services provided at Conemaugh Memorial Medical Center and Conemaugh Nason Medical Center, the Management Fee shall be five percent (5%) of the Total Estimated Semi-Annual Practice Expense Amount during the initial twenty-four (24) months of operation, and ten percent (10%) commencing on the first date of the third year of operation and continuing for each successive year of operations thereafter.

(d) With regard to Conemaugh Memorial Medical Center, the following paragraph from the separate hospital attachment shall continue to apply:

(1) Locum Tenens Expenses. Following the Effective Date set forth in the table above and continuing for the first ninety (90) days thereafter, Company shall be solely responsible for all expenses associated with obtaining qualified locum tenens providers and/or temporary staffing, including CRNAs, to provide the Services hereunder to the Facility on behalf of Contractor (the "Locum Tenens Expenses"). For months four (4) through twenty-four (24) of the initial two (2) years of operations under this Agreement, Contractor shall be solely responsible for the aforementioned Locum Tenens Expenses. Starting in month twenty-five (25) and continuing thereafter, Facility shall resume responsibility for the Locum Tenens Expenses.

3. DEFINITIONS. The terms used in this Section shall have the following meanings:

(a) "Semi-Annual" or "Semi-Annually" shall mean each six (6) month calendar period during the Term of the Agreement commencing on the Effective Date (or a corresponding part thereof).

(b) "Total Estimated Semi-Annual Practice Expense Amount" shall mean, for each Semi-Annual period or part thereof during the Term of the Agreement, the projected expenses of Contractor in providing Services (as mutually agreed upon by Contractor and Company) during the subsequent applicable Semi-Annual period. Types of expenses included in the Total Estimated Semi-Annual Practice Expense Amount shall include direct expenses incurred by Contractor that are associated with the Services (inclusive of Services provided with respect to Additional Hospitals) including, but not limited to, the following: (i) compensation paid by Contractor to physician, mid-level, medical director, and scribe; (ii) allocated billing and collection costs; and (iii) insurance costs. With respect to the estimated expenses, the parties agree that any material changes in staffing or compensation subsequent to the establishment of estimated expenses shall require the prior approval of Company, which approval shall not be unreasonably withheld.

(1) Company agrees that in connection with Contractor's recruitment of Tyson J. Jordan, M.D., Robert C. Rankins DI, M.D., and Paul Dwyer, M.D. (collectively the "Cornerstone Physicians") to provide professional and administrative services at Paris Regional Medical Center in Paris, Texas (the "Paris Agreement"), Contractor has paid the total sum of Four

Hundred Eighty-Three Thousand Five Hundred Forty and No/100 Dollars ($483,540.00) to FasciaMedica Prompta, PLLC d/b/a Cornerstone Physicians Partners (the "Cornerstone Payment") on or around July 1, 2020. Company acknowledges and agrees that the remaining portion of the Cornerstone Payment in the amount of One Hundred Sixty-One Thousand One Hundred Eighty Dollars ($161,180.00) shall: (i) be treated by Contractor as a cost incurred by Contractor under this Agreement, and (ii) included by Contractor within the Semi-Annual Practice Expense Amount as defined in Article VII(A)(3)(b) of the Master Agreement for purposes of the July 1, 2022 calculation. The parties further agree that the restrictive covenant set forth in Section V(C) of the Master Agreement shall not apply as to the Cornerstone Physicians, and Company, or its designee, shall be free to engage with the Cornerstone Physicians without paying the Existing Provider Buyout Fee. In the event one or more of the Cornerstone Physicians terminate their engagements with Contractor under the Paris Agreement prior to July 1, 2023, the applicable one third (1/3) of the Cornerstone Payment represented by such terminating physician(s) shall not be included in subsequent Cost Plus Subsidy calculations prepared by Contractor once the funds are recovered by Contractor from the applicable Cornerstone Physician(s).

(c) "Semi-Annual Professional Service Revenue" shall mean all professional fees and charges (excluding the applicable portion of the Total Estimated Semi-Annual Practice Expense Subsidy Amount) of Contractor during the applicable Semi-Annual period accounted for on the accrual basis of accounting in accordance with Generally Accepted Accounting Principles ("GAAP") for the Services rendered by Contractor's Representatives. Semi-Annual Professional Service Revenue shall also include all Grants awarded to Contractor or to its affiliated medical groups from either the Provider Relief Fund established by the CARES Act or from any other future Extraordinary Governmental Payments related solely to lost revenues under the Master Agreement.

4. PAYMENT MECHANISM. During each contract year or part thereof commencing on the Effective Date, Company shall pay Contractor monthly, within ten (10) days after the first day of each month, an amount equal to one-sixth (1/6th) of the interim Cost-Plus Subsidy Payment as an "Interim Monthly Subsidy Payment".

5. ANNUAL RECONCILIATION. Within 45 days following the end of each calendar year, Contractor shall provide Company with an opportunity to review financial performance documentation with respect to the Hospitals, after which Contractor and Company shall jointly perform a reconciliation of (i) the interim Cost-Plus Subsidy Payments made from Company to Contractor during the prior year, (ii) the aggregate of the Total Estimated Semi-Annual Practice Expense Amount paid in the prior year vs. Contractor's actual full year expenses, and (iii) the aggregate of Semi-Annual Professional Service Revenue vs. Contractor's actual professional service revenue, during the prior twelve (12) months to determine if any overpayments or underpayments were made by Company to Contractor. In the event such annual reconciliation evidences an overpayment due from, or an underpayment due to, either party, such reconciliation correction payment shall be made to the applicable party within thirty (30) days following completion of the reconciliation. In the event the parties are unable to agree on a final reconciliation of amounts due or from the other party, the parties shall mutually agree on an independent auditor to perform such reconciliation, the results of which shall be binding on both parties.

6. PROMPT BILLING, REVIEW OF FINANCIAL PERFORMANCE, RIGHT TO AUDIT BOOKS AND RECORDS. Contractor shall bill all patients promptly and accurately for all Services rendered and shall use its best efforts to collect all patient accounts. Hospital and Contractor's Representatives will provide all documentation necessary for accurate and timely billing. During the Term of this Agreement, Contractor agrees to provide monthly, Base Period to date and year to date detailed financial and statistical reports for each Hospital. Company and Contractor agree to meet monthly to review such financial performance. Both during and following termination of the Agreement, Company shall have the right, upon reasonable notice and request, to review and audit Contractor's books and records on an annual basis for the then current contract year to assure compliance with this Agreement. Such review and audit shall be solely limited to the Services provided under this Agreement. Additionally, for purposes of ensuring accurate coding, Contractor agrees to use its best efforts to document its Services fully, completely, and in a timely manner. The Parties agree to make available, and shall also cause their respective billing companies to make available, any and all documents that may be used for the execution of the audit in a reasonable and timely fashion.

7. CONTRACTOR FEE SCHEDULE. Contractor will establish a schedule of fees at each Hospital to be charged to all patients for Services provided by Contractor's Representatives. Contractor will provide a fee schedule to Hospital upon execution of the applicable Attachment and annually thereafter. Contractor agrees that Contractor shall negotiate in good faith and use its best efforts in order that Contractor can participate,

and any Contractor's Representative designated by Company and/or a Hospital can participate, in any and all programs and/or networks in which Company and/or a Hospital participates with health maintenance organizations, preferred provider organizations, other payors, and physician-hospital organizations. Company is agreeable to Contractor and the exclusive provider of such Services negotiating a mutually agreeable billing and coverage arrangement. Company agrees to assist Contractor by providing contact information for relevant programs.

8. REMITTANCE ADDRESS. All payments made by Company to Contractor under this agreement will be paid to: Contractor:

Southeastern Emergency Physicians, LLC
Post Office Box 634850
Cincinnati, Ohio 45263-4850

9. PREVIOUS AGREEMENT COVID ADJUSTMENT. The parties acknowledge and agree that during the term of the Previous Agreement, the COVID-19 pandemic required certain adjustments and mitigations to Contractor's compensation ("Covid Adjustments") in order to take into account unexpected extraordinary short-term declining volumes, related market variables affecting the Hospitals, and the Grants as a result of the COVID-19 pandemic. As a result, the Management Fee payable to Contractor for certain existing Hospitals under the Master Agreement was reduced to six percent (6%) of the Total Estimated Semi-Annual Practice Expense Amount (the "Management Fee") during the period January 1, 2020 through December 31, 2020 (the "Covid Adjustment Period"). Following the end of the Covid Adjustment Period, the parties calculated the total amount of the reduction to the management fee during the Covid Adjustment Period, the total of which was Five Million Six Hundred Ninety Thousand Six Hundred Six and No/100 Dollars ($5,690,606.00) (the "Covid Adjustment Amount"). Commencing January 1, 2021 under the Previous Agreement, the Management Fee for Hospitals returned to ten percent (10%) of the Total Estimated Semi-Annual Practice Expense Amount as set forth in the existing Section VII.A.2 of the Agreement for the remainder of the Term. Under the Previous Agreement, and continuing under this Agreement, the parties acknowledge and agree the Covid Adjustment Amount would be offset by future growth under the Previous Agreement and this Agreement, as applicable, through Additional Hospitals added as attachments to this Agreement between January 1, 2020 and December 31, 2023 (the "Offset Period"). The dollar value of the future growth of each of the Additional Hospitals that will be used to offset the Covid Adjustment Amount shall be equal to the actual Contribution Margin realized during the Offset Period for any Additional Hospital; provided however, if the Term of this Agreement continues beyond December 31, 2023, then the Contribution Margin of each of the Additional Hospitals added during the Offset Period will continue to offset the Covid Adjustment Amount through the extended term(s) Company and Contractor agree to use their best good faith efforts to achieve the projected Additional Hospital growth during the Offset Period. Company and Contractor further agree that in the event Company terminates or divests any Hospitals under this Agreement that were signed as Additional Hospitals after December 31, 2019, such Hospitals will be counted for purposes of the growth calculation for the pro rata share of the period under the Master Agreement.

B. Premium Labor Cost Reimbursement. Company and Contractor hereby acknowledge and agree that Notwithstanding the above, the parties acknowledge and agree that, for purposes of calculating the Management Fee, Contractor shall not include Premium Labor Costs within the Management Fee calculation (i.e. as a component of Total Estimated Semi-Annual Practice Expense Amount for purposes of calculating the Management Fee); provided, however, Premium Labor Costs shall continue to be included within the Total Estimated Semi-Annual Practice Expense Amount for all other purposes.

As used herein, "Premium Labor Costs" shall be defined as the differential between the base provider compensation expenses incurred and paid by Contractor in the ordinary course for full-time providers and Contractor's actual expenses for premium coverage provided by internal or external locum tenens providers, and Contractor special operations providers.

C. Remittance Address. All payments made by Company to Contractor under this agreement will be paid to:

Contractor: Southeastern Emergency Physicians, LLC
Post Office Box 634850
Cincinnati, Ohio 45263-4850

D. Smart Ribbon® Services and Applications.

1. As an additional component of the hospitalist services provided by Contractor to Company and selected Hospitals receiving hospitalist services under this Master Agreement, Contractor has entered into a relationship with a third-party vendor, IllumiCare, Inc. ("Illumicare"). Illumicare offers a technology-based service to health care entities that displays information in context with the electronic medical record (on the Smart Ribbon® or "Ribbon"), which contains one or more functional applications ("Apps"). Through use of the proprietary Smart Ribbon®, Contractor proposes to reduce the direct, variable medication and lab spend per hospital admission managed by Contractor's Providers for certain Hospitals selected by Company at its sole and absolute discretion as participating hospitals in the Ribbon application (the "Participating Hospitals"). Once selected by Company, the Participating Hospitals shall be listed in Exhibit 5 attached hereto. Company's selection of the Hospitals to be included as Participating Hospitals shall be conditioned on Company first negotiating and entering into one or more separate licensing agreements between Company, the Participating Hospitals and Illumicare for use of the Smart Ribbon at the Participating Hospitals with terms reasonably acceptable to Company. Changes in the med/lab spend per admission will be calculated on a DRG and volume adjusted basis, per the cost methodology example set forth in Exhibit 6 attached hereto (the "Cost Savings") over each calendar quarter (each a "Performance Period"). Subject to the conditions set forth above, in the event of such Cost Savings, each Participating Hospital shall pay to Contractor a fee equal to the first $12.00 of per admission calculated savings in medication and lab test costs during each Performance Period (the "Shared Savings") at such Participating Hospital. The Shared Savings amount shall be in addition to all other amounts due to Contractor pursuant to this Master Agreement and will not be taken into account for purposes of the Cost-Plus Subsidy calculation. Within thirty (30) days after the end of each quarter, Company and Contractor shall meet to determine whether Cost Savings were achieved by Contractor and the Contractor's Providers during the prior quarter. If Cost Savings were achieved, then the Shared Savings shall be distributed to Contractor within sixty (60) days of the end of the prior quarter. If Cost Savings were not achieved, Company shall owe no Shared Savings and no discharge costs to Contractor for that quarter. Company shall be responsible for all administrative implementation costs across all Participating Hospital locations participating in the Ribbon."

2. During the term of this Agreement, Company and Participating Hospitals agree to cooperate with Contractor's and IllumiCare's efforts to perform and provide the following (collectively, the "Ribbon Platform") services at Participating Hospitals:

    a. Work with each Participating Hospital's technical staff to implement and maintain a secure flow of required data (as specified in Exhibit 5 attached to this Agreement);

    b. Work with each Participating Hospital's technical staff to install and maintain the code required to display the Ribbon in context with the electronic medical record;

    c. Maintain the Ribbon Platform and make any ongoing changes necessitated by each Participating Hospital's system modifications;

    d. Contractor, through its arrangement with Illumicare, will provide electronic training and support (24/7/365) and live support (M-F, 8:00 am-6:00 pm CT) to Contractor's Providers and support/administrative personnel.

3. Company further acknowledges and agrees that Contractor, through its collaboration with IllumiCare, shall provide Apps within the Ribbon as more specifically described in Exhibit 5.

4. Invoicing. On no less than a quarterly basis, Illumicare will perform the cost savings calculations reflected in Exhibit "6", the results of which shall be made available to Company and Contractor upon request. Thereafter, Illumicare will invoice Contractor for the amounts due to Illumicare pursuant to the Illumicare Agreement. Simultaneously, Contractor will invoice Company for the amounts due as set forth herein."

5. Termination. At any time during the term of this Agreement, Company may, in its sole and absolute discretion, terminate the arrangement described in this Section VII.D. with respect to

all of the Participating Hospitals, or any of them upon written notice to Contractor. Upon such termination, the remainder of this Agreement shall remain in full force and effect.

6. Nonexclusive. The arrangement described in this Section VII.D. is non-exclusive. As such, at any time during the term of this Agreement, Company or any of its Affiliates may obtain directly from Illumicare the right to use Smart Ribbon® at any Participating Hospital without violating the Agreement.

7. The purposes of the arrangement described in this Section VII.D. is to establish a compensation system that demonstrates, in an objective manner, quality clinical improvement resulting in the reduction of waste associated with the medication and lab services at each Participating Hospital, and to compensate the Contractor for such improvements by sharing the savings that occur as a result of such efforts. The arrangement described in this Section VII.D does not compensate the Contractor for limiting, reducing or withholding medically necessary patient care services, or for increased volume or value of referrals to, or other business generated for, any Participating Hospital.

8. Ongoing Monitoring of Unintended or Inappropriate Effects. Contractor, Illumicare and Company shall each designate one (1) representative (the "Monitoring Representatives") to monitor the arrangement set forth in this Section VII.D. to ensure that it does not adversely affect patient care. On biweekly basis during the Term, the Monitoring Representatives shall meet to review this arrangement and its impact upon the Participating Hospitals and patient outcomes. The review shall assess the quality of care and safety related to services that are subject to this arrangement, to assess whether the arrangement negatively affects patient care and to confirm there is no reduction of medically necessary patient care related to the arrangement or inappropriate patient discharges. Contractor agrees that it shall cooperate with Company to address any concerns identified through such monitoring, including through changes to this Agreement if necessary. In particular, The Monitoring Representatives shall review data related to (i) mortality rates, (ii) re-admission rates, and (iii) patient harm at each of the Participating Hospitals.

VIII. **ALTERNATIVE DISPUTE RESOLUTION.** The Parties firmly desire to resolve certain disputes arising hereunder without resort to litigation in order to protect their respective business reputations and the confidential nature of certain aspects of their relationship. Accordingly, any controversy or claim arising out of or relating to this Agreement, excepting healthcare liability and/or claims sounding in negligence, and the insurance and indemnification obligations set forth in each respective Attachment below relating to third-party claims made by patients and/or their representatives, shall be settled by arbitration before a single arbitrator and administered by the American Health Lawyers Association in accordance with its rules, including arbitrator selection. The award or decision rendered by the arbitrator will be final, binding and conclusive, and judgment may be entered upon such award by any court of competent jurisdiction. The arbitration process itself, and any other information or disclosures revealed by either Party to the arbitrator or to the other Party during the arbitration process will be confidential. No disclosure of the award shall be made by the Parties except as required by the law or as necessary or appropriate to effectuate the terms thereof. The location of the arbitration shall be in in the city in which the Hospital is located, unless otherwise mutually agreed by the parties. The dispute shall be governed by the laws of the State. Further, the prevailing Party shall be entitled to recover all costs and expenses associated with arbitration, including reasonable attorneys' fees. If the arbitrator determines that neither Party has substantially prevailed, the Parties shall bear equally the fees and costs of the arbitrator and the related expense of arbitration. Nothing in this section shall preclude either party from maintaining or initiating an action, counterclaim or cross-complaint in tort or contract against the other related to any healthcare liability and/or claims sounding in negligence relating to third-party claims made by a patient and/or a patient's representatives.

IX. **PARTIES' RELATIONSHIP.** The Parties acknowledge that Contractor is an independent contractor to Company and the Hospitals for the furnishing of Contractor's Representatives who agree to render Services to patients of the Hospitals. Neither Contractor nor Contractor's Representatives shall in any way be construed as employees of any of the Hospitals or Company. Neither Contractor nor any of its agents (employees or contractors) shall have the right or authority to enter into any contract in the name of the Company or the Hospitals or otherwise bind the Company or the Hospitals in any way without the express written consent of the Company or its Hospital designee.

X. **CHANGE OF CIRCUMSTANCES.** In the event (i) Medicare, Medicaid, any third party payor or any federal, state or local legislative or regulatory authority adopts any law, rule, regulation, policy, procedure or interpretation thereof which establishes a material change in the method or amount of reimbursement or payment for Services under this Agreement, or if (ii) any or all such payors and/or authorities impose requirements which require a material change in the manner of either Party's

operations under this Agreement and/or the costs related thereto, then, upon the request of either Party materially affected by any such change in circumstances, the Parties shall enter into good faith negotiations for the purpose of establishing such amendments or modifications as may be appropriate in order to accommodate the new requirements and change of circumstances while preserving the original intent of this Agreement to the greatest extent possible. If, after thirty (30) days of such negotiations, the Parties are unable to reach an agreement as to how or whether this Agreement shall continue, then either Party may terminate this Agreement upon thirty (30) days' prior written notice.

XI. **THIRD PARTY DISCOUNTS.** Company represents that it or its Hospital designees, as appropriate, will provide to Contractor a list of all billing arrangements the Hospitals enter into with any third party that result in a discount on fees relating to Services supplied by Contractor under this Agreement. As reasonably requested by Company or the Hospitals, Contractor shall participate in such plans and/or programs, unless Contractor has a contract in force with such payor providing for the receipt of superior reimbursement rates.

XII. **NOTICES.** All notices and any other communications with regard to the subject matter of this Agreement shall, unless indicated elsewhere in this Agreement, be made to the primary contacts for Contractor and Hospital at the address shown, with copies as indicated. Any notices permitted or required by this Agreement shall be deemed made on the day personally delivered in writing or mailed by certified mail (or first class mail), postage prepaid, to the other Party at the address set forth below or to such other persons and addresses as either Party may designate in writing:

Contractor:	Southeastern Emergency Physicians, LLC 265 Brookview Centre Way Suite 400 Knoxville, TN 37919 Attention: Mid-West President
Company:	LifePoint Corporate Services, General Partnership 330 Seven Springs Way Brentwood, TN 37027 Attention: President, Ambulatory Services
With a copy to:	LifePoint Health, Inc. 330 Seven Springs Way Brentwood, TN 37027 Attention: Chief Legal Officer

XIII. **CONFIDENTIALITY.** The Parties agree that this Agreement and its provisions are strictly confidential. The Parties shall not disclose any information pertaining to any provision of this Agreement to any person or entity not a party to this Agreement except for tax, legal or accounting advisors or as otherwise required by law.

XIV. **VENDOR PROMOTION/PUBLICATION.** Company prohibits the use of Company's name or any Hospital's name by any vendor or independent contractor, or the use of any name of Company's parent company, subsidiaries, or affiliated hospitals in any advertisement, press statement or release, website, published customer list, or any publication or dissemination similar to the foregoing without receiving in advance the express written permission from the Company's Chief Executive Officer or his or her designee. Any request for permission should include the complete text of the publication, statement or document in which the name usage will appear and will be subject to edit by the Company.

XV. **MARKETING SERVICES/COMPENSATION OF CONTRACTOR'S REPRESENTATIVES.** Except as specifically provided in this Agreement, Contractor shall not perform and is not being compensated for marketing services with respect to the Services to be performed at the Hospitals. Contractor represents and warrants that no part of the compensation paid hereunder is in exchange for the referral or arrangement for referral of any patient to any of the Hospitals. Contractor represents and warrants that, in connection with the Services to be performed pursuant to this Agreement, each employee, independent contractor, or other entity or person performing Services pursuant to the Agreement shall be compensated in a manner that

complies with the Federal Anti-Kickback Statute, an exception to the Stark law, and as applicable, an appropriate exception to any state statutes similar to either or both of the foregoing federal statutes.

XVI. **SEVERABILITY**. The invalidity or unenforceability of any provision(s) of this Agreement will not affect the validity or enforceability of any other provision(s).

XVII. **NO WAIVER**. No waiver of a breach of any provision of this Agreement shall be construed to be a waiver of any breach of any other provision.

XVIII. **ASSIGNABILITY**. Because this is a personal service contract, Contractor may not assign any of its rights or obligations hereunder without the prior written consent of Company, which consent will not be unreasonably withheld. Company may not assign this Agreement to any successor to all or substantially all of Company's operating assets without the prior written consent of Contractor, which consent will not be unreasonably withheld. This Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective successors and permitted assigns.

XIX. **NAME OR OWNERSHIP CHANGE**. This Agreement shall continue in full force and effect in the event of a change in the name or ownership of Company, the Hospitals or the Contractor.

XX. **AMENDMENTS**. Amendments to this Agreement shall be made only in writing duly executed by both Parties hereto.

XXI. **ENTIRE AGREEMENT**. This Agreement constitutes the entire agreement of the Parties with respect to the subject matter hereof, and supersedes all prior agreements, contracts and understandings, oral, written or otherwise, including but not limited to any prior agreements between Contractor and/or its affiliates and any of the Hospitals, including the Previous Agreement (as defined in Section I.B, above).

XXII. **MASTER AGREEMENT**. The Parties acknowledge and agree that this Agreement serves as the Master Agreement between Company and Contractor, and its terms shall govern the financial relationship between the Hospitals and the Contractor. Hospitals receiving Services pursuant to this Agreement shall be individually identified in separate agreements that are affixed as Attachments to this Agreement, as applicable, which shall outline the specific details of provider coverage and quality criteria for each Hospital. Hospitals shall be solely responsible for contracting for management and professional services from Contractor. Contractor expressly acknowledges that Company does not manage the provision of Professional Services at Hospitals. All terms of this Agreement shall be incorporated into the Hospital Agreements as if fully repeated therein verbatim.

XXIII. **THIRD PARTY BENEFICIARIES**. This Agreement is intended to, and shall be deemed and construed to create rights and/or remedies for the Hospitals, which shall be deemed third party beneficiaries to this Agreement.

XXIV. **AGREEMENT CROSS-REFERENCE**. As required by 42 C.F.R. section 411.357 (d)(1)(ii), all service agreements between Company or its affiliated Hospitals and any physician (or an immediate family member of a physician) are maintained electronically in a master contract database that is maintained and updated centrally and is available for review upon request by an authorized government official.

XXV. **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")**. Because Contractor, on behalf of the Hospitals, may provide administrative services that involve the use and/or disclosure of individually identifiable health information relating to the Hospitals' patients (the "Protected Health Information" or "PHI"), Contractor may be deemed a business associate of the Hospitals under the federal privacy regulations set forth at 45 CFR Part 160 and Part 164 (the "HIPAA Privacy Regulations"). The HIPAA Privacy Regulations require the Hospitals to have written contracts with all business associates incorporating assurances that the business associate will appropriately safeguard the Protected Health Information, as more particularly described in the HIPAA Business Associate Agreement attached hereto and incorporated into this Agreement as Exhibit 3.

[SIGNATURES TO FOLLOW ON NEXT PAGE]

IN WITNESS WHEREOF, Company and Contractor have duly executed this Agreement as of the dates set out beneath their respective signatures, and hereby certify the following:

1) As of the date of the signatures below, this Agreement constitutes a binding agreement to perform Services as of the Effective Date and may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument;
2) The compensation arrangement is established at fair market value for the Services to be rendered and this Agreement is for Services that are needed and reasonable in scope;
3) This Agreement supersedes all prior agreements, contracts and understandings, whether written or otherwise, between the Parties relating to the subject matter hereof and does not condition the payment or the arrangement on the volume or value of any referrals or other business generated between the Parties;
4) Until the Agreement is listed in Company's Master Contract Database to the extent required by 42 C.F.R. §411.357(d)(1)(ii), no payment shall be made nor Services accepted under this Agreement; and
5) Upon the Effective Date of this Agreement, to ensure that no payments are made and no Services are accepted beyond the terms of this Agreement, or the terms of other Company-approved agreements between the Parties.

CONTRACTOR:
Southeastern Emergency Physicians, LLC

Stanley Thompson, MD
Stanley Thompson, MD (Jan 18, 2023 15:56 CST)
By: Stanley Thompson, MD
Name:
Title: CCO
Date: Jan 18, 2023

COMPANY:
LifePoint Corporate Services, General Partnership

By:
Name: Brad Dep. Chris Post
Title: SVP Dep. MHD
Date: 1/19/23

EXHIBIT 1
LIST OF HOSPITALS AND SERVICE LINES

Hospital Name	Service Line	Attachment
Bluegrass Community Hospital	Emergency Medicine	
Bolivar Medical Center	Emergency Medicine	
Bourbon Community Hospital	Emergency Medicine	
Castleview Hospital	Emergency Medicine	
Clinch Valley Medical Center	Emergency Medicine	
Clinton Memorial Hospital	Emergency Medicine	
Fleming County Hospital	Emergency Medicine	
Georgetown Community Hospital	Emergency Medicine	
Haywood Regional Medical Center	Emergency Medicine	
Jackson Purchase Medical Center	Emergency Medicine	
Lake Cumberland Regional Hospital	Emergency Medicine	
Livingston Regional Hospital	Emergency Medicine	
Logan Memorial Hospital	Emergency Medicine	
Logan Regional Medical Center	Emergency Medicine	
Lourdes Medical Center	Emergency Medicine	
Meadowview Regional Med Center	Emergency Medicine	
Memorial Medical Center of Las Cruces	Emergency Medicine	
National Park Medical Center	Emergency Medicine	
Northeastern Nevada Regional Hospital	Emergency Medicine	
Ottumwa Regional Health Center	Emergency Medicine	
Palestine Regional Medical Center	Emergency Medicine	
Paris Regional Medical Center	Emergency Medicine	
Person Memorial Hospital	Emergency Medicine	
Raleigh General Hospital	Emergency Medicine	
Riverview Regional Medical Center	Emergency Medicine	
Rutherford Regional Medical Center	Emergency Medicine	
SageWest Health Care - Riverton	Emergency Medicine	
Saint Francis Medical Center	Emergency Medicine	
Saint Mary's Regional Medical Center	Emergency Medicine	
Saline Memorial Hospital	Emergency Medicine	
Scott Memorial Health	Emergency Medicine	
Southern Tennessee Regional Health System Lawrenceburg	Emergency Medicine	
Southern Tennessee Regional Health System Pulaski	Emergency Medicine	
Southern Tennessee Regional Health System Sewanee	Emergency Medicine	
Southern Tennessee Regional Health System Winchester	Emergency Medicine	
Sovah Health - Danville	Emergency Medicine	
Sovah Health - Martinsville	Emergency Medicine	
Spring View Hospital	Emergency Medicine	
Starr Regional Medical Center - Athens	Emergency Medicine	
Starr Regional Medical Center - Etowah	Emergency Medicine	
Vaughan Regional Medical Center	Emergency Medicine	
Watertown Regional Medical Center	Emergency Medicine	
Wythe County Community Hospital	Emergency Medicine	
Bluegrass Community Hospital	Hospital Medicine	
Bourbon Community Hospital	Hospital Medicine	
Fauquier Health	Hospital Medicine	
Fleming Hospital	Hospital Medicine	
Georgetown Community Hospital	Hospital Medicine	

Jackson Purchase Medical Center	Hospital Medicine	
Los Alamos Medical Center	Hospital Medicine	
Livingston Regional Hospital	Hospital Medicine	
Meadowview Medical Center	Hospital Medicine	
Memorial Medical Center of Las Cruces	Hospital Medicine	
Northeastern Nevada Regional Hospital	Hospital Medicine	
Palestine Medical Center	Hospital Medicine	
Rutherford Regional Medical Center	Hospital Medicine	
Saint Francis Medical Center	Hospital Medicine	
Scott Memorial Hospital	Hospital Medicine	
Spring View Hospital	Hospital Medicine	
Trios Health	Hospital Medicine	
Twin County regional Hospital	Hospital Medicine	
Northeastern Nevada Regional Hospital*	Anesthesia	
Paris Regional Medical Center*	Anesthesia	
Canyon Vista Medical Center	Anesthesia	
Conemaugh Nason Medical Center*	Anesthesia	
Conemaugh Memorial Medical Center*	Anesthesia	
Conemaugh Myersdale Medical Center*	Anesthesia	
UP Health System-Portage	Anesthesia	

Anesthesia Services Effective Dates

Hospital Name*	Service Line	Effective Date of Services	Effective Date of Calculation under the Master Agreement*
Northeastern Nevada Regional Hospital	Anesthesia	May 19, 2019	May 1, 2022
Paris Regional Medical Center	Anesthesia	June 1, 2021	January 1, 2022
Canyon Vista Medical Center	Anesthesia	December 1, 2022	December 1, 2022
Conemaugh Nason Medical Center	Anesthesia	January 1, 2022	January 1, 2022
Conemaugh Memorial Medical Center	Anesthesia	February 1, 2022	February 1, 2022
Conemaugh Myersdale Medical Center	Anesthesia	February 1, 2022	February 1, 2022
UP Health System Portage	Anesthesia	September 1, 2022	September 1, 2022

*For purposes of the Cost-Plus calculation occurring under the Master Agreement, the compensation methodology for the above-noted facilities will commence calculation pursuant to the Master Agreement effective as of the dates set forth in the table above, notwithstanding the fact that Anesthesia services commenced on an earlier date. Additional Anesthesia sites will be supplemented to the table above, as necessary.

EXHIBIT 2
SUBSIDY CALCULATION

Example: subsidy Calculation

LifePoint Group Semi Annual			Start Date	Total Cost of Services (1)	Premium Labor Differential (2)	Margin (3)	Total Cost + 10% (4)	Total Net FFS Revenue (5)	Net Subsidy Due (6)	Margin % (7)	Monthly Invoice Amount (8)	Net Subsidy Due Calculation
Central	Bluegrass Community Hosp. LPG		1/1/2013	1,711,678	-	171,168	1,882,845	1,060,264	822,582	9.09%	68,548.47	
Central	Bluegrass Community Hosp. HM		1/1/2013	490,732	-	49,073	539,806	110,862	428,944	9.09%	35,745.33	
Central	Bourbon Community Hosp. HM		1/1/2013	818,358	-	81,836	900,194	345,661	554,533	9.09%	46,211.07	
Central	Bourbon Community Hosp. LPG		1/1/2013	1,853,975	148,052	185,397	2,039,372	1,488,222	699,202	8.48%	58,266.80	
Central	Clinton Memorial EM		11/1/2019	3,423,151	20,000	342,315	3,765,466	3,640,730	144,736	9.04%	12,061.30	
Central	Fleming County LPG		10/1/2012	1,644,564	-	164,456	1,809,020	905,235	903,785	9.09%	75,315.44	
Central	Fleming HM		6/1/2019	582,561	-	58,256	640,817	190,285	450,532	9.09%	37,544.37	
Central	Georgetown Community Hosp.. LPG		1/1/2013	3,254,810	57,319	325,481	3,580,291	3,709,669	(72,058)	8.95%	(6,004.86)	
Central	Georgetown Community Hosp. HM		1/1/2013	1,473,185	28,329	147,319	1,620,504	750,271	898,561	8.93%	74,880.11	
Central	Jackson Purchase LPG		1/1/2013	2,829,136	-	282,914	3,112,050	2,766,914	345,136	9.09%	28,761.35	
Central	Jackson Purchase MC HM		1/1/2013	1,223,474	-	122,347	1,345,821	913,436	432,386	9.09%	36,032.15	
Central	Lake Cumberland LPG		1/1/2013	5,205,324	-	520,532	5,725,856	5,662,979	62,877	9.09%	5,239.78	

Central	Logan Memorial Hosp. LPG		6/1/2013	2,033,319	-	203,332	2,236,651	1,552,277	684,373	9.09%	57,031.12
Central	Logan Regional Hosp. LPG		3/20/2012	3,752,365	-	375,237	4,127,602	3,565,603	561,999	9.09%	46,833.23
Central	Meadowview Regional LPG		1/1/2013	2,778,395	-	277,840	3,056,235	2,520,811	535,424	9.09%	44,618.63
Central	Meadowview HM		6/1/2019	1,607,090	5,663	160,709	1,767,799	797,906	975,555	9.06%	81,296.29
Central	Raleigh General Hosp. LPG		1/1/2010	5,550,846	42,340	555,085	6,105,931	5,414,901	733,369	9.03%	61,114.12
Central	Scott Memorial Hospital - HM		9/1/2014	385,443	36,000	38,544	423,987	213,742	246,245	8.38%	20,520.44
Central	Scott Memorial Hosp. LPG		5/26/2011	1,868,913	-	186,891	2,055,804	1,839,411	216,394	9.09%	18,032.79
Central	Springview Hospital LPG		1/1/2013	2,044,128	30,000	204,413	2,248,541	2,081,691	196,850	8.97%	16,404.16
Central	Springview Hospital HM		1/1/2013	901,301	-	90,130	991,431	401,602	589,830	9.09%	49,152.49
Central	St. Francis Health LPG		1/1/2016	6,705,681	-	670,568	7,376,249	6,608,893	767,355	9.09%	63,946.28
Central	St Francis Hospital Col. HM		1/1/2016	6,059,270	7,702	605,927	6,665,197	3,519,884	3,153,014	9.08%	262,751.16
Central	St. Francis ICU		1/29/2020	3,278,218	-	327,822	3,606,040	1,790,889	1,815,151	9.09%	151,262.58
Central	Vaughan Reg. Med Ctr. LPG		3/31/2013	3,555,726	24,000	355,573	3,911,298	2,389,639	1,545,660	9.04%	128,804.97
Central Total				65,031,642	399,404	6,503,164	71,534,806	54,241,775	17,692,435		1,474,370
East	Clinch Valley Med Ctr. LPG		10/24/2010	2,970,379	-	297,038	3,267,417	2,524,125	743,291	9.09%	61,940.94
East	Danville Regional LPG		7/1/2015	5,789,928	-	578,993	6,368,921	5,411,736	957,185	9.09%	79,765.44
East	Haywood Regional LPG		1/1/2010	3,407,251	-	340,725	3,747,977	3,475,479	272,497	9.09%	22,708.12
East	Martinsville and Henry LPG		7/1/2012	4,903,238	-	490,324	5,393,562	5,061,802	331,760	9.09%	27,646.65
East	Person Memorial Hosp. LPG		5/31/2015	2,569,767	-	256,977	2,826,744	1,967,690	859,054	9.09%	71,587.86
East	Rutherford Hospital		1/1/2010	2,465,799	48,863	246,580	2,712,379	1,378,043	1,383,199	8.93%	115,266.57

East	Rutherford Regional LPG		9/2/2016	3,795,666	14,400	379,567	4,175,233	3,321,961	867,672	9.06%	72,305.99	
East	Wythe Community Hosp. LPG		4/1/2006	2,889,233	-	288,923	3,178,157	2,704,943	473,214	9.09%	39,434.51	
East Total				28,791,262	63,263	2,879,126	31,670,389	25,845,778	5,887,873		490,656	
							-					
Mountain	Bolivar Medical Center LPG		4/7/2014	2,970,067	60,000	297,007	3,267,074	2,026,615	1,300,460	8.93%	108,371.63	
Mountain	Livingston Reg. Hosp. LPG		5/8/2000	2,184,444	-	218,444	2,402,889	1,811,413	591,476	9.09%	49,289.68	
Mountain	LP Ottumwa Regional Health Ctr.		3/1/2019	3,022,220	115,342	302,222	3,324,442	2,309,474	1,130,310	8.79%	94,192.50	
Mountain	LP Palestine Regional Med Ctr.		4/1/2018	4,246,895	-	424,690	4,671,585	4,385,833	285,751	9.09%	23,812.62	
Mountain	LP Palestine Regional Med HM		4/1/2018	2,474,226	1,500	247,423	2,721,649	1,232,609	1,490,540	9.09%	124,211.68	
Mountain	LP Paris Regional Med Ctr.		7/1/2020	4,100,966	-	410,097	4,511,062	4,155,521	355,541	9.09%	29,628.40	(Total cost of services + Margin +Premium
Mountain	Riverview Regional LPG		1/1/2010	1,765,639	-	176,564	1,942,203	1,379,665	562,538	9.09%	46,878.17	Labor Differential) less Total Net FFS Revenue
Mountain	Saint Mary's Regional Med Ctr.		5/6/2020	3,716,455	126,030	371,645	4,088,100	3,831,312	382,819	8.82%	31,901.56	
Mountain	Saline Memorial Hospital		8/1/2020	3,627,048	175,952	362,705	3,989,753	3,823,450	342,256	8.71%	28,521.30	
Mountain	Southern TN Med Ctr. LPG		1/1/2010	2,973,843	-	297,384	3,271,228	3,179,155	92,073	9.09%	7,672.75	
Mountain	S. TN Reg. HS - Sewanee LPG		1/1/1996	1,518,023	14,400	151,802	1,669,826	892,015	792,211	9.01%	66,017.54	
Mountain	S. TN Reg. - Lawrenceburg LPG		1/1/2010	2,397,211	69,996	239,721	2,636,932	2,236,451	470,476	8.86%	39,206.37	
Mountain	Star Reg. Med Ctr. - Athens LPG		11/1/1982	3,279,824	-	327,982	3,607,806	3,532,217	75,589	9.09%	6,299.09	
Mountain	Star Reg Med Ctr. - Etowah LPG		4/1/2013	1,857,819	-	185,782	2,043,601	1,274,686	768,916	9.09%	64,076.30	
Mountain	S. TN Reg. HS - Pulaski LPG		1/1/2010	2,272,067	-	227,207	2,499,274	2,021,045	478,229	9.09%	39,852.44	

Mountain	Watertown Medical Center LPG		10/1/2016	2,603,099	48,000	260,310	2,863,409	2,027,674	883,735	8.94%	73,644.61
Mountain Total				45,009,849	611,220	4,500,985	49,510,833	40,119,134	10,002,920		833,577
							-				
West	LP Memorial Med Ctr. Las Cruces		9/1/2017	5,615,741	-	561,574	6,177,315	7,311,264	(1,133,949)	9.09%	(94,495.75)
West	LP Memorial Medical Center HM		11/1/2016	2,995,338	11,415	299,534	3,294,872	2,316,553	989,734	9.06%	82,477.80
West	LP Northeastern Nevada Reg. Hos		2/10/2015	3,552,543	-	355,254	3,907,797	5,077,429	(1,169,632)	9.09%	(97,469.30)
West	LP Northeastern Nevada HM		9/1/2015	1,440,180	6,000	144,018	1,584,198	615,899	974,300	9.06%	81,191.63
West	Northeastern Nevada Reg. Hosp.		5/19/2019	1,393,006	-	139,301	1,532,307	862,251	670,056	9.09%	55,837.99
West	LP Our Lady of Lourdes		1/1/2019	3,162,958	-	316,296	3,479,254	2,775,647	703,607	9.09%	58,633.92
West	LP Riverton Memorial Hospital		8/1/2011	2,654,398	-	265,440	2,919,838	1,630,099	1,289,739	9.09%	107,478.27
West	LP Trios Health HM		10/26/2020	2,844,708	62,096	284,471	3,129,179	2,025,052	1,166,223	8.91%	97,185.27
West Total				23,658,873	79,511	2,365,887	26,024,760	22,614,194	3,490,078		290,840
Grand Total		Same Contract Sites 2020		162,491,626	1,153,398	16,249,163	178,740,789	142,820,881	37,073,306		3,089,442
Mountain	National Park Medical Ctr. LPG	New 2021	4/21/2021	3,036,653	94,800	266,128	3,302,781	2,757,956	639,626	7.83%	53,302.15
Mountain	LP Paris Regional Medical Ctr.	New 2021	6/1/2021	4,147,012	-	327,436	4,474,448	3,144,161	1,330,287	7.32%	110,857.23

East	LP Conemaugh Nason Med Ctr.	New 2022	1/1/2022	2,376,510	-	125,079	2,501,589	1,517,143	984,446	5.00%	82,037.17
Central	Fauquier Medical Center Peds.	New 2022	1/29/2022	1,286,535	-	64,327	1,350,862	176,386	1,174,476	4.76%	97,873.00
Central	Fauquier Medical Center HM	New 2022	1/29/2022	2,529,603	-	126,480	2,656,083	1,327,496	1,328,587	4.76%	110,715.58
Central	Fauquier Medical Center ICU	New 2022	1/29/2022	1,442,748	-	72,137	1,514,885	546,408	968,477	4.76%	80,706.42
East	LP Conemaugh Memorial Med Ctr.	New 2022	2/1/2022	11,724,632	-	1,000,775	12,725,407	7,896,090	4,829,317	7.86%	402,443.08
East	LP Conemaugh Meyersdale Md. Ctr	New 2022	2/1/2022	57,854	-	5,301	63,155	45,878	17,277	8.39%	1,439.75
West	LP Castleview Hospital	New 2022	2/1/2022	2,444,830	-	122,242	2,567,072	2,118,025	449,047	4.76%	37,420.58
West	LP Los Alamos Medical Ctr. HM	New 2022	2/6/2022	923,827	-	46,191	970,018	195,361	774,658	4.76%	64,554.80
East	Twin County Regional HM	New 2022	4/27/2022	1,856,410	-	92,821	1,949,231	858,992	1,090,239	4.76%	90,853.29
Grand Total		New Contracts		31,826,615	94,800	2,248,917	34,075,532	20,583,896	13,586,437		1,132,203
Combined Grand total		Same Contract Sites 2022 , New 2021, New 2022		194,318,241	1,248,198	18,498,080	212,816,321	163,404,777	50,659,742	-	4,221,645

EXHIBIT 3
HIPAA BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement (the "Agreement") is made by and among LPNT for itself and one or more of its Hospitals, clients and/or affiliates that are "covered entities" or "business associates" within the meaning of the Privacy and Security Rules (hereinafter individually and collectively referred to as "Covered Entity") and Contractor (hereinafter individually and collectively referred to as "Business Associate"). Covered Entity and Business Associate shall be collectively referred to herein as the "Parties".

WHEREAS, Covered Entity is entering into a business relationship with Business Associate that is memorialized in that certain Exclusive Emergency Department And Hospitalist Services Master Agreement, as may be amended from time to time (the "Underlying Agreement") pursuant to which Business Associate may be considered a "business associate" or "subcontractor" of Covered Entity as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including all pertinent regulations (45 CFR Parts 160 and 164) issued by the U.S. Department of Health and Human Services as either have been amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5) (collectively "HIPAA Law");

WHEREAS, the nature of the prospective contractual relationship between Covered Entity and Business Associate may involve the exchange of Protected Health Information ("PHI") as that term is defined under HIPAA Law and Sensitive Information (as defined below); and

WHEREAS, for good and lawful consideration as set forth in the Underlying Agreement, Covered Entity and Business Associate enter into this Agreement for the purpose of ensuring compliance with the requirements of the HIPAA Law and relevant state law.

NOW THEREFORE, the premises having been considered and with acknowledgment of the mutual promises and of other good and valuable consideration herein contained, the Parties, intending to be legally bound, hereby agree as follows:

I. DEFINITIONS. Terms not defined below shall have the meaning set forth in the HIPAA Law.

A. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g). With respect to Sensitive Information, "Individual" shall mean a natural person whose records containing Sensitive Information are maintained or accessed by Business Associate or disclosed by Covered Entity to Business Associate pursuant to the Underlying Agreement.

B. Breach. "Breach" shall have the same meaning as the term "breach" in 45 CFR §164.402 with respect to PHI and, with respect to Sensitive Information, shall mean any actual or suspected unauthorized disclosure, use of or access to Sensitive Information, or actual or suspected loss of Sensitive Information.

C. Designated Record Set. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR §164.501.

D. Electronic Protected Health Information, EPHI or Electronic PHI. "Electronic Protected Health Information", "EPHI" or "Electronic PHI" shall have the same meaning as the term "electronic protected health information" in 45 CFR §160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

E. Encrypt, Encrypted or Encryption. With respect to PHI, any encryption requirements set forth in this Agreement must meet the U.S. Department of Health and Human Services Guidance Specifying the Technologies and Methodologies that Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of HITECH Act.

With respect to other information and data, such references mean the process of transforming information (referred to as plaintext) using an algorithm (cipher) to make the information unreadable except to those possessing special knowledge, usually referred to as a key, and encryption must meet or exceed standards, guidelines and best practices issued by the National Institute of Standards and Technology (NIST), as in effect from time to time.

F. Limited Data Set. "Limited Data Set" has the same meaning as the term "limited data set" in 45 CFR §164.514(e)(2).

G. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E, as amended by the HITECH Act and as may otherwise be amended from time to time.

H. Protected Health Information or PHI. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR §160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. As used in this Agreement, Protected Health Information shall also include Electronic PHI.

I. Required by Law. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR §164.103, with respect to any matter involving PHI. With respect to Sensitive Information, "Required by Law" means a mandate contained in law that compels an entity to make a use or disclosure of Sensitive Information and that is enforceable in a court of law, and includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; and statutes or regulations that require the production of information.

J. Secretary. "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or his or her designee.

K. Security Incident. "Security Incident" shall have the same meaning as the tenor "security incident" in 45 CFR §164.304 with respect to PHI and with respect to Sensitive Information shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of Sensitive Information or interference with system operations in an information system.

L. Security Rule. The "Security Rule" shall mean the regulations found at 45 CFR Part 160 and Part 164, Subparts A and C, as amended by the HITECH Act and as may otherwise be amended from time to time.

M. Sensitive Information. "Sensitive Information" shall mean: (i) trade secrets, (ii) all business and proprietary information, (iii) patient-related information that is not PHI, including without limitation de-identified PHI that identifies Covered Entity or any of its affiliates or practitioners, (iv) any information that identifies, relates to, describes, or is capable of being associated with a particular Individual such as a person's name, signature, social security number, passport number, driver's license or state identification card number, insurance policy number, education, employment history, bank account number, credit card number, debit card number or any financial information, (v) any information that is designated by the disclosing Party as confidential, or (vi) any non-public information relating to Covered Entity received by Business Associate under the Underlying Agreement or learned by Business Associate about Covered Entity during the term period of this Agreement; regardless of the material or physical form on which such information is recorded or preserved, which may be by any means, including in written or spoken words, graphically depicted, printed or electromagnetically transmitted.

N. State Privacy and Security Laws. "State Privacy and Security Laws" shall mean all applicable state laws relating to privacy, security, data breach and confidentiality of the information provided to Business Associate under this Agreement.

O. Subcontractor. "Subcontractor" shall have the same meaning as the term "subcontractor" in 45 CFR § 160.103, except as otherwise provided in Article VII.

P. Unsecured Protected Health Information. "Unsecured Protected Health Information" or "Unsecured PHI" shall have the same meaning as the term "unsecured protected health information" in 45 CFR §164.402.

II. **APPLICABILITY.** This Agreement applies to the Underlying Agreement and any and all other agreements and relationships between Covered Entity and Business Associate, whether written or verbal, pursuant to which Covered Entity provides or will provide any Protected Health Information or Sensitive Information to Business Associate in any form whatsoever (collectively, the "Underlying Agreement"), whether Business Associate is characterized as a "business associate" under HIPAA or whether Business Associate is characterized as a "subcontractor" under HIPAA. As of the Effective Date, this Agreement shall automatically amend and be incorporated as part of the Underlying Agreement, whether or not specifically referenced therein. Should there be any conflict between the language of this Agreement and the Underlying Agreement (either previous or subsequent to the date of this Agreement), the language and provisions of this Agreement shall control and prevail unless the Parties specifically refer in a subsequent written agreement to this Agreement by its title and date and specifically state that the provisions of the later written agreement shall control over this Agreement. Business Associate acknowledges and agrees that this Agreement and the standards established hereunder will apply to all PHI received, accessed or created by Business Associate, whether the Covered Entity to which such PHI relates is characterized as a "covered entity" under HIPAA, or is characterized as a "business associate" under HIPAA.

III. **USE OR DISCLOSURE OF PHI BY BUSINESS ASSOCIATE.**

A. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Underlying Agreement, provided that such use or disclosure would not violate the Privacy Rule, if done by Covered Entity.

B. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out its legal responsibilities. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the PHI will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

C. Business Associate shall only use and disclose PHI if such use or disclosure complies with each applicable requirement of 45 CFR §164.504(e), and shall only access, request, use and disclose the minimum information necessary to perform the duties required for Covered Entity, consistent with the requirements of 45 CFR §164.502.

D. Business Associate shall use reasonable efforts to limit its access, uses, disclosures, and requests for PHI to (i) a Limited Data Set unless Business Associate submits a written justification for additional data elements under the Covered Entity's Third Party Data Release Policy and Covered Entity specifically approves such request, and (ii) the minimum necessary to accomplish the intended purposes of such use, disclosure or request, in accordance with the minimum necessary standards at 45 CFR §§ 164.502(b) and 164.514(d) and in any guidance issued by the Secretary.

E. Business Associate may not use PHI in a manner or to accomplish a purpose or result that would violate the HIPAA Privacy or Security Rules, including without limitation engaging in information blocking or otherwise terminating Covered Entity's ability to access the PHI. Without submitting a complete and accurate solution risk analysis tool to Covered Entity and obtaining the prior written consent of LifePoint Health's Information Governance Officer (who may be contacted at infogov@lpnt.net), neither Business Associate nor its agents or subcontractors shall transfer or export any PHI or Sensitive Information outside the United States or store any PHI or Sensitive Information in a hosted/cloud computing environment. Additionally, Business Associate shall not use, authorize to use or disclose the PHI or Sensitive Information for the purpose of developing information or statistical compilations for use by third parties or other division or subsidiary of Business Associate or for any commercial exploitation.

IV. DUTIES OF BUSINESS ASSOCIATE RELATIVE TO PHI.

A. Business Associate shall not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

B. Business Associate shall be directly responsible for full compliance with the relevant requirements of the Privacy Rule to the same extent as Covered Entity.

C. Business Associate shall comply with the applicable provisions of the Security Rule directing the implementation of Administrative, Physical and Technical Safeguards for Electronic Protected Health Information and the development and enforcement of related policies, procedures, and documentation standards (including but not limited to designation of a security official), and shall enter into written agreements with any Subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of Business Associate pursuant to which the Subcontractors shall agree to comply with the applicable requirements of the Security Rule. Business Associate shall implement safeguards and policies, procedures, and documentation consistent with the requirements of 45 C.F.R. §§ 164.306, 164.308, 164.310, 164.312, 164.314 and 164.316. Any hard drives on any computers or laptops that are used to access, receive, send, or maintain Covered Entities' Electronic Protected Health Information must be Encrypted and all communications must be Encrypted if sending Electronic Protected Health Information over an open network. Mobile devices or external or removable media, including, without limitation backup tapes, used for sending, receiving, or storing Electronic Protected Health Information must be Encrypted and password protected.

D. In the event of an unauthorized use or disclosure of PHI or a Breach of Unsecured PHI, Business Associate shall mitigate, to the extent practicable, any harmful effects of said disclosure that are known to it.

E. Business Associate agrees to enter into a written agreement with any Subcontractor that creates, receives, maintains, or transmits PHI on behalf of Business Associate, which complies with the requirements of 45 C.F.R. § 164.504(e)(2) through (e)(4), and pursuant to which the Subcontractor agrees to the same restrictions and conditions that apply to Business Associate with respect to such PHI and agrees to implement reasonable and appropriate safeguards, which shall be no less than that required of Business Associate under the Underlying Agreement, to protect the PHI.

F. To the extent applicable, Business Associate shall provide access to Protected Health Information in a Designated Record Set at reasonable times, at the request of Covered Entity or, as directed by Covered Entity, to an Individual (or Individual's designee) in order to meet the requirements under 45 CFR § 164.524. Business Associate shall notify Covered Entity within five (5) days of receipt of any request for access by an Individual. Covered Entity shall determine whether to grant or deny any access requested by the Individual. The information shall be provided in the form or format requested, if it is readily producible in such form or format, or in summary, if the Individual has agreed in advance to accept the information in summary form. If the Individual requests an electronic copy of his or her PHI maintained in a Designated Record Set electronically, Business Associate shall provide the Individual (or Individual's designee) with access to the information in the electronic form and format requested by the Individual, if it is readily producible in such form or format, or, if not, in a machine readable electronic form and format agreed to by the Individual. No fee for copying or providing access to the PHI may be charged.

G. If Business Associate maintains a Designated Record Set on behalf of Covered Entity, Business Associate shall amend the PHI maintained by Business Associate as directed by Covered Entity within five (5) days of such request. Business Associate shall notify Covered Entity within five (5) days of receipt of any request for amendment by an Individual. Business Associate shall promptly make amendment(s) to Sensitive Information requested by Covered Entity and will do so in the time and manner requested by Covered Entity to enable it to comply with law. Covered Entity shall determine whether to grant or deny any access or amendment requested by an Individual. Business Associate shall have a process in place for requests for amendments and for appending such requests to the Designated Record Set, as requested by Covered Entity. No fee for copying or amending the PHI or Sensitive Information may be charged.

H. Business Associate shall, upon request with reasonable notice and at no charge, provide Covered Entity access to its premises for a review and demonstration of its internal practices and procedures for safeguarding PHI. The fact that Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's

premises, systems, policies and procedures does not relieve Business Associate of its responsibility to comply with this Agreement, nor does Covered Entity's: (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of Covered Entity's enforcement rights under this Agreement.

I. Business Associate agrees to document and make available such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528 and Section 13405(c) of the HITECH Act, and any implementing regulations. Should an Individual make a request to Covered Entity for an accounting of disclosures of his or her PHI pursuant to 45 C.F.R. § 164.528, Business Associate agrees to promptly provide Covered Entity with information in a format and manner sufficient to respond to the Individual's request. No fee for providing the accounting of disclosures of PHI may be charged. This Section shall survive termination of the Agreement.

J. If an Individual requests Business Associate to restrict the use or disclosure of PHI, Business Associate will forward the request to Covered Entity within five (5) days of Business Associate's receipt of the request. Covered Entity will be responsible for making all determinations regarding the grant or denial of an Individual's request for restrictions, and Business Associate will make no such determinations. Business Associate will restrict the use or disclosure of PHI consistent with Covered Entity's instructions, and shall further comply with any Individual's request for restrictions on PHI disclosures that Covered Entity or Business Associate is required by law to honor, including without limitation, requested restrictions on payment or health care operations-related disclosures to health plans when the Individual (or other person on behalf of the Individual) has paid the Individual's health care provider in full, unless otherwise required by law. No fee for providing the restriction of PHI may be charged.

K. Business Associate shall make its internal practices. books, records, and any other material requested by the Secretary relating to the use, disclosure, and safeguarding of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for the purpose of determining compliance with the Privacy Rule or other laws. The aforementioned information shall be made available to the Secretary in the manner and place as designated by the Secretary or the Secretary's duly appointed delegate. Under this Agreement. Business Associate shall comply and cooperate with any request for documents or other information from the Secretary directed to Covered Entity that seeks documents or other information held by Business Associate. Notwithstanding this provision, no attorney-client, accountant-client or other legal privilege will be deemed waived by Business Associate or Covered Entity as a result of this Section. Except to the extent prohibited by law, Business Associate agrees to notify Covered Entity immediately upon receipt by Business Associate of any and all requests by or on behalf of any and all government authorities served upon Business Associate relating to this Section or Protected Health Information.

L. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 42 C.F.R. §164.502(j)(1).

M. Business Associate may not de-identify any Protected Health Information without the express prior written consent of the Covered Entity, and if such consent is given, Business Associate must comply with the requirements set forth at 45 C.F.R. § 164.514 for de-identifying PHI. Business Associate may only use PHI to provide Data Aggregation services to the extent expressly required pursuant to the Underlying Agreement and only as permitted for Covered Entity's health care operations under 45 CFR § 164.504(e)(2)(i)(B). Business Associate will not disclose any Limited Data Set, de-identified, or aggregated data derived from PHI (collectively, "Derivative Data") that divulges Covered Entity's name or any identifying information of Covered Entity or any of its affiliates or practitioners without providing at least thirty (30) calendar days advance written notice to Covered Entity for pre-distribution review and an opportunity to redact any information Covered Entity considers confidential, including any reference to the Covered Entity, its affiliates or practitioners. In any event, Covered Entity shall have sole ownership of any Derivative Data unless Covered Entity specifically agrees otherwise in writing in advance of its creation. Business Associate shall not sell any Protected Health Information without the express prior written consent of Covered Entity. Business Associate shall not transmit, to any Individual for whom Business Associate has Protected Health Information, any communication about a product or service that encourages the recipient of the communication to purchase or use that product or service in violation of any of the marketing prohibitions set forth in the HIPAA Law. Business Associate shall not use or disclose Protected Health Information for fundraising purposes as prohibited under the HIPAA Law.

N. Covered Entity shall have the right, at its expense, during Business Associate's normal business hours, to evaluate, test, and review Business Associate's HIPAA-HITECH policies and procedures, facilities, books, records and systems which contain Covered Entity's PHI and EPHI in order to ensure compliance with the terms and conditions of this Agreement and the HIPAA Law. Covered Entity shall have the right to conduct such audit by use of its own employees or by use of outside consultants and auditors. Business Associate agrees to cooperate with Covered Entity, and to otherwise provide any reasonable assistance to Covered Entity necessary for Covered Entity to carry out any audit as permitted herein, at no additional cost to Covered Entity. Upon Covered Entity's written request, Business Associate agrees to provide an annual written attestation of its compliance to the HIPAA Law in the form and format requested by Covered Entity in order to obtain satisfactory assurances in accordance with the HIPAA Law that Business Associate will appropriately safeguard the information with which it is entrusted. Covered Entity shall protect the confidentiality of all confidential and proprietary information of Business Associate to which Covered Entity or its agents have access during the course of such audit. The fact that Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, system, books, records, agreements, policies and procedures does not relieve Business Associate of its responsibility to comply with this Agreement, nor does Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of Covered Entity's enforcement rights under this Agreement. Notwithstanding the foregoing, Covered Entity assumes no obligation to perform any inspection or audit of Business Associate's practices or policies, and assumes no liability for any violation or breach caused by Business Associate, whether an audit is performed or not.

O. To the extent Business Associate is to carry out any covered entity obligation of Covered Entity under the Privacy Rule, Business Associate shall agree to comply with the same Privacy Rule requirements that apply to Covered Entity in the performance of such obligation. When accessing or using the systems, information or facilities of any Covered Entity, Business Associate will comply with all applicable policies and procedures of the Covered Entity.

P. Business Associate acknowledges and agrees that PHI may include Patient Identifying Information (as defined under 42 C.F.R. § 2.11) of, from or relating to a Program (as defined under 42 C.F.R. § 2.11). Notwithstanding any agreement to the contrary, Business Associate acknowledges and agrees (1) that in receiving, storing, processing or otherwise dealing with any Patient Identifying Information (as defined under 42 C.F.R. § 2.11), Business Associate is fully bound by the regulations set forth at 42 C.F.R. Part 2, as amended from time to time; (2) if necessary, Business Associate will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by 42 C.F.R. Part 2, and (3) Business Associate will not access, use or disclose Patient Identifying Information (as defined under 42 C.F.R. § 2.11) if such access, use or disclosure would result in a violation of law.

V. REPORTING.

A. Privacy Breach. Business Associate will report to Covered Entity any use or disclosure of Covered Entity's PHI or Sensitive Information that is not permitted by this Agreement or the Underlying Agreement within two (2) business days of discovery of the unauthorized use or disclosure. In addition, Business Associate will report to Covered Entity following discovery and without unreasonable delay, but in no event later than two (2) days following discovery of any suspected or actual Breach of Unsecured Protected Health Information or Sensitive Information or any actual or suspected disclosure or inappropriate access of Covered Entity's information which is subject to State Privacy and Security Laws. Business Associate shall cooperate with Covered Entity in investigating the potential or actual breach, disclosure or inappropriate access and in meeting Covered Entity's obligations under the HITECH Act and any other state or federal privacy or security breach notification laws, including, without limitation, assisting the Covered Entity with performing a risk assessment as set forth in 45 C.F.R. §164.402(2) and providing any information and documentation related to such risk assessment to the Covered Entity promptly upon request. Any such report shall contain at a minimum the information set forth on Appendix 4 attached hereto and incorporated by reference. Since time is of the essence under the HITECH Act and State Privacy and Security Laws, in addition to providing the report in accordance with the notice provisions contained in Section XIII.E below, a copy of the report shall be emailed to the Covered Entity's Privacy Officer At reportable.eventrdipnt.net or to such other person as Covered Entity shall request in writing of Business Associate. To the extent any Breach of Unsecured Protected Health Information or Sensitive Information or unauthorized acquisition or access to information subject to State Privacy and Security Laws is attributable to either: (i) a breach of the obligations under this Agreement by Business Associate or (ii) a violation of the HIPAA Law or State Privacy and Security Laws by Business Associate

or its Subcontractors, Business Associate shall bear (a) the costs incurred by Covered Entity in complying with its legal obligations relating to such breach or violation, and (b) in addition to other damages for which Business Associate may be liable for under this Agreement, the following expenses incurred by Covered Entity in responding to such breach: (1) the cost of preparing and distributing notifications to affected Individuals, (2) the cost of providing notice to government agencies, credit bureaus, and/or other required entities, (3) the cost of providing affected Individuals with credit monitoring services for a specific period not to exceed twenty-four (24) months, or longer if required by law, to the extent the incident could lead to a compromise of the data subject's credit or credit standing, (4) call center support for such affected Individuals for a specific period not to exceed thirty (30) days from the date the breach notification is sent to such affected Individuals and (5) the cost of any other measures required under applicable law.

B. Security Incident. Unless otherwise reportable as a Breach of Unsecured PHI or State Privacy and Security Law breach. Business Associate agrees to report to Covered Entity any Security Incident affecting Electronic Protected Health Information of Covered Entity within two (2) business days of becoming aware of the Security Incident. Business Associate shall mitigate. to the greatest extent practicable, any harmful effect known to Business Associate of a Security Incident and follow the HHS Office for Civil Rights HIPAA Guidance on Ransomware with respect to security incidents involving malware.

VI. **SENSITIVE INFORMATION**. This Article VI shall apply only Wand to the extent that Business Associate is given access to Sensitive Information, as defined above. Business Associate may use or disclose Sensitive Information only for the benefit of Covered Entity and to perform functions, activities, or services for the benefit of Covered Entity as specified in the Underlying Agreement and in accordance with the policies and procedures of Covered Entity. Except as otherwise limited in this Agreement, Business Associate may disclose Sensitive Information as Required by Law. To the extent Business Associate discloses Sensitive Information to third-parties. Business Associate shall obtain reasonable assurances from the person to whom the information is disclosed that the Sensitive Information will remain confidential and be used or further disclosed only as Required by Law or in accordance with the standards applicable to Business Associate under this Agreement, with requirements that the recipient notify Business Associate of any instances of which it is aware in which the confidentiality of the information has been Breached. Business Associate warrants, represents and agrees that each of the data elements of any Sensitive Information that it may access or receive from or on behalf of Covered Entity is minimally necessary to permit Business Associate to provide the services under the Underlying Agreement. Business Associate will use appropriate safeguards and procedures to prevent further use, unauthorized access, destruction, modification, or disclosure of Sensitive Information other than as provided for by the Underlying Agreement and this Agreement, and will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, security, integrity and availability of Sensitive Information that it receives, maintains, transmits or creates on behalf of Covered Entity, which in any event shall be no less than the Payment Card Industry ("PCI") Security Standards. Business Associate will promptly notify Covered Entity of any attempted or successful unauthorized access, use, disclosure, modification, or destruction of Sensitive Information or interference with system operations in an information system. To the extent that Sensitive Information is licensed by Covered Entity from third parties. Business Associate will comply with all restrictions and terms of any third party licenses. Further, Business Associate will (I) provide Covered Entity with access to the Sensitive information as requested by Covered Entity, and (2) comply with the standards and requirements of Sections IV.A, C, D, E. H, and K with respect to Sensitive information in the same manner as such provisions apply to PHI and EPH I.

VII. **SECURITY OF CUSTOMER DATA.**

A. Definitions. The following definitions will apply only with respect to terms of this Article VII:

1. "Authorized User" means: (a) Covered Entity and each of its employees, clients, patients and authorized agents and contractors, including, without limitation, physicians, nurses and medical staff, whether on-site or remote, affiliated with Covered Entity; (b) consultants and other independent contractors performing services for Covered Entity; and (c) any governmental bodies lawfully requesting or requiring access to facilities of Covered Entity.

2. "Customer Data" means all data and information provided to Business Associate by or on behalf of Covered Entity for processing, all user traffic and access data, usage statistics, images, and individual identifiable and other profile data generated or collected by or for Business Associate in connection with Covered Entity's and Authorized Users' use of the Software and Services, the document indexes and table structures used to organize any of the foregoing data, and any and all updates or modifications to or derivatives of any of the foregoing made by or for Business Associate.

3. "Disabling Code" means any virus, worm, trap door, back door, timer, counter or other limiting routine, instruction or design that would erase or alter data or programming or cause any Software, Service, or the network, equipment, or data of a Covered Entity, Affiliates and/or third parties to become inaccessible, inoperable or incapable of being used in the full manner for which it was designed, licensed or created, which otherwise disrupt the proper operation of any system, or compromise the confidentiality of any information of Covered Entity, Affiliates and/or third parties.

4. "Documentation" means: (a) all operations, design, user manuals (operational, educational and otherwise) and maintenance and support manuals and all other written materials related to any Software or Service; (b) any report, specifications, or other written Work Product produced by Business Associate for, or at the request of, Covered Entity that describes any Software or Service.

5. "Product" means anything provided by Business Associate to Covered Entity under the Underlying Agreement other than Services or Work Product.

6. "Service" means any service provided by Business Associate to Covered Entity under the Underlying Agreement.

7. "Software" means any Product or Work Product provided to Covered Entity under the Underlying Agreement. As used herein, the term "Software" includes Documentation, unless the context otherwise requires.

8. "Strong Authentication" means an authentication system that leverages two different types of data that serve as proof of the identity of the specific user trying to authenticate (e.g., a certificate and a password, a password and the answer to a secret user question, SecurID Token Code and PIN, or a password and Encrypted session cookie). User identifiers (UIDs) are never considered one of the factors in Strong Authentication.

9. "Strong Password" means a password that contains at least seven (7) characters in length and contains characters from at least three of the following categories: (i) upper case letters, (ii) lower case letters, (iii) numbers, and/or (iv) special characters.

10. "Subcontractor" means a subcontractor or independent contractor used by Business Associate to create, receive, maintain, or transmit Customer Data or Sensitive Information or to provide Services under the Underlying Agreement. Nothing in this Schedule authorizes the use of a Subcontractor beyond the extent permitted by the Underlying Agreement.

11. "Business Associate Personnel" means Business Associate, Business Associate's employees, Subcontractors and Subcontractors' employees providing Services to Covered Entity under the Underlying Agreement.

12. "Work Product" means any software, data, or other subject matter developed in the course of performing Services, including custom software, user interfaces, custom documentation, report formats, and file structures.

B. Safeguarding Customer Data. Business Associate shall, and shall cause Business Associate Personnel to, comply with the requirements set forth below.

1. Security. Business Associate shall store Customer Data on secure computers located in a physically secure data center, Business Associate shall establish, maintain, and comply with environmental, safety and facility procedures, data security practices and other safeguards against the destruction, loss, alteration, or unauthorized access or disclosure of Customer Data in the possession of Business Associate that are: (i) in conformance with the requirements set forth in this Agreement; (ii) in conformance with, and sufficient for Covered Entity to meet, applicable laws; and (iii) no less rigorous than those maintained by Business Associate for its own information of a similar nature or for any of Business Associate's other customers.

2. Encryption. Without limiting the foregoing: (i) Business Associate shall employ technology that is at least consistent with industry standards for firewalls and other security technology to help prevent Business Associate's computers and systems from being accessed by unauthorized persons; (ii) Business Associate shall use the HTTPS standard for all data transmissions, and shall ensure that all Customer Data is Encrypted while in transmission between Business Associate's data center and the Covered Entity's computer system or other device (as applicable) using TLS 1.0 network communications security protocol or greater if available; (iii) Business Associate shall provide and maintain the ability to transfer files via secure FTP, Encrypted email, or HTTPS; (iv) for Customer Data at rest. Business Associate shall employ an Encryption algorithm specified in NIST SP 800-111; and (v) Business Associate shall provide and maintain Encrypted passwords for access to Business Associate's systems.

3. Monitoring. Business Associate shall perform commercially reasonable monitoring of the Services and all Business Associate equipment and software for health and performance, and Business Associate engineers shall be on-call at all times to resolve any system issues.

4. Recovery of Lost Data. Business Associate shall develop and maintain procedures for the reconstruction of lost Customer Data, and Business Associate shall correct, at Covered Entity's request, any loss or unauthorized or inappropriate destruction or alteration of any Customer Data caused by the act or omission of Business Associate or any Business Associate Personnel.

5. No Caching. Business Associate represents, warrants, and covenants that no Customer Data will be cached or stored on any Authorized User's workstation, computer, or other device, except to the extent that, and only to the extent that, an Authorized User affirmatively and intentionally saves such Customer Data to such workstation, computer, or device.

6. Backup. Business Associate will perform regular backups all Customer Data in accordance with industry standards.

7. Remote Access. All remote control Software and remote access to systems on the Covered Entity network or system hosting Customer Data will be subject to review and continued approval by Covered Entity, and must meet configuration requirements as specified by Covered Entity. Software shall not allow for remote access from untrusted networks by default. Each of the Business Associate Personnel who uses a remote support solution shall be required to have a unique ID and Business Associate shall keep an audit log of all such access for a length of time based on regulatory requirements associated with data types and in accordance with Covered Entity requirements. Business Associate shall periodically, and no less than quarterly, review such audit logs for unauthorized or inappropriate access by Business Associate Personnel. Additionally, Business Associate shall audit the procedural, administrative, physical and technical safeguards used by Business Associate Personnel with access to Customer Data, at least once a year.

8. Personnel and Data in the United States Only. Business Associate represents, warrants, and covenants that all Software and Services will only be provided by Business Associate Personnel residing within the United States of America. Business Associate shall ensure that any information learned by it as a result of entering into the Underlying Agreement, including any Customer Data, will never leave the jurisdiction of the United States of America and will never be accessed by anyone from outside the United States of America. Any modification to the foregoing limitation will require the express written consent of LifePoint Health's Information Governance Officer (who may be contacted at infogovrdlpnt.net).

9. Audit Logging. Business Associate represents and warrants that the Software and Services shall automatically record and log each access to Customer Data by any person, through any portion of the system, and will provide Covered Entity the capability to readily create access reports. Where PHI is involved, Business Associate represents and warrants that the Software and Services shall automatically record and log each access to PHI by any person, through any portion of the system, and will provide Covered Entity the capability to readily create reports showing the following with respect to each such access: (i) Date/time of record access; (ii) Unique username of accessing person; (iii) Name of accessing person and identifying initials of any professional license, degree, or certification (e.g., RN, MD, RT); (iv) Specific data elements/fields accessed; (v) Duration of access; (vi) For each data element/field, what was read by accessing person; (vii) For each data element/field, description of action taken (whether information was created, modified, accessed, viewed, printed, deleted, included in a report, etc.); (viii) For each data element/field, the purpose of the access (treatment, payment, operations, etc.); (ix) Patient name; (x) Patient MRN; (xi) Patient DOB; (xii) Study/Case ID; (xiii) User's relationship to the patient; (xiv) IP address used to access the record; and (xv) Record of any printing activity. In addition, Business Associate shall, at any time upon Covered Entity's request, promptly make available to Covered Entity's personnel all of the foregoing audit logs and related information pertaining to access to or use of Customer Data and PHI.

10. Media Disposal. As part of the Services provided and at no additional charge to Covered Entity, to the extent that this Agreement allows or provides for disposal or destruction of Sensitive Information and/or Customer Data, Business Associate shall dispose of all electronic media that stores Sensitive Information and Customer Data using shredding or other secure means, in accordance with current NIST Guidelines for Media Sanitization for the type of media involved and provide Customer a certificate of destruction. Upon Covered Entity's reasonable request, Business Associate will provide Covered Entity with a written report of all electronic media used in the provision of Services to Covered Entity which has been disposed of in the previous twelve (12) months. Such reports will identify the media disposed of including serial number of the unit and media, if a serial number is available, the method of destruction, and the date the media were disposed of.

11. Authentication. Business Associate shall assign a unique user ID to any Business Associate user who accesses Customer Data on Business Associate managed systems. Business Associate shall configure the unique user ID so that it enables tracking of each Business Associate user's activity within the system. Business Associate shall require authentication by Business Associate users for access to Customer Data on Business Associate managed systems. Business Associate shall configure Business Associate managed systems to support Strong Authentication for accessing Customer Data from any open network (e.g., Internet, open wireless). Business Associate shall configure Business Associate managed systems to expire passwords at least every one-hundred and eighty (180) days and require a password change on the next successful login. For Business Associate managed systems that cannot support Strong Passwords, Business Associate shall configure such Business Associate managed systems to expire passwords every ninety (90) days. Unless otherwise agreed by Covered Entity, Business Associate shall ensure that Business Associate managed systems will require Strong Password for user authentication.

12. User Accountability. Business Associate shall report to Covered Entity, on request, all user accounts and their respective access rights within the system within five (5) business days or less of the request.

13. Account Termination. Business Associate shall disable user accounts of all Business Associate users or Authorized Users for the system within two (2) business days of becoming aware of the termination of such individual. In the cases of termination for cause, Business Associate shall disable such user accounts as soon as administratively possible but no later than the next business day.

14. Multi-Factor Authentication. Business Associate shall configure Business Associate managed systems to require multi-factor authentication when hosting Customer Data.

15. Mobile Devices. Business Associate shall Encrypt and password protect mobile devices or external or removable media, including, without limitation backup tapes, used for sending, receiving, or storing Customer Data.

C. Data Security. Upon notice from Covered Entity, Business Associate shall provide (and shall cause its Subcontractors to provide) Covered Entity, its accountants, and representatives with access to and any assistance that they may require with respect to the Software, Services, Customer Data, and compliance with the confidentiality, privacy, and data security related provisions of this Agreement, for the purpose of performing related audits or inspections. Covered Entity may, upon advance written notice to the Business Associate, perform remote scans and assessments of Business Associate's Products and/or Services. If any audit results in Business Associate being notified that Business Associate (or any subcontractor) is not in compliance with this Agreement, any applicable law or any audit requirement, the parties will meet to discuss such notice. Business Associate shall remedy (and shall cause its Subcontractors to remedy) all failures promptly, and in no event later than as required by law or a governmental authority.

D. Breach Notification Costs. If, as the result of any act or omission of Business Associate or any Business Associate Personnel, a person is required to be notified of unauthorized access, disclosure, or use of the person's personal information, Business Associate shall bear and pay, and compensate and reimburse Covered Entity for, all costs associated with such notification and related communication and for the costs of providing a credit monitoring service to the affected person.

E. Virus Warrants. Business Associate represents and warrants that no component of any of the Software or Services includes, and that any method of transmitting such Software and Services will not introduce, any Disabling Code. Business Associate shall immediately provide Covered Entity written notice in reasonable detail upon becoming aware of the existence of any Disabling Code in the Software or Services. Without limiting the foregoing, Business Associate shall use best efforts and all necessary precautions to prevent the introduction and proliferation of any Disabling Code in Covered Entity's computer systems or networks as a result of the implementation or use of the Software or Services or in any Business Associate systems used to provide Software or Services. In the event Business Associate or Covered Entity discovers the existence of any Disabling Code (whether intentionally or unintentionally introduced), Business Associate shall use its best efforts, in cooperation with Covered Entity, to effect the prompt removal of the Disabling Code from the Software and Services on Covered Entity's computer systems and networks and the repair of any files or data encrypted thereby, and the expenses associated with the removal of the Disabling Code and restoration of the data will be borne by Business Associate.

G. SOC Audits. Business Associate shall, prior to execution of the Underlying Agreement and annually thereafter, complete, obtain and provide to Covered Entity an independent audit report of Business Associate's systems and processes ("Security Assessment") covering (i) HITRUST CSF adherence, security, availability, processing integrity, confidentiality, privacy and such additional common criteria as Covered Entity may reasonably require, (ii) controls over all relevant business and IT processes related to the services provided by Business Associate relevant to Covered Entity's financial reporting; (iii) controls over the maintenance of financially relevant master files and configurations; (iii) controls over relevant reports and data outputs (base or custom) produced by Business Associate or its systems; (iv) controls over Business Associate users who may have access to Covered Entity's systems as applicable; and (v) such other controls and issues as Covered Entity may reasonably require. The Security Assessment will meet the standards for and be in the form of a SOC-2 report or other format reasonably requested and approved by an authorized officer of Covered Entity. The Security Assessment must be issued by a reputable independent firm appropriately qualified to complete the Security Assessment. If any Security Assessment identifies material weaknesses or fail points (for the purposes of this Section, a "fail point" includes any issue that would result in a "qualified" opinion), Business Associate shall act promptly to resolve such issues, and shall advise Covered Entity regarding such actions. Failure by Business Associate to resolve such issues within thirty (30) days (or such longer period as may be approved by Covered Entity) will be deemed a material breach of this Agreement.

VIII. TERM AND TERMINATION.

A. Term. The Term of this Agreement shall be effective as of the date the Underlying Agreement is effective (the "Effective Date"), and shall terminate when all of the Protected Health Information, Sensitive Information and Customer Data provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy the Protected Health Information, Sensitive Information and Customer Data, protections are extended to such information, in accordance with the termination provisions in this Article VIII. Notwithstanding anything to the

contrary contained in this Agreement, Business Associate shall not destroy any Protected Health Information or Sensitive Information without the prior written consent of Covered Entity.

B. Termination for Cause. Upon Covered Entity's knowledge of a breach by Business Associate, Business Associate's violation of the HIPAA Laws, a Breach of Unsecured Protected Health Information or Sensitive Information by Business Associate or any Subcontractor of Business Associate, or any other material breach of this Agreement, Covered Entity shall, within its sole discretion, either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, terminate this Agreement; or

2. Immediately terminate this Agreement.

C. Effect of Termination.

1. Except as provided in paragraph C(2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy (at Covered Entity's sole discretion) all Protected Health Information, Sensitive Information and Customer Data received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity within five (5) days of the effective date of the termination. This provision shall apply to Protected Health Information, Sensitive Information and Customer Data that is in the possession of subcontractors or agents of Business Associate. Business Associate shall not retain any copies of the Protected Health Information, Sensitive Information or Customer Data. Business Associate will be responsible for recovering any PHI, Sensitive Information and Customer Data from such agents or subcontractors at no cost to Covered Entity.

a. Standards for Return —Information that is in electronic format shall be provided to Covered Entity at no additional charge. The format to be provided should be one that is commonly used for export (i.e., comma delimited, text file, Word, Excel or Access database) that is agreeable to Covered Entity.

b. Standards for Destruction — If Covered Entity agrees to destruction, Business Associate and its agents and subcontractors must destroy the media on which the Protected Health Information, Sensitive Information or Customer Data has been stored or recorded in one of the following ways (except as otherwise provided in Article VII):

(i) Any paper, film, or other hard copy media must be shredded or destroyed such that the Protected Health Information or Sensitive Information cannot be read or otherwise reconstructed. Redaction is specifically excluded as a means of data destruction.

(ii) Business Associate must clear, purge, or destroy electronic media consistent with the NIST Guidelines for Media Sanilizalion (Special Publication 800-88) such that the Protected Health Information or Sensitive Information cannot be retrieved and must provide Covered Entity with appropriate evidence of destruction (i.e., a Certificate of Sanitization in the form shown in the NIST Guidelines fir Media Sanitization) within five (5) days of the destruction.

2. In the event that Business Associate determines that returning or destroying the Protected Health Information, Sensitive Information and/or Customer Data is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. If such written notification that return or destruction of Protected Health Information, Sensitive Information and/or Customer Data is infeasible and agreed to by Covered Entity, Business Associate shall extend Individual rights and the protections of this Agreement to such Protected Health Information, Sensitive Information and Customer Data retained by Business Associate or its agents and subcontractors and limit further uses and disclosures of such Protected Health Information, Sensitive Information and Customer Data,

as applicable, to those purposes that make the return or destruction infeasible, for so long as Business Associate or its agents and subcontractors maintain such Protected Health Information, Sensitive Information and/or Customer Data.

3. Should Business Associate make a disclosure of PHI, Sensitive Information and/or Customer Data in violation of this Agreement, Covered Entity shall have the right, upon notice, to terminate (in whole or in part) any contract, other than this Agreement, then in force between the Parties, including without limitation the Underlying Agreement.

IX. REMEDIES IN EVENT OF BREACH, DISCLAIMER AND INDEMNIFICATION.

A. Business Associate hereby recognizes that irreparable harm may result to Covered Entity, and to the business of Covered Entity, in the event of breach by Business Associate of any of its obligations, covenants, or assurances contained in this Agreement. As such, in the event of a breach by the Business Associate of any of the obligations, covenants and assurances contained in Articles II through VIII above, Covered Entity shall be entitled to enjoin and restrain Business Associate from any continued violation of such Articles. Covered Entity retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI or Sensitive Information by Business Associate, its agents or subcontractors for so long as Business Associate, its agents or subcontractors maintain Protected Health Information or Sensitive Information.

B. PHI, SENSITIVE INFORMATION AND CUSTOMER DATA IS PROVIDED TO BUSINESS ASSOCIATE SOLELY ON AN "AS IS" BASIS. COVERED ENTITY DISCLAIMS ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY, NON-INFRINGEMENT AND FITNESS FOR A PARTICULAR PURPOSE. As between Covered Entity and Business Associate, any PHI, Sensitive Information and/or Customer Data shall be deemed to be the exclusive property of Covered Entity. In no event shall Business Associate or its subcontractors claim any ownership rights with respect to such PHI, Sensitive Information or Customer Data.

C. Business Associate will indemnify and hold Covered Entity and its officers, directors, employees, agents, affiliates, successors and assigns (each an "Indemnified Party") harmless, from and against any and all claims, demands, losses, liabilities, damages, costs, penalties, fines and expenses (including, without limitation, in-house counsel and other reasonable attorneys' fees and costs) arising out of or related to either: (i) the Business Associate's breach of its obligations under this Agreement and/or (ii) any third-party claim based upon any breach of this Agreement, violation of HIPAA Laws or State Privacy and Security Laws by Business Associate or by its employees, agents or subcontractors ("Claim"). If any Indemnified Party learns of a Claim, the Indemnified Party may defend the Claim (in which case Business Associate shall reimburse the Indemnified Party for losses, liabilities, damages, costs, penalties, fines and expenses upon demand) or may, in its discretion at any time, tender defense of the Claim to Business Associate and require that Business Associate directly assume responsibility for defending the Claim, with counsel approved by the Indemnified Party; provided, however, the Indemnified Party will use reasonable efforts to avoid prejudicial delays in tendering defense to Business Associate. If Business Associate assumes the defense of a Claim, Covered Entity shall have the right, at its expense, to participate in the defense of such Claim, and Business Associate shall not make any admissions on behalf of the Covered Entity nor take any final action with respect to such Claim without the prior written consent of Covered Entity. This Section shall survive termination of this Agreement and any Claim is without regard to any limitation or exclusion of damages or liability provisions otherwise set forth in the Agreement or the Underlying Agreement.

D. Business Associate shall obtain and continuously maintain (during the term of this Agreement and thereafter) the following insurance coverages for Business Associate and its employees, agents and independent contractors in the following amounts: (a) not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate of commercial general liability insurance; and (b) Ten Million Dollars ($10,000,000) per occurrence and Ten Million Dollars ($10,000,000) annual aggregate of Security and Privacy Liability ("Cyber Liability") insurance. The Cyber Liability insurance shall cover, among other things, breaches of this Agreement, and if requested by Covered Entity, Covered Entity will be included as an additional named insured on Business Associate's Cyber Liability insurance. Business Associate shall provide Covered Entity with certificates of insurance or other written evidence of the insurance policy or policies required herein prior to the effective date of the Agreement and as of each annual renewal of such insurance policies during the term of the Agreement, and

thereafter as requested by Covered Entity from time to time. Further, in the event of any modification, termination, expiration, non-renewal or cancellation of any of such insurance policies, Business Associate shall give mitten notice thereof to Covered Entity not more than ten (10) days following Business Associate's receipt of such notification.

X. **MODIFICATION.** Except as provided in this Article X, this Agreement may only be modified through a writing signed by the Parties. To the extent any term in this Agreement conflicts with the requirements of the HIPAA Law or other laws, rules or regulations applicable to Covered Entity, if such laws, rules or regulations are modified, or additional laws, rules or regulations are adopted, this Agreement shall be deemed to have been modified as necessary to allow Covered Entity to comply with applicable laws, rules and regulations. The Parties agree to take such action as is necessary to amend this Agreement Iron time to time as is necessary for Covered Entity to comply with the requirements of the HIPAA Law and other applicable laws, and Bu.siness Associate will execute such amendments as Covered Entity may request to reflect any modifications required to permit Covered Entity to comply with applicable laws, rules or regulations.

XI. **INTERPRETATION OF THIS CONTRACT IN RELATION TO OTHER CONTRACTS BETWEEN THE PARTIES.** Should there be any conflict between the language of this contract and any other contract entered into between the Parties (either previous or subsequent to the date of this Agreement), including, without limitation, the Underlying Agreement, the language and provisions of this Agreement shall control and prevail unless the Parties specifically refer in a subsequent written agreement to this Agreement by its title and date and specifically state that the provisions of the later written agreement shall control over this Agreement.

XII. **COMPLIANCE WITH STATE LAW.** Business Associate shall comply with State Privacy and Security Laws. If the HIPAA Law and the law of the State in which Covered Entity is located conflict regarding the degree of protection provided for Protected Health Information, Business Associate shall comply with the more restrictive protection requirement.

XIII. **MISCELLANEOUS.**

A. No Agency Relationship. The Parties expressly agree and assert that no agency relationship is created between Covered Entity and Business Associate by this Agreement or the Underlying Agreement with regard to Business Associate's HIPAA obligations. The Parties agree that each individual Party has its own independent HIPAA compliance obligations and that Business Associate will provide any services as an independent contractor. Business Associate acknowledges that any Breaches of Unsecured PHI shall be considered to be independent acts or omissions by Business Associate and beyond the scope of work or duties anticipated by Covered Entity for the Underlying Agreement; any uses or disclosures of PHI not in compliance with the de-identification, marketing and sale of PHI prohibitions of this Agreement and/or in violation of the minimum necessary standards or other HIPAA violations shall not be anticipated by Covered Entity, and as such, Business Associate shall not be authorized to act as Covered Entity's agent in this regard

B. Assignment/No Third Party Beneficiaries. Neither party may assign any of its rights or this Agreement or delegate any of its obligations to any party without the consent of the other, except that Covered Entity may assign this Agreement without the consent of Business Associate to any affiliate or in conjunction with a merger, reorganization, consolidation, change of control or sale of all or substantially all of its assets. Business Associate acknowledges and agrees that each Covered Entity (as defined in the introductory paragraph of this Agreement) will he considered a Party to this Agreement, but nothing express or implied in this Agreement confers upon any person, other than the Parties and their respective successors or permitted assigns, any rights, remedies, obligations, or liabilities whatsoever.

C. Survival. Any provisions of this Agreement which expressly or by implication are intended to survive its termination or expiration will survive and continue to bind the parties as long as Business Associate maintains PHI, Sensitive Information or Customer Data, including, without limitation, Section VIII.C, with respect to the continuing obligations for returning, destroying or protecting PHI, Section V, with respect to breach reporting and reimbursement of expenses, Article IX with respect to obligations to indemnify and to maintain insurance, and all limitations, restrictions and standards applying to Business Associate's maintenance, use or disclosure of PHI, Sensitive Information and/or Customer Data.

D. Ambiguity. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the HIPAA Law, State Privacy and Security Laws, and other applicable legal obligations.

E. Notice to Covered Entity. Any notice required under this Agreement to be given Covered Entity shall be made in writing to:

Address: LifePoint Health
330 Seven Springs Way
Brentwood, TN 37027
Attention: Compliance, Privacy Off

With copy to: LifePoint Health
330 Seven Springs Way
Brentwood, TN 37027
Attention: Compliance, Privacy Off
Attention: Legal Department

F. Notice to Business Associate. Any notice required under this Agreement to be given Business Associate shall be made in writing to Business Associate.

IN WITNESS WHEREOF and acknowledging acceptance and agreement of the foregoing, the Parties affix their signatures hereto.

COVERED ENTITY:
LifePoint Corporate Services, General Partnership

By: / Ch Frost

Name: Conrad Dale Christopher Frost

Title: SVP, DFPO / NMD 1/16/23

BUSINESS ASSOCIATE:
Southeastern Emergency Physicians, LLC

Stanley Thompson, MD

By: Stanley Thompson, MD (Jan 19, 2023 10:59 CST)

Name: Stanley Thompson, MD

Title: CCO

APPENDIX 4

FORM OF NOTIFICATION TO COVERED ENTITY OF

BREACH OF UNSECURED PHI AND STATE LAW

Date completed: _____

This notification is made pursuant to the Business Associate Agreement between _____ (Covered Entity), and _____ (Business Associate).

Business Associate hereby notifies Covered Entity that there has been an actual or potential breach of unsecured (unencrypted) protected health information (PHI) or Sensitive Information or information subject to State Privacy and Security Laws that Business Associate (or its agents or subcontractors) has used or has had access to under the terms of the Business Associate Agreement.

I. **Characteristics of the Breach**

1. Date of the breach: _____ Date the breach was discovered: _____

2. Description of the breach: _____

3. How was the breach discovered? _____

4. Number of individuals affected by the breach: _____

5. Are over 500 individuals affected by the breach?

   Yes _____ No

6. Have you been able to identify all individuals affected by the breach?

   Yes _____ No _____

   If yes, for how many of the affected individuals do you have current addresses? _____

7. Does the information disclosed in the breach identify, or can reasonably be used to identify, specific patients?

   Yes _____ No _____

   If no, please explain why the information does not identify, or cannot reasonably be used to identify, specific patients:

   _____

8. Does the information disclosed in the breach contain any sensitive information or other information that can be used in a manner that would be adverse or cause financial or reputational harm to the individual?

   Yes _____ No _____

   If no, explain why the information cannot be used in an adverse or harmful manner to the individual:

9. Was all of the patient(s') information compromised or only portions?

   Yes _____ No _____

   If only portions of the information, explain which portions of the information were compromised:

10. Indicate type of breach:

☐ Theft	☐ Unauthorized Access	☐ Unknown
☐ Loss	☐ Hacking/IT Incident	☐ Other: _____
☐ Improper Disposal	☐ Phishing	

11. Location of breached information:

☒ Laptop	☐ Portable Media/Device	☐ Unknown
☐ Desktop Computer	☐ EMR	☐ Other: _____
☐ Email	☐ Paper	

12. Description of types of unsecured PHI or other data involved in the breach:

☐ Demographic (full or partial name)	☐ Account number	☐ ICD-9-CM or CPT Codes
☐ Social security number	☐ Disability Code	☐ Driver's license, insurance card, or other form of identification
☐ Date of birth	☐ Financial (billing info, credit card # or check/bank account number	☐ Other: _____
☐ Home Address	☐ Clinical (any mention of diagnosis, procedure, or treatment provided)	

13. Are the patient(s) or the patient(s') family members aware of the incident?

Yes ____ No ____

If yes, Describe _____

II. Description of Safeguards

14. Safeguards that were in place prior to the breach:

☐ Firewalls	☐ Encrypted wireless	☐ Secure browser
☐ Packet Filtering	☐ Logic access control	☐ Biometrics
☐ Intrusion detection	☐ Anti-virus software (list product name): _____	☐ Strong authentication
☐ Other:	☐ Physical security:	

15. Was the data encrypted in compliance with the encryption standards set forth in the U.S. Department of Health and Human Services Guidance Specifying the Technologies and Methodologies that Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of HITECH Act?

Yes _____ No _____

If yes, please identify the method of encryption: _____

_____

_____

If no, please identify any other methods of securing the information (for example, password protected file): _____

_____

_____

III. The Recipient

16. Can you determine whether the PHI was actually acquired or viewed by the unintended recipient?

Yes _____ No _____

If yes, please explain how and provide any information regarding the information viewed, length of time viewed, whether it was e-mailed or saved to another device and who viewed the information:

_____

_____

17. Did the breach involve a good faith, unintentional acquisition, access or use of PHI by the entity's employee/workforce member? (For example, a billing employee receives and opens an e-mail containing PHI about a patient which a nurse mistakenly sent to the billing employee. The billing employee notices that he is not the intended recipient, alerts the nurse of the misdirected e-mail, and then deletes it.)

Yes _____ No _____

If yes, please explain: _____

_____

_____

18. Did the breach involve an inadvertent disclosure to another authorized person within the entity or Organized Health Care Arrangement in which the entity participates? (For example — A physician who has authority to use or disclose PHI at a hospital by virtue of participating in an organized health care arrangement with the hospital is similarly situated to a nurse or billing employee at the hospital.)

Yes _____ No _____

If yes, please explain: _____

_____

_____

19. Did the breach involve a recipient who could not reasonably have retained or remembered the data? (For example — A covered entity, due to a lack of reasonable safeguards, sends a number of explanations of benefits (EOBs) to the wrong individuals. A few of the EOBs are returned by the post office, unopened, as undeliverable.)

Yes _____ No _____

If yes, please explain: _____

_____

_____

20. Was the unauthorized person who received the PHI or Sensitive Information or to whom the disclosure was made covered by HIPAA and/or a licensed healthcare provider'?

Yes _____ No _____

If yes, please identify the licensed healthcare provider, the type of license and any state confidentiality regulations which require the licensed provider to maintain the confidentiality of the information: _____

_____

_____

21. Can any of the information be used by an unauthorized recipient to further the recipient's own interests?

Yes _____ No _____

If no, explain why none of the information cannot be used by an unauthorized recipient to further the recipient's own interests?

_____

_____

_____

IV. Addressing the Breach

22. Description of what Business Associate is doing to investigate the breach: _____

_____

_____

_____

_____

_____

23. Has law enforcement been notified?

Yes _____ No _____

If so, describe _____

_____

_____

24. Did law enforcement ask for patient notification delay (based on hindering an investigation or causing harm to national security)

Yes _____ . No _____

If yes, please provide documentation of the police request and deadline for notifications: _____

_____

_____

25. Was satisfactory assurance obtained from the recipient of PHI or Sensitive Information indicating that PHI or Sensitive Information will not be further used or disclosed?

Yes _____ No _____

If yes, please attach and explain: _____

_____

26. Has the information been returned or properly destroyed? (If destroyed — need to obtain satisfactory assurance that the information was destroyed.)

Yes _____ No _____

If yes, please attach the assurances and explain the circumstances: _____

_____

27. Description of what Business Associate is doing to mitigate harm to the individual(s): _____

_____

_____

28. Description of what Business Associate is doing to protect against any further breaches: _____

_____

_____

29. Contact information to ask questions and obtain additional information:

Name: _____

Title: _____

Address: _____

Email Address: _____

Phone Number: _____

EXHIBIT 4
HOSPITAL ATTACHMENT EXAMPLE

EXCLUSIVE PROFESSIONAL SERVICES AGREEMENT Attachment _____

Date of Agreement	_____		
"Effective Date" See restriction in Section V.A	_____	**"Initial Term"** See Section V.A.	Effective Date and continuing through [_____]
"Contractor"	Southeastern Emergency Physicians, LLC	**"Hospital"**	_____ d/b/a _____
"Contractor Address"	265 Brookview Centre Way Suite 400 Knoxville, TN 37919 Attention: CEO	**"Hospital Address"**	_____ _____ Attention: CEO
"State"	_____		
"Initial Term Year 1 Total Annual Practice ED Subsidy Amount"	An amount as determined in Exhibit 1 to the Exclusive Emergency Department and Hospitalist Services Master Agreement between LifePoint Corporate Services, General Partnership ("Company") and Southeastern Emergency Physicians, LLC, a Tennessee limited liability company ("Contractor") effective as of [____] (the "Master Agreement").	**Such allocation will be based on the relative cost of providing the services per the schedules checked below. Specific hospital's revenue and expense for the services provided will be considered in determining this allocation**	
Terms of shared excess revenue/profits:	Per the Master Agreement		

The following checked Schedules are attached to and made a part of this Agreement:

	Schedule	Title
☐	1	Emergency Department Agreement
☐	2	Hospitalist Agreement

IN WITNESS WHEREOF, Hospital and Contractor have duly executed this Agreement as of the dates set out beneath their respective signatures.

The undersigned hereby certifies that:

1) As of the date of the signatures below, this Agreement constitutes a binding agreement to perform services as of the Effective Date and may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument;
2) The compensation arrangement is established at fair market value for the services to be rendered and this Agreement is for services that are needed and reasonable in scope;
3) This Agreement supersedes all prior agreements, contracts and understandings, whether written or otherwise, between the parties relating to the subject matter hereof and does not condition the payment or the arrangement on the volume or value of any referrals or other business generated between the parties;
4) Until the Agreement is listed in Hospital's Master Contract Database to the extent required by 42 C.F.R. § 411.357(d)(1)(ii), no payment shall be made nor services accepted under this Agreement; and
5) Upon the Effective Date of this Agreement, to ensure that no payments are made and no services accepted beyond the terms of this Agreement, or the terms of other company approved agreements between the parties.

THIS EXCLUSIVE PROFESSIONAL SERVICES AGREEMENT (the "Agreement") is hereby entered into by and between Hospital and Contractor who may hereafter be referred to individually as a "Party" and collectively as the "Parties" in connection with the Exclusive Emergency Department and Hospitalist Services Master Agreement (the "Master Agreement") dated the [___] day of [____], 2022, by and between LifePoint Corporate Services, General Partnership ("Company") and Contractor.

RECITALS

WHEREAS, Hospital has determined that coverage by an exclusive group of providers based at Hospital is necessary to meet the needs of patients at Hospital; and

WHEREAS, Hospital has determined that the proper, orderly and efficient delivery of emergency department services (the "ED Services") and/or hospitalist services (the "HM Services") at the Hospital (ED Services and HM Services are collectively known as the "Services") can be accomplished best by entering into an exclusive coverage arrangement; and

WHEREAS, Contractor will, at its expense, arrange coverage for Hospital through licensed physicians (individually referred to as "Physician" and collectively referred to as "Physicians"), and certified nurse practitioners or physician assistants (individually referred to as "Allied Health Practitioner" and collectively referred to as "Allied Health Practitioners") (Physicians and Allied Health Practitioners collectively referred to as "Contractor's Representatives") authorized and licensed to practice medicine where Hospital is located (the "State"), who are qualified to provide the services as defined in this Agreement; and

WHEREAS, Hospital desires to contract with Contractor as set forth herein to obtain management services of Contractor with respect to the professional component of services provided at the Hospitals so as to permit the development and operation of certain departments at Hospital; and

WHEREAS, this Agreement is entered into for the purpose of defining the Parties' respective rights and responsibilities; and

WHEREAS, the terms of the Master Agreement are incorporated herein as though fully repeated verbatim.

NOW, THEREFORE, in consideration of the premises and mutual covenants and agreements herein set forth, the Parties hereto agree as follows:

I. CONTRACTOR'S REPRESENTATIONS.

A. Organization. Contractor represents and warrants that it is a corporation or limited liability company duly organized and validly existing under the laws of its state of incorporation and has the corporate power and authority to execute and deliver this Agreement, and to carry out its provisions.

B. Services. Contractor shall (through appropriately licensed Contractor's Representatives) provide professional services needed at the Hospital, including but not limited to those services described as set forth in any attachment(s) defined as Professional Service Agreement(s) (the "Services") attached hereto.

C. Professional Qualifications. Contractor shall ensure that all Contractor's Representatives utilized to provide Services under this Agreement continuously have and maintain the following credentials:

1. Contractor's Representatives will be qualified by training and experience to provide the Services; and

2. The Contractor's Representatives assigned to Hospital shall have the Medical Staff or allied health privileges required to provide Services under this Agreement in accordance with the applicable requirements and Medical Staff bylaws, and each of Contractor's Representatives shall comply with Hospital policies and procedures. Medical Staff bylaws, and rules and regulations for Hospital.

D. Approval of Contractor's Representatives and Substitutes.

1. Contractor agrees it shall not use any Physician or Allied Health Professional to provide the Services under this Agreement to Hospital without first obtaining appropriate medical staff or allied health privileges and other approvals required by such Hospital's Medical Staff bylaws. Contractor agrees that all of Contractor's Representatives are subject to continuing approval of Hospital.

2. Contractor shall provide a substitute for any of Contractor's Representatives who are unable to provide services required under this Agreement. As a condition of providing services under this Agreement, any such substitute shall satisfy all qualification requirements applicable to the Contractor's Representatives.

3. Contractor agrees to cause each of Contractor's Representatives and substitutes to comply with his or her assigned Hospital policies and procedures. Medical Staff bylaws and rules and regulations. Failure to do so shall be grounds for Hospital to request Contractor to immediately remove the Contractor's Representative or substitute as described under Section II below. Hospital shall supply a copy of its Medical Staff Bylaws to Contractor within thirty (30) days of execution of this Agreement (if not already supplied), and shall supply an updated version upon any revision.

E. Compliance.

1. Contractor and Contractor's Representatives shall perform all Services under this Agreement in accordance with any and all regulatory and accreditation standards applicable to Hospital and the Services, including, without limitation, those requirements imposed by the Medicare Conditions of Participation, The Joint Commission accreditation standards, the AMA Code of Ethics, the rules and regulations of the Board of Medicine in the State, the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Federal Anti-Kickback and Stark statutes and regulations, federal and state regulations governing the security and privacy of health information, and other applicable state and federal regulations, all as amended from time to time.

2. Contractor represents and warrants that as of the date of this Agreement: (i) neither it nor any Contractor's Representative is excluded, debarred or otherwise ineligible to participate in Medicare, Medicaid or any other federal or state healthcare programs or in any federal or state procurement or non-procurement programs; and (ii) neither it nor any Contractor's Representative has been convicted of a criminal offense that could lead to such debarment or exclusion. Contractor shall immediately remove from service hereunder any Contractor's Representative for whom this representation and warranty is no longer true and shall so inform the Hospital to which Contractor's Representative is assigned. In the event this representation and warranty becomes untrue as to Contractor, Hospital may deem this Agreement terminated immediately. Contractor agrees this is an ongoing representation and will immediately notify Hospital in the event the foregoing representation and warranty is no longer completely accurate. Contractor acknowledges and agrees this is a material term of the Agreement and any breach or nonfulfillment of same will entitle the Hospital to terminate this Agreement immediately.

F. Quality Programs. Contractor and Contractor's Representatives shall furnish any and all information, records and other documents related to Contractor's service at the Hospital, which Hospital may reasonably request in furtherance of quality assurance, utilization review, risk management, and any other plans and/or programs adopted by Hospital to assess and improve the quality and efficiency of the Hospital's services. As reasonably requested, Contractor and Contractor's Representatives shall participate in one or more of such plans and/or programs, including participating in training on any such program at Hospital's request.

G. Medical Records for All Patients Evaluated and/or Treated by Contractor's Representatives. Unless otherwise specifically agreed to by the Parties, all patients evaluated and/or treated by Contractor's Representatives shall have a medical record created and a charge assigned, including all direct admissions undertaken by Contractor's Representatives. Contractor shall prepare timely, complete and accurate medical records in accordance with Hospital's policies and all professional standards applicable to medical records documentation. All such records shall be entered into Hospital's medical records system, including full use of Computerized Physician Order Entry. Medical records for patients evaluated and/or treated by Contractor's Representatives in Hospital shall at all times remain the property of Hospital.

II. **REMOVAL OF PHYSICIANS PROVIDED BY CONTRACTOR.** Contractor's Representatives shall be removed at the request of Hospital to which such Contractor's Representative is assigned, as follows:

A. For Cause. Upon Hospital's written notice to Contractor to remove any of Contractor's Representatives, with or without cause, Contractor shall remove Contractor's Representative immediately from providing Services. In that event, Contractor shall immediately provide a qualified replacement for Contractor's Representative. If Contractor fails to obtain alternative coverage within one hundred twenty (120) days that is acceptable to Hospital, then, without limiting any other remedies that Hospital may have under this Agreement or applicable law, Hospital may, following written notice to Contractor, obtain appropriate alternative coverage at Contractor's expense. If Hospital is requesting removal of a Contractor Representative for "cause", Hospital shall briefly describe the "cause" to Contractor in

writing. If Hospital does not provide a description of the "cause" for the requested removal, then such removal will be deemed a "without cause" removal for purposes of Section X(A) hereof. For-cause removals may include, but are not limited to, a Contractor's Representative who: (1) is convicted of a crime other than a minor traffic violation; (2) has a guardian or trustee of its person or estate appointed by a court of competent jurisdiction; (3) becomes disabled so as to be unable to perform the duties required by this Agreement; (4) fails to maintain professional liability insurance required by this Agreement; (5) has his/her license(s) and/or privileges required to perform the services contemplated by this Agreement either suspended, revoked or otherwise limited; (6) is debarred, sanctioned or excluded by a state or federal health care program; (7) if applicable, has his/her federal and/or state registration to prescribe and dispense controlled substances suspended, revoked or otherwise limited; (8) fails to comply with any of the terms and conditions of this Agreement after being given notice of that failure and a reasonable opportunity to comply; (9) acts in a manner that Hospital determines to be detrimental to patient safety or negatively affects Hospital's reputation or operations; or (10) fails to comply with any policy or lawful directive of the Hospital. The parties agree that Hospital's requested removal of a Contractor Representative shall have no impact on Contractor's relationship with the affected Contractor Representative, and that any subsequent decision by Contractor to terminate its relationship with the Contractor Representative shall be at the sole discretion of Contractor. Failure of Contractor to remove Contractor's Representative shall be deemed a material breach of this Agreement, and Hospital may immediately terminate this Agreement.

B. Effect on Contractor's Representatives Medical Staff Appointment and Clinical Privileges. Because this is an exclusive Agreement, as more particularly described in Section IV, the medical staff appointment and clinical privileges of all Contractor's Representatives providing services to Hospital shall be incident to and coterminous with this Agreement, and, upon termination or expiration of this Agreement or upon removal of Contractor's Representative by Contractor, the appointment and clinical privileges of the Contractor's Representative shall automatically terminate except as otherwise provided below. Notwithstanding the foregoing, a Contractor Representative's Medical Staff Appointment and Clinical Privileges will not automatically terminate upon termination or expiration of this Agreement unless a continuation of such privileges, in Hospital's reasonable judgment, would be inconsistent with Hospital's ability to contract exclusively with a successor provider of Services. Any rights that the Contractor's Representatives may have to any hearing or appeal procedures prior to termination of Medical Staff Appointment or Clinical Privileges, pursuant to the bylaws or policies of a Hospital or its Medical Staff, or any other state or federal statute, regulation or judicial decision are hereby waived with respect to any termination of Medical Staff Appointment or Clinical Privileges resulting from the items listed herein. Unless otherwise required by law, no reporting to any third party, such as the National Practitioner Data Bank, shall take place for any termination hereunder for non-clinical or non-competency issues. Contractor will require each Contractor's Representative providing Services under this Agreement to execute a separate Contractor Representative Agreement Regarding Medical Staff Membership and Privileges in substantially the same form as ADDENDUM I, attached hereto and incorporated by reference into this Agreement. If Contractor has a substantially similar provision in its contracts with its Physician and Allied Health Practitioners, Contractor will not be required to comply with the requirement in the foregoing sentence.

III. OBLIGATIONS OF HOSPITAL.

A. Hospital Billing. Hospital shall be responsible for, and solely entitled to, billing and collection of all Hospital services rendered to the patients to whom the Services are provided and non-physician provider services performed for the general benefit of its patients, except those for professional services rendered by Contractor's Representatives who are either contracting with or employed by Contractor.

B. Supplies, Equipment, Etc. Hospital will make available the space, utilities, equipment, supplies (to include drugs and narcotics) and services (including housekeeping and laundry) reasonably necessary for the proper operation of the Services. Hospital will maintain its equipment in good order and repair.

C. Facilities and Personnel. Hospital shall provide adequate facilities, along with appropriate numbers of competent support personnel (including nursing staff) for the operation of the Services as determined in Company's sole and reasonable discretion after consultation with Contractor, provided such consultation is requested by Contractor with respect to a particular facility in writing. Hospital shall provide other reasonable support services necessary for proper operation of the Services (including scheduling non-Contractor's Representative personnel, preparing and filing of patient treatment consents and providing other services which are reasonable and mutually agreed upon). Hospital shall provide an adequate medical records system for use in provision of the Services.

D. Transcription. Hospital will provide appropriate dictation, transcription, and medical record services to Contractor for use by Contractor's Representatives for documentation made by Contractor's Representatives in Hospital medical record.

E. Medical Staff On Call. Hospital shall have available specialty physicians on-call in accordance with its Medical Staff bylaws.

F. Materials to Patients. Hospital will, in good faith, attempt to distribute to patients to whom the Services are provided materials describing the separate billing relationship between the patients and Contractor. Such materials will be supplied to Hospital by Contractor on a form acceptable to Hospital.

G. Compliance. Hospital represents and warrants that as of the date of this Agreement: (i) Hospital is not excluded, debarred or otherwise ineligible to participate in Medicare, Medicaid or any other federal or state healthcare programs or in any federal or state procurement or non-procurement programs; and (ii) Hospital has not been convicted of a criminal offense that could lead to such debarment or exclusion. In the event this representation and warranty becomes untrue as to Hospital, Contractor may deem this Agreement terminated immediately. Hospital agrees this is an ongoing representation and will immediately notify Contractor in the event the foregoing representation and warranty is no longer completely accurate. Hospital acknowledges and agrees this is a material term of the Agreement and any breach or nonfulfillment of same will entitle the Contractor to terminate this Agreement immediately.

H. Billing Information. Hospital shall supply Contractor with information necessary for Contractor to bill patients for services rendered by the Contractor's Representatives. In order to allow Contractor to accurately and timely bill for professional services provided by Contractor Representatives hereunder, Hospital agrees to provide Contractor, with either: (i) an electronic file transfer containing patient medical records and related information, including, but not limited to, physician transcription, physician notes, insurance cards and demographic information necessary to conduct physician billing ("Billing Documents"), or (ii) the requested assistance necessary to obtain legible paper copies of Billing Documents to forward to Contractor, which assistance shall include, but not be limited to:

1. Hospital will locate any missing Department records and forward such missing records to Contractor within three (3) working days.

2. Hospital will use commercially reasonable efforts to arrange for patient signatures on forms noting patient's responsibility for paying Contractor's billings.

3. Hospital shall bear the expense of providing one copy of relevant patient medical records to be sent to Contractor.

4. Hospital will comply within three (3) working days with other reasonable requests for information or record handling (including requests regarding insurance) by Contractor.

In the event Hospital has implemented an Electronic Medical Records ("EMR"), Contractor will electronically transmit Billing Documents from Hospital to Contractor. In such event, Hospital will work cooperatively with Contractor and Contractor's Information Technology department to facilitate the timely and accurate flow of Billing Documents to Contractor. This information will be transmitted from Hospital to Contractor in a secure HIPAA compliant electronic format on a daily basis. The Billing Documents transmitted in this fashion will include, but not be limited to: ADT Registration information (patient demographics, payor information, and disposition), event times, and to the extent possible patient clinical record.

Each Hospital shall assist Contractor in obtaining patient signatures on assignment of insurance benefits and other reasonably appropriate forms supplied to the respective Hospital by Contractor. Any collection efforts by the Hospitals and Contractor will comply with all federal and state laws and regulations.

IV. EXCLUSIVITY

A. Hospital concludes that an exclusive relationship for the Services will best facilitate the delivery of efficient, effective and quality patient care. Such a relationship is expected to enhance patient services provided by Contractor and the Hospital, improve the relationships between Contractor, the Hospital's Medical Staffs and Hospital, afford effective utilization of the Hospital's equipment, provide consistent service and quality control, provide prompt availability of professional services, simplify scheduling of patients and physician coverage, enhance the efficient and effective administration of the Services — all of which enhance the quality of patient care.

B. During the Term of this Agreement, Contractor shall be the exclusive provider of the Services described in this Agreement, and therefore, Hospital will ensure does not extend medical staff privileges for the practice of the Services at Hospital to any provider not employed by or under contract with Contractor. However, nothing in the preceding

sentence shall be construed to limit the rights of community-based physicians with medical staff privileges at the Hospital to provide care for their patients while they are admitted to the same.

V. TERM AND TERMINATION

A. This Agreement shall be effective as of the Effective Date, beginning at 12:00 a.m. in the applicable time zone of the Hospital and shall continue for the Initial Term. **[NOTE: The Effective Date cannot be a date that occurs before the dates that both the Hospital and Contractor signed the Agreement. If the Agreement is submitted for approval with an Effective Date that occurs before the last party (The Hospital or Contractor) signed the Agreement, the Effective Date will automatically be changed to the date that the Contractor or Hospital signed, whichever is later. Contractor will not be compensated for services provided to the Hospital prior to the Effective Date.]** Notwithstanding the foregoing, this Agreement will automatically renew for additional twelve (12) month periods following the expiration of the Initial Term, with each such additional twelve (12) month period to be called an "Additional Term", until (i) such time as a new Agreement is executed by the Parties, or (ii) this Agreement is otherwise terminated as provided herein. For purposes of this Agreement, "Term" shall mean the Initial Term and any Additional Term.

B. Either Party may terminate this Agreement at any time in the event the other Party engages in an act or omission constituting a material breach of any term or condition of this Agreement. The Party electing to terminate this Agreement shall provide the breaching Party with written notice specifying the nature of the breach. If a dispute arises regarding the materiality of a breach, then both Parties shall submit the issue to a mutually agreed upon arbitrator pursuant to Section VIII of this Agreement for resolution of the dispute. The breaching Party shall then have twenty (20) days from the date of the notice or twenty (20) days from the date of the arbitrator's decision in which to remedy the breach and conform its conduct to this Agreement. If such corrective action is not taken within the time specified, this Agreement shall terminate at the end of the twenty (20) day period without further notice or demand, provided, however, that Hospital may not terminate this Agreement if Contractor is diligently pursuing the remedy of the breach.

C. Either Party may terminate this Agreement immediately as specified in Sections I.E.2 and III.G, of this Agreement.

D. Either Party may terminate this Agreement immediately if either Party makes a general assignment for the benefit of creditors, or files a petition for relief in bankruptcy or under similar laws for the protection of debtors, or upon the initiation of such proceedings against either Party if the same are not dismissed within forty-five (45) days of service;

E. Either Party may terminate this Agreement immediately if any of the following events occur with regard to Hospital:

1. Loss of Hospital's certification as a Medicare provider;

2. Closure of Hospital;

3. Contractor's general assignment for the benefit of creditors. Contractor's petition for relief in bankruptcy or under similar laws for the protection of debtors, or upon the initiation of such proceedings against Contractor if the same are not dismissed within forty-five (45) days of service; or

4. Hospital's general assignment for the benefit of creditors, or Hospital's petition for relief in bankruptcy or under similar laws for the protection of debtors, or upon the initiation of such proceedings against Hospital if the same are not dismissed within forty-five (45) days of service; or

5. Beginning on the Effective Date and for the Term of the Agreement, Contractor's failure to achieve an overall minimum score of sixty (60) points on the "ED Physician Scorecard" or "Hospitalist Physician Scorecard", if applicable (as may be further defined in this Agreement) at Hospital for any two consecutive quarters during the Term of this Agreement or any renewal period thereof. Contractor, however, shall have the right, at its own expense, to review and audit any performance metric contained in the ED Physician Scorecard or Hospitalist Physician Scorecard, including all underlying data. Hospital agrees to resolve any discrepancy found during an audit performed by Contractor to the Parties' mutual satisfaction. If a dispute arises or the Parties are unable to resolve the discrepancy to their mutual satisfaction, then both Parties shall submit the issue to a mutually agreed upon arbitrator pursuant to Section VIII of this Agreement for resolution of the dispute.

F. This Agreement shall terminate upon termination of the Master Agreement (as defined on the cover page of this Agreement).

G. Except as provided herein, upon any termination of this Agreement, neither Party shall have further rights against, or obligations to, the other Party except with respect to any rights or obligations accruing prior to the date and time of termination and any obligations, promises or agreements which expressly extend beyond the termination, including but not limited to the terms herein related to insurance coverage, restrictive covenants, dispute resolution and confidentiality provisions. Contractor shall have reasonable access to any Hospital's information and records pursuant to Section III (H) of the Agreement for a period of six months after termination of this Agreement for Contractor's billing, risk management and/or quality/peer review purposes.

VI. RISK MANAGEMENT

A. Required Risk Reduction Education. As fair market value consideration, Hospital may reimburse or pay all actual expenses associated with the costs of any educational sessions related to the Service that Contractor and/or Contractor's Representatives are directed to attend by Hospital. All such expenses must be reasonable, and the Contractor and/or Contractor's Representatives must be authorized in advance, and in writing by the Hospital's CEO, to incur such expenses, and such expenses must be paid in accordance with Hospital's policies and procedures. All such expenses are limited to those incurred by Contractor and/or Contractor's Representatives only (e.g., expenses of spouses and other family members are excluded from reimbursement).

B. Provision of Services for Risk Management, Employment Purposes, or Other Obligations of Hospital. Contractor agrees to provide Services as requested by Hospital in response to risk management issues, employee health efforts, or other contractual obligations as reasonably requested by Hospital. In these situations, if requested by Hospital to waive Contractor's fees after the Services have been provided, Contractor shall bill the Hospital for its professional charges rather than the patient or the patient's insurance plan. Contractor agrees to accept the then current year Medicare Physician Fee Schedule reimbursement amount, or where applicable, state workers' compensation amounts, for any such services rendered.

VII. **ALTERNATIVE DISPUTE RESOLUTION**. The Parties firmly, desire to resolve certain disputes arising hereunder without resort to litigation in order to protect their respective business reputations and the confidential nature of certain aspects of their relationship. Accordingly, any controversy or claim arising out of or relating to this Agreement, excepting healthcare liability and/or claims sounding in negligence, and the insurance and indemnification obligations set forth in Section XI, below relating to third-party claims made by patients and/or their representatives, shall be settled by arbitration before a single arbitrator and administered by the American Health Lawyers Association in accordance with its rules, including arbitrator selection. The award or decision rendered by the arbitrator will be final, binding and conclusive, and judgment may be entered upon such award by any court of competent jurisdiction. The arbitration process itself, and any other information or disclosures revealed by either Party to the arbitrator or to the other Party during the arbitration process will be confidential. No disclosure of the award shall be made by the Parties except as required by the law or as necessary or appropriate to effectuate the terms thereof. The location of the arbitration shall be in in the city in which the Hospital is located, unless otherwise mutually agreed by the parties. The dispute shall be governed by the laws of the State. Further, the prevailing Party shall be entitled to recover all costs and expenses associated with arbitration, including reasonable attorneys' fees. If the arbitrator determines that neither Party has substantially prevailed, the Parties shall bear equally the fees and costs of the arbitrator and the related expense of arbitration. Nothing in this section shall preclude either party from maintaining or initiating an action, counterclaim or cross-complaint in tort or contract against the other related to any healthcare liability and/or claims sounding in negligence relating to third-party claims made by a patient and/or a patient's representatives.

VIII. **PARTIES' RELATIONSHIP**. The Parties acknowledge that Contractor is an independent contractor to Hospital for the furnishing of Contractor's Representatives who agree to render Services to patients of the Hospital. Neither Contractor nor Contractor's Representatives shall in any way be construed as employees of any of the Hospital. Neither Contractor nor any of its agents (employees or contractors) shall have the right or authority to enter into any contract in the name of the Hospital or otherwise bind the Hospital in any way without the express written consent of the Hospital designee.

IX. **PERFORMANCE DATA**. Hospital agrees to comply with Contractor's reasonable request for financial and performance data related to utilization at Hospital. Contractor shall make such requests no more than quarterly during the Term of this Agreement.

X. INSURANCE AND INDEMNIFICATION.

A. Contractor hereby agrees to indemnify and hold harmless Hospital and Hospital's officers, directors, employees, agents, successors and assigns from and against any claim, damage, loss, expense, liability, obligation, action or cause of action, including reasonable attorneys' fees and reasonable third party costs of investigation, which Hospital may sustain, pay, suffer or incur by reason of any negligent act or omission of Contractor and/or its directors, employees, agents, independent contractors, contractors or subcontractors, including but not limited to Contractor's Representatives, in connection with services provided and duties undertaken under this Agreement, including any

claims for personal injury, healthcare liability or wrongful death, and including, without limitation, any claims arising from any for "cause" removal of Contractor's Representatives or Contractor's termination of its relationship with any Contractor Representative following any for "cause" removal requested by Hospital pursuant to Section II.A, above. For the avoidance of confusion, the parties hereby acknowledge that Contractor shall not be obligated to indemnify Hospital with respect to (i) any claims pursued by a Contractor Representative arising or accruing from a "without cause" removal, or (ii) any for "cause" removal requests by Hospital that Contractor reasonably and in good faith believes may result in actual or potential violation of any applicable federal, state or local employment, anti-retaliation and/or whistleblowing laws as set forth in writing from Contractor to Hospital. Such written notice by Contractor pursuant to clause (ii) above shall clearly articulate the relevant known or alleged facts supporting Contractor's belief, shall cite the applicable underlying law(s), shall clearly explain the rationale supporting Contractor's conclusion(s), and shall be provided to Hospital within three (3) business days after Contractor determines that such removal request may result in an actual or potential violation of law and regardless of the date of removal of the Contractor Representative. The parties hereby acknowledge and agree that while timely and adequate notice pursuant to clause (ii) shall temporarily relieve contractor of the obligation to indemnify Hospital, Hospital shall automatically retain all rights to challenge Contractor's refusal to indemnify pursuant to the dispute resolution procedures set forth in this Agreement. To ensure coverage in the event of an act or omission as described above, Contractor shall (i) maintain in force at all pertinent times at its sole expense a policy of general and professional liability insurance in the minimum amount of One Million Dollars ($1,000,000.00) per occurrence, Three Million Dollars ($3,000,000.00) in the annual aggregate, naming Hospital as an additional insured thereon, or such higher amount as may be required by the laws of the State; and (ii) if applicable, participate in the appropriate state compensation fund. Contractor shall furnish, upon execution of this agreement and annually a copy of the policy of insurance and a Certificate of Insurance evidencing the aforementioned coverage.

B. Hospital hereby agrees to indemnify and hold harmless Contractor from and against any claim, damage, loss, expense, liability, obligation, action or cause of action, including reasonable attorneys' fees and reasonable costs of investigation, which Contractor may sustain, pay, suffer or incur by reason of any negligent act or omission of Hospital, or its employees in connection with services provided and duties undertaken under this Agreement, including any claims for personal injury or wrongful death.

C. Contractor and Hospital each agree and it is the stated intent of each that they shall only be liable to the other party under this Section for the proportionate liability or representative share of negligence allocated to such party based on the negligent acts or omissions of each party and its directors, employees, agents, independent contractors, contractors or subcontractors, including but not limited to Contractor's Representatives. If such allocation is not determined by a court of competent jurisdiction and the parties in good faith are otherwise unable to agree to such allocations, either party hereto may bring an action, including a summary or expedited proceeding, to compel binding arbitration of such matter.

XI. **ACCESS TO BOOKS AND RECORDS.** In the event it is held that Section 1861(v)(1)(1) of the Social Security Act is applicable to this Agreement, it is agreed:

A. Until expiration of five (5) years after furnishing services and pursuant to this Agreement, Contractor shall make available upon written request of the Secretary of Health and Human Services or the U.S. Comptroller General, or any of their duly authorized representatives, this Agreement, books, documents and records of Contractor that are necessary to verify the nature and extent of costs incurred by Hospital under this Agreement.

B. If Contractor carries out any of the duties of this Agreement through a subcontract with a related organization with a value of Ten Thousand Dollars ($10,000) or more over a twelve (12) month period, such agreement must contain a clause to the effect that until the expiration of five (5) years after the furnishing of services under the subcontract, the related organization shall make available, upon written request of the Secretary of Health and Human Services, the U.S. Comptroller General, or any of their duly authorized representatives, the subcontract, any books, documents, and records of the related organization that are necessary to verify the nature and extent of costs incurred by Hospital under this subcontract.

C. In the event said sections are found to be inapplicable to this Agreement, this article shall be deemed not to be a part of this Agreement and shall be null and void with respect thereto.

XII. **NOTICES.** Any notice required or permitted to be given hereunder shall be in writing and may be given by: (1) hand delivery and shall be deemed given on the date of delivery; (2) registered or certified mail and shall be deemed given the third day following the date of mailing, or (3) overnight delivery by reputable overnight delivery service such as Federal Express or UPS and shall be deemed given the following day. All notices to Contractor or Hospital shall be addressed to Contractor or Hospital

at the addresses as set forth on the signature page, together with a required copy to: LifePoint Hospitals, 330 Seven Springs Way, Brentwood, TN 37027, Attention: Chief Legal Officer.

XIII. **CONFIDENTIALITY**. The Parties agree that this Agreement and its provisions are strictly confidential. The Parties shall not disclose any information pertaining to any provision of this Agreement to any person or entity not a party to this Agreement except for tax, legal, or accounting advisors or as otherwise required by law.

XIV. **VENDOR PROMOTION/PUBLICATION**. Hospital prohibits the use of Hospital's name by any vendor or independent contractor, or the use of any name of Hospital's subsidiaries, or affiliated hospitals in any advertisement, press statement or release, website, published customer list, or any publication or dissemination similar to the foregoing without receiving in advance the express written permission from Hospital's Chief Executive Officer or his or her designee. Any request for permission should include the complete text of the publication, statement, or document in which the name usage will appear and will be subject to edit by the Hospital.

XV. **MARKETING SERVICES/COMPENSATION OF CONTRACTOR'S REPRESENTATIVES**. Except as specifically provided in this Agreement, Contractor shall not perform and is not being compensated for marketing services with respect to the Services to be performed at the Hospital. Contractor represents and warrants that no part of the compensation paid hereunder is in exchange for the referral or arrangement for referral of any patient to of Hospital. Contractor represents and warrants that, in connection with the Services to be performed pursuant to this Agreement, each employee, independent contractor, or other entity or person performing Services pursuant to the Agreement shall be compensated in a manner that complies with the Federal Anti-Kickback Statute, an exception to the Stark law, and as applicable, an appropriate exception to any state statutes similar to either or both of the foregoing federal statutes.

XVI. **SEVERABILITY**. The invalidity or unenforceability of any provision(s) of this Agreement will not affect the validity or enforceability of any other provision(s).

XVII. **NO WAIVER**. No waiver of a breach of any provision of this Agreement shall be construed to be a waiver of any breach of any other provision.

XVIII. **ASSIGNABILITY**. Contractor may not assign any of its rights or obligations hereunder without the prior written consent of Hospital, which consent will not be unreasonably withheld. Hospital may not assign this Agreement to any successor to all or substantially all of Hospital's operating assets without the prior written consent of Contractor, which consent will not be unreasonably withheld. This Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective successors and permitted assigns.

XIX. **AMENDMENTS**. Amendments to this Agreement shall be made only in writing duly executed by both Parties hereto.

XX. **ENTIRE AGREEMENT**. This Agreement constitutes the entire agreement of the Parties with respect to the subject matter hereof, and supersedes all prior agreements, contracts and understandings, oral, written or otherwise, including but not limited to any prior agreements between Contractor and/or its affiliates and Hospital.

XXI. **THIRD PARTY BENEFICIARIES**. This Agreement is intended to, and shall be deemed and construed to create rights and/or remedies for the Hospitals, which shall be deemed third party beneficiaries to this Agreement.

XXII. **AGREEMENT CROSS-REFERENCE**. As required by 42 C.F.R. section 411.357 (d)(1)(ii), all service agreements between Company or its affiliated Hospitals and any physician (or an immediate family member of a physician) are maintained electronically in a master contract database that is maintained and updated centrally and is available for review upon request by an authorized government official.

EXHIBIT 5

The Participating Hospitals will be determined at the sole and absolute discretion of Company following the Effective Date of this Agreement and subject to the conditions set forth in Article VII.D of the Agreement.

Data Requirements and Applications

IllumiCare shall provide the following Apps within the Ribbon, each as described in their respective App Schedule (attached hereto and incorporated by reference herein):

Schedule	App
1	Stewardship
2	Benchmarking
3	PDMP Auto-Login
4	Length of Stay (LOS)

SCHEDULE 1 – STEWARDSHIP

Description

The Stewardship App gives providers the human and economic cost of medications, labs and radiology tests, along with specific recommendations about how to lower costs/risks (see Fig 1).

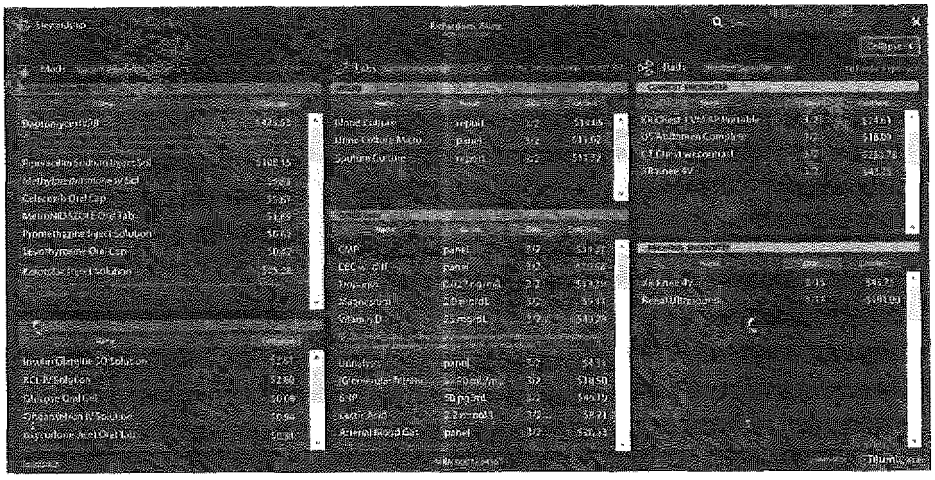


Figure 1

Data Required

- HL7 Feeds:
  - Admit/Discharge/Transfer (ADT)
  - Pharmacy (ORM and RDE)
  - Laboratory (ORM and ORU)
  - Radiology (ORM and ORU)
- Optional Cost Data / Interface:
  - Daily, wholesale acquisition cost of medications
  - Periodic cost accounting data on labs and radiology tests
- Weekly Flat-File of Discharges with (per discharge):
  - Final MS-DRG and APR-DRG
  - Variable and/or direct costs (optional)

SCHEDULE 2 – BENCHMARKING

Description

The Benchmarking App shows each provider how they compare to their peers on a DRG-adjusted basis in spending/utilization of medications, labs and radiology tests (see Fig 2).

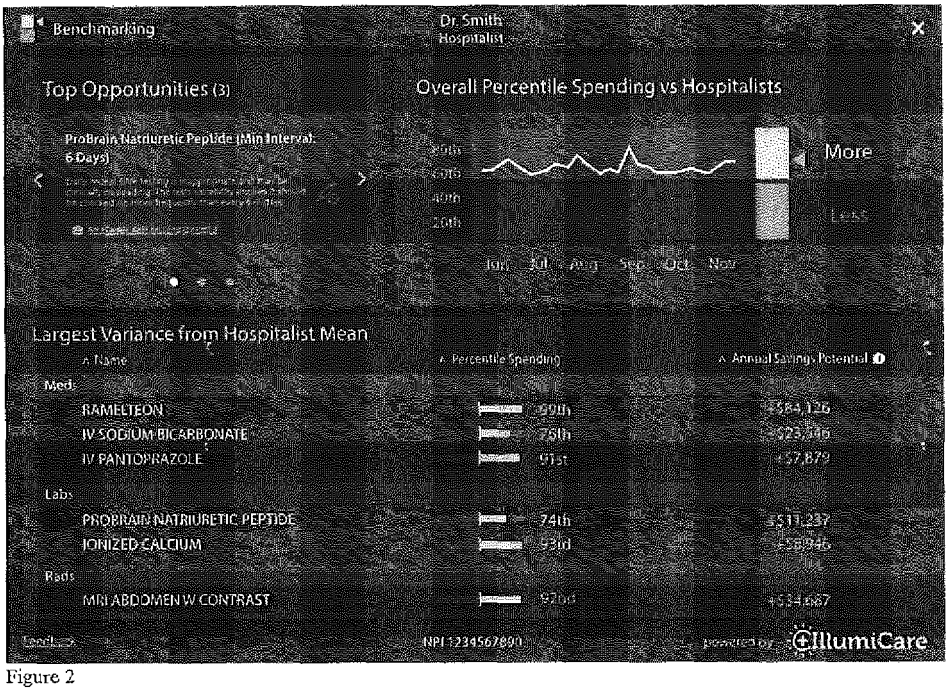


Figure 2

Data Required

Same as the Stewardship App.

SCHEDULE 3 – PDMP AUTO-LOGIN

Description

The PDMP Auto-Login App gives Users are view of outpatient opioid exposures (by opening the state PDMP results with that user's credentials) (Fig. 3).

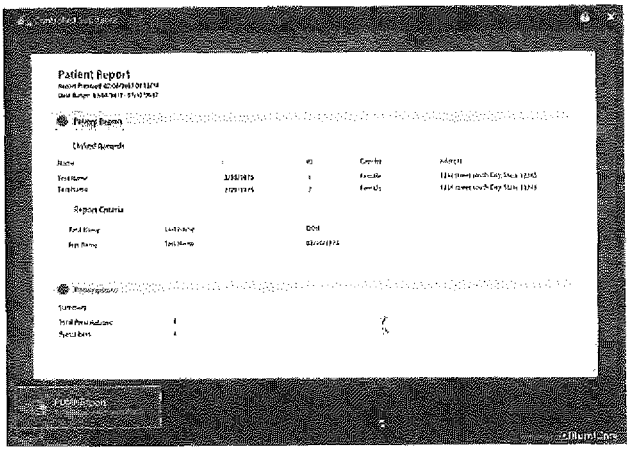


Figure 3

Data Required

None additional

SCHEDULE 4 – LENGTH OF STAY (LOS)

Description

The LOS App allows any IllumiCare user access to a display of clinical barriers and allows streamlined communication with case management to improve discharge length of stay. (see Fig 4).

Figure 4

Data Required

Minimum Functionality: Same as Stewardship app

Full Functionality: Same as Stewardship app, plus:

- Working DRG or GMLOS (ADT/BAR or flat file);
- Med Admin (RAS); and
- Peripheral Device Data, e.g., foley catheter, central line, etc. (flat file)

EXHIBIT 6

[Cost Savings Calculation Examples]

Step 1.

	A	B	C	D	E	F
DRG Category	Pre-Ribbon Total Number of Admissions	Pre-Ribbon Avg Cost	Post-Ribbon Total Number of Admissions	Post-Ribbon Avg Cost	Incremental Difference Pre and Post Ribbon	Extrapolated Difference Post-Ribbon
177 - Respiratory Infections And Inflammations With Mcc	77	$1,106	159	$734	-$372	-$59,150
291 - Heart Failure And Shock With Mcc	186	$327	337	$244	-$83	-$27,826
621 - O.r. Procedures For Obesity Without Cc/Mcc	88	$327	194	$214	-$114	-$22,062
853 - Infectious And Parasitic Diseases With O.r. Procedures With Mcc	69	$769	121	$635	-$134	-$16,213
871 - Septicemia Or Severe Sepsis Without Mv >96 Hours With Mcc	302	$519	460	$489	-$30	-$13,844
... cont. for all DRGs w >10 admissions						
					B - D	E x C

Step 2. - Total Column E
Divide by Total of Column C

Overall Cost Change: -$474,772
-147

Contractor Representative Agreement Regarding Medical Staff Membership and Privileges

The undersigned hereby acknowledge and agrees that:

1. The undersigned is a Physician who may provide services to Hospital pursuant to Agreement between Hospital and Contractor.

2. Pursuant to the Agreement, Hospital has certain rights of approval over Physicians and others who provide services, and that; in addition. Hospital may request removal of a Physician or other provider of services under the Agreement. The undersigned understands that this will mean that Hospital may refuse to permit the undersigned to provide services under the Agreement, or request that the undersigned be removed from the permitted list of individuals providing services under the Agreement.

3. The undersigned agrees to the following: the medical staff appointment and clinical privileges of all Physicians and practitioners providing services under the Agreement shall be incident to and coterminous with the Agreement, and upon termination or expiration of the Agreement or upon removal of any Physician or practitioner by Contractor (independently or at Hospital's request) or Hospital's refusal to permit a Physician or practitioner to perform services under the Agreement, the appointment and clinical privileges of such Physician or practitioner shall automatically terminate except as otherwise provided below. Notwithstanding the foregoing, a Contractor Representative's Medical Staff Appointment and Clinical Privileges will not automatically terminate upon termination or expiration of the Agreement unless a continuation of such privileges, in Hospital's reasonable judgment, would be inconsistent with Hospital's ability to exclusively contract with a successor provider of emergency services. Any rights that the Physician or practitioner may have to any hearing or appeal procedures prior to termination of medical staff appointment or clinical privileges, pursuant to the bylaws or policies of Hospital or the Medical Staff, or any other state or federal statute, regulation or judicial decision, are hereby waived with respect to any termination of Medical Staff Appointment or Clinical Privileges at Hospital as described herein. Unless otherwise required by law, no reporting to any third party, such as the National Practitioner Data Bank, shall take place for any termination hereunder for non-clinical or non-competency issues.

ACKNOWLEDGED AND AGREED:

PHYSICIAN:

Signature: _____

Name: _____

Date: _____

CONTRACTOR:

Signature: _____

Name: _____

Title: _____

Date: _____

EMERGENCY DEPARTMENT AGREEMENT

TERMS AND CONDITIONS

This Schedule 1 ("Schedule 1") is attached to and made a part of the Agreement. Definitions contained herein shall have the same meaning as contained in the Agreement. Should a conflict arise between the terms contained in the Agreement and this Schedule 1, then the terms of this Schedule 1 shall control.

Contractor will be responsible for carrying out the duties identified throughout this Schedule 1 and, additionally, the duties defined hereunder (collectively referred to as the "Services"), plus any Schedules identified below, each of which constitute an integral part of this Agreement:

SCHEDULE	TITLE
1.A	Services, Coverage, and Quality Criteria
1.B	ED Physician Scorecard

SERVICES, COVERAGE, AND QUALITY CRITERIA — EMERGENCY DEPARTMENT

I. **DESCRIPTION OF SERVICES.** Hospital is engaging the services of Contractor to enter into an exclusive relationship for professional Emergency Department ("ED") services which will best facilitate efficient, effective and quality emergency medical care for patients presenting to Hospital's ED. This engagement is expected to improve the services provided at the Hospital, afford effective utilization of the Hospital's equipment and resources, provide consistent service and quality control; provide prompt availability of professional services; simplify scheduling of physician coverage, and enhance the efficient and effective administration of ED services. Contractor and Contractor's Representatives shall practice within Hospital, assuming the role of ED physician or physician extender for patients presenting to Hospital emergency department ("Program Patients"). Allied Health Practitioners, if and when utilized, shall assist Contractor with their duties and responsibilities. Contractor shall provide to Program Patients all professional emergency medicine services that are medically necessary and within the capabilities of the Contractor's Representatives. Contractor's Representatives shall not be responsible for a Program Patient's care after discharge or admission, provided however, Contractor's Representatives shall participate in the Code Team utilized at Hospital, including responses to codes and to other emergency situations involving Program Patients admitted to Hospital.

A. DUTIES OF CONTRACTOR. In addition to the coverage requirements referenced above, Hospital and Contractor agree that the following shall be required duties of Contractor with respect to the Service:

1. Drive performance and be accountable to ED Service line initiatives around quality, service, throughput and growth in coordination with Hospital.

2. Participate in all quality programs outlined by Hospital that improve patient outcomes: Improvement in Value Based Purchasing metrics including but not limited to: core measures, mortality, HCAHPS, readmissions, Medicare Spending Per Beneficiary, and other quality outcome measures.

3. Participate in development and execution of programs and/or educational programs related to service for medical personnel at Hospital, including but not limited to ED Nursing Staff and other Hospital staff, students, interns, residents, as well as Contractor's employees, subcontractors and agents.

4. Must comply with EMTALA, CMS, The Joint Commission and all regulatory agency rules and regulations.

5. Assist and participate in educating the community and creating awareness around services, as requested.

6. Provide the following program enhancement services:

(a) Participate in development and implementation of evidence-based care guidelines that are consistent with local and national standards.

(b) Lead and drive quality improvement in coordination with ED Nurse Director and appropriate Hospital personnel to ensure appropriate care by all of Contractor's Representatives.

(c) In coordination with ED service line initiatives, lead, support and drive improvement through implementation of best practices to drive improved patient outcomes around quality, service and throughput.

(d) Engage and be accountable to quality assurance and improvement initiatives by attending meetings, leading committees, measuring results and holding those accountable to established goals and objectives.

(e) Select a designee for Hospital to meet on a monthly basis with the medical director, case manager, Hospital administration, ED nurse director, and key medical staff leaders i.e. hospitalist, and other individuals necessary to provide input on enhancements for the improvement of Services at Hospital.

(f) Must remain compliant with timely completion of medical records describing the results for all the medical services performed by Contractor's Representatives in ED.

(g) Provide onsite physician supervision for outpatient services rendered at Hospital in order to meet supervision requirements under Medicare.

7. Establish expectations and hold Medical Director and Contractors' Representatives accountable to establishing effective working relationships with ED Nurse Director and personnel, other departments, the Medical Staff, and the administration.

8. Contractor's Regional Medical Directors and Regional Nursing/Clinical Directors must meet with Hospital's ED Services Team at least quarterly to review program goals and objectives around performance related to quality, service, throughput and growth.

9. Contractors support service structure; i.e. customer service and performance improvement, etc., resources; must be accountable to and establish goals consistent with Hospital's ED Service Line priorities both on priority hospitals and metrics.

10. Contractor must use the ED Physician Scorecard, as established in Schedule 1.B, attached hereto and incorporated herein by reference, to align provider and Hospital objectives through a financial withhold in the Medical Director's contract.

11. Agree to work on related projects and perform such other related duties as mutually agreed upon by both parties.

B. DUTIES OF CONTRACTOR'S REPRESENTATIVES. Hospital and Contractor agree that the following shall be required duties of each of the Contractor's Representatives assigned to the Hospitals:

1. Must be consistent with Duties outlined in Section "A" above.

2. Provide emergency department medical treatment as needed for all patients presenting to the Hospital's emergency department.

3. Participate in the Code Team utilized at the Hospital, including responses to codes.

4. Consult with other Medical Staff physicians as needed to assist with evaluations, transfers, and/or admission of program patients or unassigned patients.

5. Meet all behavior and professional conduct requirements of the medical staff bylaws and rules of regulations.

6. Meet all other requirements of the medical staff bylaws, rules and regulations.

7. Complete appropriate documentation of patient medical records and signing of final medical record within required timeframes as required by the Medical Staff Bylaws and Rules and Regulations of Hospital.

8. Work cooperatively with all medical staff and Hospital personnel.

C. MEDICAL DIRECTOR. Contractor shall designate one physician to serve as the Medical Director ("Medical Director") of the Services for each Hospital.

D. The expectations and obligations for the Medical Director include:

1. In conjunction with the ED Nurse Director, drive performance and be accountable to the ED Service line initiative around quality, service, throughput and growth in coordination with the Hospital.

2. Lead and drive quality improvement in coordination with ED Nurse Director and appropriate Hospital personnel to ensure appropriate care by all providers in the ED.

3. In coordination with the ED service line initiative, lead, support and drive improvement through implementation of best practices to drive improved patient outcomes around quality, service and throughput.

4. Educate and hold the ED providers accountable to implement best practices supported by the Hospital around quality, throughput, service and growth and hold the ED providers accountable to meeting the goals and objectives (targets) established.

5. Engage and be accountable to quality assurance and improvement initiatives by attending meetings, leading committees, measuring results and holding those accountable to established goals and objectives (targets).

6. Serve as the professional liaison of the physicians associated with the emergency department program and work closely with Hospital and administration to solve program problems

7. Develop and implement programs to educate medical staff physicians across Hospital on the benefits of the Services to the patients and the community served by Hospital.

8. Establish a culture of safety by creating a professional atmosphere conducive to a high standard of patient care, investigate patient complains and incident reports, hold providers accountable to expectations, and provide high levels of service measured by ED patient Satisfaction.

9. Lead the monthly ED operations committee in coordination with the ED nurse director. The purpose of this multidisciplinary committee is to address key operational priorities around quality, service throughput and growth. The meetings should be data driven based on objective metrics that will drive improvement and patient outcomes in the emergency department.

10. Establish a close working relationship with the case manager of Hospital's emergency department program to ensure a high standard of patient care, proper patient care protocols are developed and maintained, coordinate work flow with the other ancillary departments within Hospital, and assist in the coordination of case management services.

11. Serve as an advisor to Hospital's quality improvement program.

12. In collaboration with the ED Nurse Director, revise existing policies and develop new policies as needed.

13. Participate in Hospital meetings, including but not limited to those related to performance improvement, quality improvement, patient experience, and utilization review.

14. Periodically review emergency department patient records to ensure the documentation, treatment, treatment plans, consults and tests ordered meet the appropriate standard of care.

15. Participate in the Hospital's peer review activities as requested/needed by Hospital.

16. Oversee the administration and management of Hospital's emergency department program and the Agreement with Hospital.

17. Ensure appropriate coverage for Hospital by scheduling coverage of the Services on a monthly basis, including on-site coverage.

18. Facilitate an evaluation process as it relates to the performance of all Contractor's Representatives that treat patients at Hospital. The performance evaluation may include input from other specialists who consult on patients presenting to Hospital's Emergency Department, Hospital personnel, etc. Performance shall be evaluated on the basis of professional attitude, professional capabilities, patient relations attitude and overall effectiveness as determined appropriate by Contractor and Hospital.

II. COVERAGE. In accordance with the terms of this Agreement, Contractor shall:

A. Ensure and deliver to Hospital continuous, twenty-four (24) hour on-site emergency medicine coverage, seven (7) days per week, fifty-two (52) weeks per year.

B. In order to provide the comprehensive coverage set forth above and meet patient needs, Contractor shall provide to Hospital a minimum number of qualified Physician coverage hours ("Qualified Physician Hours"), and if applicable, a minimum number of physician extender or Allied Health Practitioner coverage hours ("Allied Health Practitioner Hours).

Provider	Hours/day needed
Physician	
NP/PA	

C. Any adjustments to staffing requirements and hours of coverage other than those set forth in Section 2 above shall be agreed upon by Hospital and Contractor in writing.

D. In no event shall any Physician or Allied Health Practitioner providing services under the Agreement work more than twelve (12) consecutive hours in a twenty-four (24) hour period, unless prior advance written approval has been obtained from Hospital's Chief Executive Officer or his or her designee. Such advance written approval shall be waived in the case of a catastrophic event or extraordinary medical crisis.

III. **QUALITY CRITERIA.** Hospital and Contractor shall mutually agree upon an "ED Physician Scorecard" which shall be set forth in Schedule I .B. Beginning on the Effective Date, Contractor shall cause Contractor's Representatives to meet the quality criteria set forth in the ED Physician Scorecard (the "ED Physician Scorecard") for the Hospital, which shall be effective as of the date that the ED Physician Scorecard is agreed upon by the Parties, which shall be no later than the Effective Date. The agreed upon ED Physician Scorecard shall be attached as Schedule 1.B, which may be amended from time to time by mutual agreement of the Parties. Any amendments to the ED Physician Scorecard shall be implemented prior to the commencement of a new contract year, shall be based on the prior year's trends and achievements, and shall be mutually agreed upon. The Parties further agree to use their best commercially reasonable efforts to negotiate the ED Physician Scorecard to be applicable hereunder within sixty (60) days of the Effective Date. Each of the quality criteria in the ED Physician Scorecard will be monitored quarterly during the Term of the Agreement, and Hospital will deliver the results of such assessment to Contractor thirty (30) days from the assessed quarter end. The Parties acknowledge and agree that targets identified for each of the quality criteria meet only the minimum level of performance required from Contractor and Contractor's Representatives which shall be an annual overall score of sixty (60) points (the "Minimum Score").

SCHEDULE 1.B

ED PHYSICIAN SCORECARD

Points Possible	ED Physician Scorecard Hospital Name 2016	Service Provider	Quarter 1		Quarter 2		Quarter 3		Quarter 4		YTD
		Goal	Results	Points Earned	Results	Pointed Earned	Results	Points Earned	Results	Points Earned	Points Earned
	Delivering Compassionate Care										
12.5	Patient overall rating of ED	Tier Med									
12.5	Patient overall rating of ED MD	Tier Med									
25	Total Points Earned										
	Delivering High Quality Care										
10	ED Core Measure Performance (* denotes preliminary)	100%									
10	% LWOT	<1.0%									
10	% Fully Staffed	85%									
30	Total Points Earned										
	Operational Excellence										
10	Arrival Time to MSE	Tier Med									
10	MSE to Disposition	Tier Med									
10	Decision to Admit to Depart Time	Tier Med									
15	Discharges LOS	Tier Med									
45	Total Pointed Earned										
100	Grand Total										

HOSPITALIST SERVICES AGREEMENT

TERMS AND CONDITIONS

This Schedule 2 ("Schedule 2") is attached to and made a part of the Agreement. Definitions contained herein shall have the same meaning as contained in the Agreement. Should a conflict arise between the terms contained in the Agreement and this Schedule 2, then the terms of this Schedule 2 shall control.

Contractor will be responsible for carrying out the duties identified throughout this Schedule 2 and, additionally, the duties defined hereunder (collectively referred to as the "Services"), plus any Schedules identified below, each of which constitute an integral part of this Agreement:

SCHEDULE	TITLE
2.A	Services, Coverage, and Quality Criteria
2.B	Hospitalist Physician Scorecard

SERVICES, COVERAGE, AND QUALITY CRITERIA - HOSPITALIST SERVICES

II. **DESCRIPTION OF SERVICES.** Hospital is engaging the services of Contractor to enter into an exclusive relationship for professional hospitalist services which will best facilitate efficient, effective and quality inpatient care for area physicians who choose to concentrate on outpatient care. This engagement is expected to improve the relationships between outlying physician practices, the Medical Staff and other services provided at the Hospital; afford effective utilization of the Hospital's equipment and resources, provide consistent service and quality control; provide prompt availability of professional services; simplify scheduling of patients and physician coverage, and enhance the efficient and effective administration of the service. Contractor shall provide inpatient hospitalist services for all unassigned patients and for all patients referred by community physicians of the Hospital's twenty-four (24) hours per day, seven (7) days per week. Contractor agrees to provide onsite coverage as required to attend patients on the hospital medicine service.

A. DUTIES OF CONTRACTOR. In addition to the coverage requirements referenced above, Hospital and Contractor agree that the following shall be required duties of Contractor with respect to the Services:

1. Conduct daily patient rounds beginning by 8:00 a.m. or such other times agreed upon by the Hospital, accompanied by the Hospital's case manager or primary nurse, if available.

2. Complete documentation to meet CMS and all other payer requirements for justifying admissions and continuing stays.

3. Attend interdisciplinary care/case management meetings.

4. Participate in the marketing campaign to be utilized to promote the services of the hospitalist program at Hospital as reasonably requested by the Hospital and as part of the campaign. Contractor Representatives will complete periodic visits to referring physicians to determine their level of satisfaction with the program.

5. Participate in the Code Team.

6. Participate in all quality programs outlined by Hospital that include reduction of inpatient mortality, patient harms, readmissions and improvement in patient outcomes, including, without limitation, HCAHPS and the Physician Quality Reporting System. .

7. Assist Hospital in compliance with all Core Measures. The Joint Commission requirements, and all regulatory agency rules and regulations.

8. Ensure achievement and maintenance of mutually agreed upon quality criteria, including, but not limited to, the following:

   a. Initial assessment of all patients within six (6) hours of admission, and an initial assessment of all patients in the intensive care/critical care unit no later than two (2) hours after admission or sooner if warranted by the patient's condition.

   b. Provide requested consultations within six (6) hours after routine requests, and within two (2) hours for those designated as "urgent request."

   c. Conduct and document medical history and physical examination for each patient within twenty four (24) hours of admission.

9. Assist the Hospital's education department as may be reasonably requested in grand rounds and CME depending upon Contractor's Representatives' availability.

10. Provide the following Program Enhancement services:

    a. Develop and implement evidence-based Order sets and support hospital CPOE initiative.

    b. Regularly review quality indicators with case manager to ensure appropriate care by all of Contractor's Representatives.

c. Discuss and develop protocol changes as needed to ensure quality care.

d. Attend meetings, participate in quality assurance and quality improvement ("QA/QI") activities, and educational functions to evaluate and maintain the quality of care of the hospitalist program.

e. Meet on a bi-monthly basis with the medical director, care manager, hospital administration (as appropriate), emergency department director and other individuals necessary to provide input on enhancements for the betterment of the hospitalist program.

f. Participate in Medical Staff activities including but not limited to attending committee meetings.

g. Ensure timely completion of medical records as required in the Hospital's Medical Staff Bylaws, describing the results of all medical services performed by Contractor's Representatives in the hospitalist program. Upon request, participate in the development of and will, upon implementation of, utilize the Hospital's health information system.

11. Encourage and develop effective working relationships with all other departments, the Medical Staff, the administration and staff within the hospitalist program.

12. Utilize Hospital's Hospitalist Scorecard when developed.

13. Provide Hospital with the following: the daily admission/census reports; anticipated discharge date with disposition updated daily; length of stay by DRG, and physician, on a monthly basis; patient perception index on a monthly basis and any other reports reasonably requested by Hospital.

14. Agree to work on other projects and perform such other duties as mutually agreed upon by both Parties.

B. DUTIES OF CONTRACTOR'S REPRESENTATIVES. Hospital and Contractor agree that the following shall be required duties of each of the Contractor's Representatives assigned to Hospital:

1. Accept direct, inpatient admissions from physicians on Hospital's medical staff utilizing the Service.

2. Timely consult with direct admit patients after admission.

3. Conduct initial patient assessments and admission procedures.

4. Formulate and implement a treatment plan.

5. Schedule and review clinical and diagnostic tests as medically necessary for each patient.

6. Provide timely and regular reports to primary care physicians and family members, if applicable, regarding all aspects of the patient's medical condition and course of treatment.

7. Conduct rounds daily as necessary for the acuity of the patient's conditions.

8. Respond to in-house codes and urgent requests for assistance from the Rapid Response Team.

9. Coordinate and integrate specialty and subspecialty consultations.

10. Coordinate patient transfers to and from the intensive care unit, medical/surgical unit, skilled nursing facility or home to provide continuity of cart.

11. Discharge the patient back to the care of the primary care physician, if applicable.

12. Arrive at Hospital within time frame required by the Hospital's Medical Staff bylaws, as amended from time to time, when emergent care is needed for critically ill patients.

13. Provide emergency room on call coverage as needed for primary care physicians utilizing the Services and accept all unassigned patients that present.

14. At the request of members of the Medical Staff, provide inpatient consultations or co-management services.

15. Participate in all quality programs outlined by Hospital that include reduction of inpatient mortality, patient harms, readmissions and improvement in patient outcomes and be an active member on committees of the Medical Staff.

16. Provide emergent care for all inpatients regardless of the attending physician.

17. Consult with emergency department physicians as needed either by phone or on site, to assist with evaluations, transfers, and/or admission of Program Patients or unassigned patients accepted by Contractor.

18. Meet all behavior and professional conduct requirements of the Medical Staff bylaws and rules and regulations.

19. Meet all other requirement of the medical staff bylaws, rules, and regulations including appropriate documentation in the medical record and signing final medical record within required timeframes.

20. Coordinate with discharge planning and social work departments as appropriate for each patient.

21. Inform Hospital and/or the primary care physician of any problems identified after a patient is discharged, if aware.

22. Be responsible for arranging post-acute care follow-up for all patients discharged from the hospitalist program and completing all required forms to facilitate transition of care for these patients to the respective post-acute setting.

23. Complete patient discharge summaries as required by the Medical Staff bylaws of the Hospital.

24. Provide onsite physician supervision for hospital medicine services rendered at the Hospital in order to meet supervision requirements under Medicare, to the extent appropriate based upon Contractor Representatives' privileges and experience.

25. Work cooperatively with all Medical Staff and Hospital personnel.

26. Maintain ICU/CCU privileges and ventilator management privileges.

C. MEDICAL DIRECTOR. Contractor shall designate one physician to serve as the Medical Director ("Medical Director") of the Services for each Hospital.

1. Program Operations

a. Serve as the professional liaison of the physicians associated with the hospitalist program and will work closely with Hospital administration to solve program problems.

b. Work to improve program efficiency, help create a professional atmosphere conducive to a high standard of patient care, investigate patient complaints and incident reports, and interact with the Hospital Medical Staff and related hierarchy as needed.

c. Work with Hospital to revise existing policies and develop new policies as the need arises, and develop necessary clinical protocols.

d. Work closely with the case manager of the hospitalist program to help ensure a high standard of patient care, to help ensure that proper patient care protocols are developed and maintained, to help coordinate work flow with the other ancillary departments within the Hospital, and to assist in the coordination of case management services.

e. Participate in Hospital committee meetings, including but not limited to those related to performance improvement and utilization review.

f. Assist in the development and implementation of a program to educate Medical Staff physicians on the benefits of the Services to their patients and the community served by the Hospital.

g. Assist the Hospital in evaluating the quality of patient care provided by Contractor's Representatives, including participating in peer review activities as needed.

h. Work very closely with the emergency department Medical Director to ensure coordination of care for all admitted patients and timely transfer to the inpatient unit.

2. Patient Care Activities

a. Serve as an advisor to the Hospital's quality improvement program as it relates to hospitalist patients.

b. Periodically review hospitalist patient records to ensure the documentation, treatment, treatment plans, consults and tests ordered are appropriate.

c. Participate in peer review activities as requested by the Hospital.

III **COVERAGE**. In accordance with the terms of this Agreement, Contractor shall:

A. Ensure and deliver to the Hospital continuous, twenty-four (24) hour hospitalist coverage, seven (7) days per week, fifty-two (52) weeks per year.

B. In order to provide the comprehensive coverage set forth above and meet patient needs, Contractor shall provide to Hospital qualified physician coverage ("Qualified Physician"), and if applicable, physician extender or Allied Health Practitioner coverage ("Allied Health Practitioner").

C. Any adjustments to staffing requirements and hours of coverage shall be agreed upon by Hospital and Contractor in writing.

IV. **QUALITY CRITERIA**. Hospital and Contractor shall mutually agree upon a Hospitalist Physician Scorecard which shall be set forth in Schedule 2.B. Beginning on the Effective Date, Contractor shall cause Contractor's Representatives to meet the quality criteria set forth in the Hospitalist Physician Scorecard (the "Hospitalist Physician Scorecard") for the Hospital which shall be effective as of the date that the Hospitalist Physician Scorecard is agreed upon by the Parties, which shall be materially similar to the document attached hereto and incorporated into this Agreement by reference as Schedule 2.B, and which may be amended from time to time by mutual agreement of the Parties. Any amendments to the Hospitalist Physician Scorecard shall be implemented prior to the commencement of a new contract year, and shall be based on the prior year's trends and achievements, and shall be mutually agreed upon. The Parties further agree to use their best commercially reasonable efforts to negotiate the Hospitalist Physician Scorecard to be applicable hereunder within sixty (60) days of the Effective Date. Each of the quality criteria in the Hospitalist Physician Scorecard will be monitored quarterly during the Term of the Agreement, and Hospital will deliver the results of such assessment to Contractor thirty (30) days from the assessed quarter end. The Parties acknowledge and agree that targets identified for each of the quality criteria meet only the minimum level of performance required from Contractor and Contractor's Representatives which shall be an annual score of sixty (60) points (the "Minimum Score").Hospital shall report to Contractor monthly on all performance metrics no later than the fifteenth (15'11) day of the following month, with the exception of those metrics which are reported on a quarterly (Core Measures), semi-annually (Patient Satisfaction) or annual basis, which shall be within five (5) days after the quarterly, semi-annual or annual publication.

HOSPITALIST PHYSICIAN SCORECARD

Points Possible	Hospitalist Physician Scorecard Hospital Name 2016	Service Provider	Quarter 1		Quarter 2		Quarter 3		Quarter 4		YTD
		Goal	Results	Points Earned	Results	Pointed Earned	Results	Points Earned	Results	Points Earned	Points Earned
	Delivering Compassionate Care										
	HCAHPS										
15	HCAHPS Composite: Doctor Communication	50-75th %tile									
	Medical Staff Satisfaction										
10	Medical Staff Satisfaction Composite	.05>									
25	Total Points Earned			0		0		0		0	0
	Delivering High Quality Care										
10	Discharge Summary Completed within 24 hours	≥ 95%									
10	CPOE Medication Compliance	≥ 80%									
10	Query Response Time	24 Hours									
10	Sepsis Core Measures	100%									
40	Total Points Earned			0		0		0		0	0
	Operational Excellence										
10	Discharge Orders before Noon	> 60%									
10	Decision to Admit to ED Depart Time	Tier Med									
15	% Fully Staffed	85%									
35	Total Points Earned			0		0		0		0	0
100	**Grand Total**			**0**		**0**		**0**		**0**	**0.00**

ANESTHESIA SERVICES AGREEMENT

TERMS AND CONDITIONS

This Schedule 3 ("Schedule 3") is attached to and made a part of the Agreement. Definitions contained herein shall have the same meaning as contained in the Agreement. Should a conflict arise between the terms contained in the Agreement and this Schedule 3, then the terms of this Schedule 3 shall control.

Contractor will be responsible for carrying out the duties identified throughout this Schedule 3 and, additionally, the duties defined hereunder (collectively referred to as the "Anesthesia Services"), plus any Schedules identified below, each of which constitute an integral part of this Agreement:

SCHEDULE	TITLE
3.A	Services, Coverage, and Quality Criteria – Anesthesia Services
3.B	Anesthesia Scorecard

SERVICES, COVERAGE, AND QUALITY CRITERIA - ANESTHESIA SERVICES

I. **DESCRIPTION OF SERVICES AND COVERAGE.** Hospital is engaging Contractor to enter into an exclusive relationship for professional anesthesia services (the "Anesthesia Services") which will best facilitate efficient, effective and quality medical care for patients receiving medical treatment at Hospital who require Anesthesia Services. This engagement is expected to improve the Anesthesia Services provided at Hospital; afford effective utilization of Hospital's equipment and resources, provide consistent service and quality control; provide prompt availability of professional services; simplify scheduling of physician coverage, and enhance the efficient and effective administration of the service. Contractor's Representatives shall, within Hospital, practice exclusively according to the Anesthesia Services required herein and provide to all patients the professional Anesthesia Services that are medically necessary and within the capabilities of Contractor and Contractor's Representatives.

A. COVERAGE. In accordance with the terms of this Agreement, Contractor shall provide coverage as detailed in this section.

1. Staffing. In order to provide and deliver continuous coverage via onsite coverage and on-call coverage (as set forth in Section I.A.2, below), twenty-four (24) hour, seven (7) days per week, fifty-two (52) weeks per year and meet patient needs, Contractor shall provide coverage with an onsite daily minimum of ( ) Physicians and ( ) CRNAs.

2. Days and Hours coverage shall be provided: **HOSPITAL-SPECIFIC COVERAGE REQUIREMENTS TO BE ADDED**

3. Contractor's Representatives providing "on call coverage" for the Hospital shall arrive and be prepared to deliver direct patient care within thirty (30) minutes of receiving notice of need for Anesthesia Services, or as otherwise required by Hospital's Medical Staff Bylaws.

4. Either Party may request reasonable changes to call coverage requirements or onsite hours of staffing. Hospital and Contractor agree to meet within thirty (30) days of request to review, and discuss, with resolution and implementation date if applicable, of agreed upon changes within ninety (90) days of meeting. Any changes to staffing requirements or hours of coverage with financial implications shall be reflected in the form of an amendment to this Agreement that is executed by both Parties. Nothing contained in the section shall preclude Contractor from optimizing Contractor's staff so long as the coverage requirements set forth in Section I.A.1., above, is not affected.

B. DUTIES OF CONTRACTOR. In addition to the coverage requirements referenced above, Hospital and Contractor agree that the following shall be required duties of Contractor with respect to the Anesthesia Services:

1. Assist in efforts to educate the Medical Staff and Hospital employees about the Anesthesia Services, as requested.
2. Participate in all quality programs outlined by Hospital that include reduction of patient harms and improvement in patient outcomes that relate to the Anesthesia Services. Contractor will, on Contractor's own behalf and in support of Hospital's efforts, use commercially reasonable efforts to optimize HCAHPS, PQRS, MACRA, and other value-based reimbursement.
3. Assist Hospital in compliance with all Core Measures, Joint Commission requirements, CMS Conditions of Participation, and all other applicable regulatory agency rules and regulations.
4. Develop and provide educational and training programs related to the Anesthesia Services for medical personnel at Hospital, including, but not limited to, students, interns, residents and staff as well as Contractor's employees, subcontractors and agents.
5. Provide the following enhancement services:

    a. Develop and implement clinical protocols and care plans that are consistent with local and national standards and other efficiency tools for the Anesthesia Services.
    b. Regularly review quality indicators with appropriate Hospital personnel to ensure appropriate care by all of Contractor's Representatives.
    c. Discuss and develop protocol changes as needed to equal or better local area and Hospital comparatives.

d. Participate in quality improvement ("QA/QI") activities and attend meetings and educational functions to evaluate and maintain the quality of care of Anesthesia Services.
e. Communicate on at least a monthly basis with applicable medical directors, Surgical Services Director, Hospital Administration (as appropriate), and other individuals necessary to provide input on enhancements for the betterment of Anesthesia Services at Hospital.
f. Participate in Medical Staff activities including, but not limited to, regularly attending committee meetings.
g. Ensure timely dictation of results of all Anesthesia Services performed at Hospital.
h. Encourage and develop effective working relationships with all other departments, the Medical Staff and the administration and staff associated with the Anesthesia Services.
i. Oversee and review for appropriateness and outcomes all moderate sedation services performed at Hospital.

6. Work on other related projects and perform such other related duties as mutually agreed upon by the Parties.

C. DUTIES OF CONTRACTOR'S REPRESENTATIVES. Hospital and Contractor agree that the following shall be required duties of Contractor's Representatives:

1. Provide Anesthesia Services as requested for Hospital's patients requiring Anesthesia Services.
2. Participate in all quality programs outlined by Hospital that include reduction of patient harms and improvement in patient outcomes.
3. Be an active member on Hospital's medical staff committees.
4. Consult with other medical staff physicians as needed.
5. Meet all behavior and professional conduct requirements of the Bylaws and rules and regulations.
6. Meet all other requirement of the Bylaws, rules and regulations, including appropriate documentation in the medical record within required timeframes.
7. Work cooperatively with all medical staff and Hospital personnel.

D. MEDICAL DIRECTOR. Contractor shall designate one (1) Physician, agreed upon by Hospital CEO, to serve as Medical Director ("Medical Director") of the Anesthesia Services. The Medical Director shall regularly communicate with Hospital's Chief Executive Officer and Surgical Services Director regarding his/her oversight of clinical performance, coordination of care issues and other necessary administrative duties. The Medical Director will devote the required hours of services per month to the performance of the administrative duties listed below that are commensurate with the budgeted compensation for the same services included in the subsidy associated with this Agreement in order to fulfill all applicable legal or operational requirements. The expectations and obligations for the Medical Director include but are not limited to the following:

1. Program Operations.

a. Through exemplary leadership, Medical Director will work towards creating and maintaining a professional atmosphere conducive to a high standard of patient care, providing collaborative support of perioperative team, actively participating in ongoing improvements towards program efficiency, investigating patient complaints and incident reports, and interacting with the medical staff and medical staff hierarchy as needed.
b. Serve as the professional liaison for the providers associated with the Anesthesia Services and work closely with Hospital administration to solve program problems.
c. Work with Hospital to revise existing policies and develop new policies as the need arises.
d. Work closely with the Director of Hospital's Surgical Services department to: ensure a high standard of patient care by maintaining needed patient care protocols, helping coordinate operating room efficiencies, coordinating work flow with the other ancillary departments within Hospital and assisting in the coordination all perioperative services.
e. Regularly participate in Hospital committee meetings, including, but not limited to, those related to performance improvement and utilization review.
f. Assist in the development and implementation of a program to educate medical staff physicians on the benefits of the Anesthesia Services to their patients and the community served by Hospital.

g. Assist Hospital in evaluating the quality of patient care provided by Contractor's Representatives, including participating in peer review activities as needed.

h. Develop and provide educational and training programs related to the Anesthesia Services for personnel at Hospital, including, but not limited to, students, interns, residents and staff.

2. Patient Care Activities.

a. Serve as an advisor to Hospital's quality improvement program as it relates to Hospital's patients requiring Anesthesia Services.

b. Periodically review patient records to ensure that the documentation, treatment, treatment plans, consults and tests ordered meet the appropriate standard of care.

c. Participate in peer review activities as requested by Hospital.

3. Administrative Functions.

a. Oversee the administration and management of Anesthesia Services and the Agreement with Hospital.

b. Ensure appropriate coverage for Hospital by scheduling coverage of the Anesthesia Services on a monthly basis, including on-site coverage, as described above in Section I.A.2.

c. Facilitate an evaluation process as it relates to the performance of all of Contractor's Representatives who treat patients at Hospital. The performance evaluation may include input from other physicians, hospital personnel, etc. Performance shall be evaluated on the basis of professional attitude, professional capabilities, patient relations attitude and overall effectiveness as determined appropriate by Contractor and Hospital.

II. **QUALITY CRITERIA.** Contractor shall cause Contractor's Representatives to meet the quality criteria set forth in the Anesthesia Scorecard (the "Anesthesia Scorecard") for Hospital, which shall be materially similar to the document set forth in Schedule 1.B, and which may be amended from time to time by Hospital subject to Contractor's reasonable approval. The Parties agree to use their best commercially reasonable efforts to negotiate the Anesthesia Scorecard to be applicable hereunder within ninety (90) days of the Effective Date of this Agreement. If not finalized within the ninety (90) day period, the measures as reflected will become the agreed-upon measures by default, with targets based upon Company's facilities of similar demographics. Each of the quality criteria in the Anesthesia Scorecard will be monitored quarterly during the Term of the Agreement, and Hospital will deliver the results of such assessment to Contractor thirty (30) days from the assessed quarter end. The Parties acknowledge and agree that targets identified for each of the quality criteria meet only the minimum level of performance required from Contractor and Contractor's Representatives, and that an annual overall score of sixty (60) points (the "Minimum Score") must be maintained. In the event Hospital fails to report any performance metric as required hereunder, Contractor shall be deemed to have fully met any such unreported metric that is not reported by Contractor by Hospital.

ANESTHESIA SCORECARD

A	POINT VALUE	COMPLIANCE TIME OUT	THRESHOL	BENCHMAR	MEASUREMENT NOTES
1	10	Lead Anesthesia Time out Participate in Surgical Time Out Participate in Debrief	< 3	0	Incidents of reported Non-compliance/yr
B		**EVALUATION and**			
2	15	Pre-Op Eval/Documentation Post-Op Eval/Documentation Immediate Pre Anesthesia Eval/Doc Anesthesia Consent executed/chart	< 3	0	Incidents of reported Non-compliance / yr
C		**MEDICATION**			
3	15	CDC Safe Use Initiatives Narcotic management Proper labeling and storage	< 3	0	Incidents of reported Non-compliance / yr
D		**STANDARDS**			
4	10	Following AORN Practice of Survey Readiness	< 3	0	Incidents of reported Non-compliance / yr
E		**EFFICIENCY**			
5	10	Case Delays	< 0.5%	0.5%	Anesthesia delays as % of all delays
6	10	Day of Surgery Case Canx	< 0.1%	0.1%	Cases Canx by Anesthesia as % of all Canx
F		**PROFESSIONALISM**			
7	10	Patient Satisfaction	> Mean	>75%	HCAHPS Anesthesia Specific
8	10	Culture	75%	100%	Participation in COSE Survey When Given
G		**SSI BUNDLE PERFORMANCE**			
9	10	Compliance with SSI Bundle	< 3	0	Incidents of reported Non-compliance / yr

FIRST AMENDMENT TO PROFESSIONAL SERVICES AGREEMENT

This First Amendment to Professional Services Agreement (the "First Amendment") is hereby entered into and made effective upon full execution (the "Effective Date"), by and between RCHP-Ottumwa, LLC d/b/a Ottumwa Regional Health Center ("Facility") and Southeastern Emergency Physicians, LLC ("Contractor"). **[NOTE: The Effective Date cannot be a date that occurs before the dates that both the Facility and Contractor signed the First Amendment. If the First Amendment is submitted for approval with an Effective Date that occurs before the last party (The Facility or Contractor) signed the First Amendment, the Effective Date will automatically be changed to the date that the Contractor or Facility signed, whichever is later. Contractor will not be compensated for services provided to the Facility prior to the Effective Date.]**

WHEREAS, Facility and Contractor entered into that certain Professional Services Agreement regarding emergency department Services, effective as of March 1, 2019, which is listed in the MediTract contract database as # 62460.68803C (the "Agreement");

WHEREAS, the parties desire to amend the Agreement to add certain medical director services for Facility's Mobile Intensive Care Services, as more particularly described below; and

WHEREAS, the parties hereby ratify and affirm that this First Amendment is not made to induce the value or volume of referrals made to the Facility by the Contractor or any of its physician affiliates or other potential referral sources;

NOW THEREFORE, the Agreement is hereby amended as of the Effective Date of this First Amendment as follows:

1. Amendments

   a. DESCRIPTION OF SERVICES. Section 1 of Schedule 1.A shall be amended by adding the following new Section I.D

      D. MEDICAL DIRECTOR – OTTUMWA REGIONAL MOBILE INSTENSIVE CARE SERVICES ("ORMICS") ("ORMICS Medical Director"). Contractor will designate one physician, who is agreeable to Facility, to serve as the ORMICS Medical Director jointly covering the ED and ambulance services, or one Medical Director over each service separately who works in tandem with the ED Medical Director and ED Service line Director. ORMICS Medical Director will perform the following duties:

         1. Perform weekly review of ORMICS Ambulance Calls.
         2. Attend quarterly Wapello County EMS Meetings.
         3. Perform monthly review of Ottumwa Fire Department and County EMS First Responder run sheets and CQI audits
         4. Perform review and revision of ORMICS, Ottumwa Fire Department and County EMS First Responder protocols and assurance of compliance with Iowa EMS Systems Standards.
         5. Attend annually, or as needed, meetings with Iowa EMS Bureau Chief.
         6. Other duties as reasonably requested.

   b. USE OF FACILITY LEASED APARTMENT. Facility may from time to time and in its sole discretion permit Contractor to use an apartment leased by Facility as a location for Contractor's Representatives to reside while providing Services under this Agreement.

Facility will charge Contractor a per diem rate that reflects Facility's cost to lease the space.

2. No Other Changes

Except as specifically amended herein, all terms and conditions of the Agreement shall remain in full force and effect, except as otherwise amended in writing.

IN WITNESS WHEREOF, this First Amendment is executed by Facility and Contractor as of the date and year first above written, and the parties hereby certify for and on behalf of each of themselves that:

Each of the undersigned hereby certifies:

1) As of the date of the signatures below, this Amendment and related Agreement constitutes a binding agreement as of the Effective Date of this Amendment and may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument;

2) The compensation arrangement is established at fair market value for the services to be rendered and this Agreement is for services that are needed and reasonable in scope;

3) This Agreement supersedes all prior agreements, contracts and understandings, whether written or otherwise, between the parties relating to the subject matter hereof and does not condition the payment or the arrangement on the volume or value of any referrals or other business generated between the parties;

4) Until the Agreement is listed in Facility's Master Contract Database to the extent required by 42 C.F.R. § 411.357(d)(1)(ii), no payment shall be made nor services accepted under this Agreement; and

5) Upon the Effective Date of this Agreement, the parties agree to ensure that no payments are made and no services rendered beyond the terms of this Agreement, or the terms of other company approved agreements between the parties.

CONTRACTOR:
Southeastern Emergency Physicians, LLC

By: _____
(Signature)

Name: Stanley C. Thompson, MD

Title: Chief Clinical Officer

Date: 7/2/2019

FACILITY:
RCHP-Ottumwa, LLC d/b/a Ottumwa Regional Health Center

By: _____
(Signature)

Name: PHILIP J. NOEL III

Title: CEO

Date: 6/7/2019

Attachment 43

EXCLUSIVE PROFESSIONAL SERVICES AGREEMENT

"Effective Date" See restriction in **Section V.A**	March 1, 2019	**"Initial Term"** **See Section V.A**	Effective Date and continuing through December 31, 2020
"Contractor"	Southeastern Emergency Physicians, LLC	**"Hospital"**	RCHP-Ottumwa, LLC d/b/a Ottumwa Regional Health Center
"Contractor Address"	265 Brookview Centre Way Suite 400 Knoxville, TN 37919 Attention: CEO	**"Hospital Address"**	1001 E. Pennsylvania Avenue Ottumwa, IA 52501 Attention: CEO
"State"	Iowa		
"Initial Term Year 1 Total Annual Practice ED Subsidy Amount "	An amount as determined in Exhibit 1 to the Exclusive Emergency Department and Hospitalist Services Master Agreement between LifePoint Corporate Services, General Partnership ("Company") and Southeastern Emergency Physicians, LLC, a Tennessee limited liability company ("Contractor") effective as of January 1, 2018 (the "Master Agreement"). **Such allocation will be based on the relative cost of providing the Services per the schedules referenced below that are included in this Agreement. The Hospital's specific revenue and expense for the Services provided will be considered in determining this allocation.**		
Terms of shared excess revenue/profits:	Per the Master Agreement		
Other Terms:	During the time period beginning on the Effective Date and continuing through April 15, 2019 (the "Scheduling Time Frame"), the Hospital may assist Contractor with scheduling the appropriate level of Services needed to properly address patient needs and effectively coordinate with other applicable operations of the Hospital. In the event any of Services set forth in this Agreement are rendered by a duly licensed and qualified third party that is scheduled by Hospital during the Scheduling Time Frame, Hospital hereby agrees to be responsible for paying the fees associated with the Services rendered by any such third party (the "Temporary Coverage Fees"). Further, Contractor hereby acknowledges and agrees that any Temporary Coverage Fees incurred by the Hospital during the Scheduling Time Frame shall be excluded from the calculation of the Cost-Plus Subsidy Payment set forth and defined in the Master Agreement between Company and Contractor.		

The following Schedules are attached to and made a part of this Agreement:

Schedule	Title
1	Emergency Department Agreement

[SIGNATURES TO APPEAR ON THE FOLLOWING PAGE]

IN WITNESS WHEREOF, Hospital and Contractor have duly executed this Agreement as of the dates set out beneath their respective signatures. The undersigned hereby certify that:

1) As of the date of the signatures below, this Agreement constitutes a binding agreement to perform Services as of the Effective Date and may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument;
2) The compensation arrangement is established at fair market value for the Services to be rendered and this Agreement is for Services that are needed and reasonable in scope;
3) This Agreement supersedes all prior agreements, contracts and understandings, whether written or otherwise, between the parties relating to the subject matter hereof and does not condition the payment or the arrangement on the volume or value of any referrals or other business generated between the parties;
4) Until the Agreement is listed in Hospital's Master Contract Database to the extent required by 42 C.F.R. § 411.357(d)(1)(ii), no payment shall be made nor Services accepted under this Agreement; and
5) Upon the Effective Date of this Agreement, to ensure that no payments are made and no Services accepted beyond the terms of this Agreement, or the terms of other company approved agreements between the parties.

CONTRACTOR:
Southeastern Emergency Physicians, PLLC

By: Stanley Thompson MD
Name: Stanley Thompson, MD
Title: CCO Teamhealth Lifepoint Group
Date: 2/25/2019

HOSPITAL:
RCHP Ottumwa, LLC
d/b/a Ottumwa Regional Health Center

By: Philip J Noel III
Name: Philip J. Noel, III
Title: CEO
Date: 2-25-2019

Revised 12.2018

THIS EXCLUSIVE PROFESSIONAL SERVICES AGREEMENT (the "Agreement") is hereby entered into by and between Hospital and Contractor who may hereafter be referred to individually as a "Party" and collectively as the "Parties" in connection with the Exclusive Emergency Department and Hospitalist Services Master Agreement (the "Master Agreement") dated the 1st day of January, 2018, by and between LifePoint Corporate Services, General Partnership ("Company") and Contractor.

RECITALS

WHEREAS, Hospital has determined that coverage by an exclusive group of providers based at Hospital is necessary to meet the needs of patients at Hospital; and

WHEREAS, Hospital has determined that the proper, orderly and efficient delivery of emergency department services (the "ED Services") and/or hospitalist services (the "HM Services") at the Hospital (ED Services and HM Services are collectively known as the "Services") can be accomplished best by entering into an exclusive coverage arrangement; and

WHEREAS, Contractor will, at its expense, arrange coverage for Hospital through licensed physicians (individually referred to as "Physician" and collectively referred to as "Physicians"), and certified nurse practitioners or physician assistants (individually referred to as "Allied Health Practitioner" and collectively referred to as "Allied Health Practitioners") (Physicians and Allied Health Practitioners collectively referred to as "Contractor's Representatives") authorized and licensed to practice medicine where Hospital is located (the "State"), who are qualified to provide the services as defined in this Agreement; and

WHEREAS, Hospital desires to contract with Contractor as set forth herein to obtain management services of Contractor with respect to the professional component of services provided at the Hospitals so as to permit the development and operation of certain departments at Hospital, and

WHEREAS, this Agreement is entered into for the purpose of defining the Parties' respective rights and responsibilities; and

WHEREAS, the terms of the Master Agreement are incorporated herein as though fully repeated verbatim.

NOW, THEREFORE, in consideration of the premises and mutual covenants and agreements herein set forth, the Parties hereto agree as follows:

I. CONTRACTOR'S REPRESENTATIONS.

A Organization. Contractor represents and warrants that it is a corporation or limited liability company duly organized and validly existing under the laws of its state of incorporation and has the corporate power and authority to execute and deliver this Agreement, and to carry out its provisions.

B. Services. Contractor shall (through appropriately licensed Contractor's Representatives) provide professional services needed at the Hospital, including but not limited to those services described as set forth in any attachment(s) defined as Professional Service Agreement(s) (the "Services") attached hereto.

C. Professional Qualifications. Contractor shall ensure that all Contractor's Representatives utilized to provide Services under this Agreement continuously have and maintain the following credentials:

1. Contractor's Representatives will be qualified by training and experience to provide the Services; and

2. The Contractor's Representatives assigned to Hospital shall have the Medical Staff or allied health privileges required to provide Services under this Agreement in accordance with the applicable requirements and Medical Staff bylaws, and each of Contractor's Representatives shall comply with Hospital policies and procedures, Medical Staff bylaws, and rules and regulations for Hospital.

D. Approval of Contractor's Representatives and Substitutes.

1. Contractor agrees it shall not use any Physician or Allied Health Professional to provide the Services under this Agreement to Hospital without first obtaining appropriate medical staff or allied health privileges and other approvals required by such Hospital's Medical Staff bylaws. Contractor agrees that all of Contractor's Representatives are subject to continuing approval of Hospital.

2. Contractor shall provide a substitute for any of Contractor's Representatives who are unable to provide services required under this Agreement. As a condition of providing services under this Agreement, any such substitute shall satisfy all qualification requirements applicable to the Contractor's Representatives.

3. Contractor agrees to cause each of Contractor's Representatives and substitutes to comply with his or her assigned Hospital policies and procedures, Medical Staff bylaws and rules and regulations. Failure to do so shall be grounds for Hospital to request Contractor to immediately remove the Contractor's Representative or substitute as described under Section II below. Hospital shall supply a copy of its Medical Staff Bylaws to Contractor within thirty (30) days of execution of this Agreement (if not already supplied), and shall supply an updated version upon any revision.

E. Compliance.

1. Contractor and Contractor's Representatives shall perform all Services under this Agreement in accordance with any and all regulatory and accreditation standards applicable to Hospital and the Services, including, without limitation, those requirements imposed by the Medicare Conditions of Participation, The Joint Commission accreditation standards, the AMA Code of Ethics, the rules and regulations of the Board of Medicine in the State, the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Federal Anti-Kickback and Stark statutes and regulations, federal and state regulations governing the security and privacy of health information, and other applicable state and federal regulations, all as amended from time to time.

2. Contractor represents and warrants that as of the date of this Agreement: (i) neither it nor any Contractor's Representative is excluded, debarred or otherwise ineligible to participate in Medicare, Medicaid or any other federal or state healthcare programs or in any federal or state procurement or non-procurement programs; and (ii) neither it nor any Contractor's Representative has been convicted of a criminal offense that could lead to such debarment or exclusion. Contractor shall immediately remove from service hereunder any Contractor's Representative for whom this representation and warranty is no longer true and shall so inform the Hospital to which Contractor's Representative is assigned. In the event this representation and warranty becomes untrue as to Contractor, Hospital may deem this Agreement terminated immediately. Contractor agrees this is an ongoing representation and will immediately notify Hospital in the event the foregoing representation and warranty is no longer completely accurate. Contractor acknowledges and agrees this is a material term of the Agreement and any breach or nonfulfillment of same will entitle the Hospital to terminate this Agreement immediately.

F. Quality Programs. Contractor and Contractor's Representatives shall furnish any and all information, records and other documents related to Contractor's service at the Hospital, which Hospital may reasonably request in furtherance of quality assurance, utilization review, risk management, and any other plans and/or programs adopted by Hospital to assess and improve the quality and efficiency of the Hospital's services. As reasonably requested, Contractor and Contractor's Representatives shall participate in one or more of such plans and/or programs, including participating in training on any such program at Hospital's request.

G. Medical Records for All Patients Evaluated and/or Treated by Contractor's Representatives. Unless otherwise specifically agreed to by the Parties, all patients evaluated and/or treated by Contractor's Representatives shall have a medical record created and a charge assigned, including all direct admissions undertaken by Contractor's Representatives. Contractor shall prepare timely, complete and accurate medical records in accordance with Hospital's policies and all professional standards applicable to medical records documentation. All such records shall be entered into Hospital's medical records system, including full use of Computerized Physician Order Entry. Medical records for patients evaluated and/or treated by Contractor's Representatives in Hospital shall at all times remain the property of Hospital.

II. **REMOVAL OF PHYSICIANS PROVIDED BY CONTRACTOR.** Contractor's Representatives shall be removed at the request of Hospital to which such Contractor's Representative is assigned, as follows:

A. For Cause. Upon Hospital's written notice to Contractor to remove any of Contractor's Representatives for cause, Contractor shall remove any of Contractor's Representatives, with or without cause, Contractor shall remove any such Contractor's Representatives immediately from providing Services. In that event, Contractor shall immediately provide a qualified replacement for Contractor's Representative. If Contractor fails to obtain alternative coverage within one hundred twenty (120) days or a longer time frame that is acceptable to Hospital, then, without limiting any other remedies that Hospital may have under this Agreement or applicable law, Hospital may, following written notice to Contractor, obtain appropriate alternative coverage at Contractor's expense. If Hospital is requesting removal of a Contractor's Representative for "cause", Hospital shall briefly describe the "cause" to Contractor in writing. If Hospital does not provide a description of the "cause" for the requested removal, then such removal will be deemed a "without cause"

removal for purposes of Section X.A hereof. For-cause removals may include, but are not limited to, a Contractor's Representative who: (1) is convicted of a crime other than a minor traffic violation; (2) has a guardian or trustee of its person or estate appointed by a court of competent jurisdiction; (3) becomes disabled so as to be unable to perform the duties required by this Agreement; (4) fails to maintain professional liability insurance required by this Agreement; (5) has his/her license(s) and/or privileges required to perform the respective Services contemplated by this Agreement either suspended, revoked, or otherwise limited; (6) is debarred, sanctioned, or excluded by a state or federal health care program; (7) if applicable, has his/her federal and/or state registration to prescribe and dispense controlled substances suspended, revoked, or otherwise limited; (8) fails to comply with any of the terms and conditions of this Agreement after being given notice of that failure and a reasonable opportunity to comply; (9) acts in a manner that Hospital determines to be detrimental to patient safety or negatively affects Hospital's reputation or operations; or (10) fails to comply with any policy or lawful directive of the Hospital. The parties agree that Hospital's requested removal of a Contractor's Representative shall have no impact on Contractor's relationship with the affected Contractor's Representative, and that any subsequent decision by Contractor to terminate its relationship with such Contractor's Representative shall be at the sole discretion of Contractor. Failure of Contractor to remove any such Contractor's Representatives pursuant to this Section shall be deemed a material breach of this Agreement, and Hospital may immediately terminate this Agreement.

B. Effect on Contractor's Representatives Medical Staff Appointment and Clinical Privileges. Because this is an exclusive Agreement, as more particularly described in Section IV, the medical staff appointment and clinical privileges of all Contractor's Representatives providing services to Hospital shall be incident to and coterminous with this Agreement, and, upon termination or expiration of this Agreement or upon removal of Contractor's Representative by Contractor, the appointment and clinical privileges of the Contractor's Representative shall automatically terminate except as otherwise provided below. Notwithstanding the foregoing, a Contractor Representative's Medical Staff Appointment and Clinical Privileges will not automatically terminate upon termination or expiration of this Agreement unless a continuation of such privileges, in Hospital's reasonable judgment, would be inconsistent with Hospital's ability to contract exclusively with a successor provider of Services. Any rights that the Contractor's Representatives may have to any hearing or appeal procedures prior to termination of Medical Staff Appointment or Clinical Privileges, pursuant to the bylaws or policies of a Hospital or its Medical Staff, or any other state or federal statute, regulation or judicial decision are hereby waived with respect to any termination of Medical Staff Appointment or Clinical Privileges resulting from the items listed herein. Unless otherwise required by law, no reporting to any third party, such as the National Practitioner Data Bank, shall take place for any termination hereunder for non-clinical or non-competency issues. Contractor will require each Contractor's Representative providing Services under this Agreement to execute a separate Contractor Representative Agreement Regarding Medical Staff Membership and Privileges in substantially the same form as ADDENDUM 1, attached hereto and incorporated by reference into this Agreement. If Contractor has a substantially similar provision in its contracts with its Physician and Allied Health Practitioners, Contractor will not be required to comply with the requirement in the foregoing sentence.

III. OBLIGATIONS OF HOSPITAL.

A. Hospital Billing. Hospital shall be responsible for, and solely entitled to, billing and collection of all Hospital services rendered to the patients to whom the Services are provided and non-physician provider services performed for the general benefit of its patients, except those for professional services rendered by Contractor's Representatives who are either contracting with or employed by Contractor.

B. Supplies, Equipment, Etc. Hospital will make available the space, utilities, equipment, supplies (to include drugs and narcotics) and services (including housekeeping and laundry) reasonably necessary for the proper operation of the Services. Hospital will maintain its equipment in good order and repair.

C. Facilities and Personnel. Hospital shall provide adequate facilities and competent personnel for the operation of the Services. Hospital shall provide other reasonable support services necessary for proper operation of the Services (including scheduling non-Contractor's Representative personnel, preparing and filing of patient treatment consents and providing other services which are reasonable and mutually agreed upon). Hospital shall provide an adequate medical records system for use in provision of the Services.

D. Transcription. Hospital will provide appropriate dictation, transcription, and medical record services to Contractor for use by Contractor's Representatives for documentation made by Contractor's Representatives in Hospital medical record.

E. Medical Staff On Call. Hospital shall have available specialty physicians on-call in accordance with its Medical Staff bylaws.

F. Materials to Patients. Hospital will, in good faith, attempt to distribute to patients to whom the Services are provided materials describing the separate billing relationship between the patients and Contractor. Such materials will be supplied to Hospital by Contractor on a form acceptable to Hospital.

G. Compliance. Hospital represents and warrants that as of the date of this Agreement. (i) Hospital is not excluded, debarred or otherwise ineligible to participate in Medicare, Medicaid or any other federal or state healthcare programs or in any federal or state procurement or non-procurement programs; and (ii) Hospital has not been convicted of a criminal offense that could lead to such debarment or exclusion. In the event this representation and warranty becomes untrue as to Hospital, Contractor may deem this Agreement terminated immediately. Hospital agrees this is an ongoing representation and will immediately notify Contractor in the event the foregoing representation and warranty is no longer completely accurate. Hospital acknowledges and agrees this is a material term of the Agreement and any breach or nonfulfillment of same will entitle the Contractor to terminate this Agreement immediately.

H. Billing Information. Hospital shall supply Contractor with information necessary for Contractor to bill patients for services rendered by the Contractor's Representatives. In order to allow Contractor to accurately and timely bill for professional services provided by Contractor Representatives hereunder, Hospital agrees to provide Contractor, with either: (i) an electronic file transfer containing patient medical records and related information, including, but not limited to, physician transcription, physician notes, insurance cards and demographic information necessary to conduct physician billing ("Billing Documents"), or (ii) the requested assistance necessary to obtain legible paper copies of Billing Documents to forward to Contractor, which assistance shall include, but not be limited to:

1. Hospital will locate any missing Department records and forward such missing records to Contractor within three (3) working days.

2. Hospital will use commercially reasonable efforts to arrange for patient signatures on forms noting patient's responsibility for paying Contractor's billings.

3. Hospital shall bear the expense of providing one copy of relevant patient medical records to be sent to Contractor.

4. Hospital will comply within three (3) working days with other reasonable requests for information or record handling (including requests regarding insurance) by Contractor.

In the event Hospital has implemented an Electronic Medical Records ("EMR"), Contractor will electronically transmit Billing Documents from Hospital to Contractor. In such event, Hospital will work cooperatively with Contractor and Contractor's Information Technology department to facilitate the timely and accurate flow of Billing Documents to Contractor. This information will be transmitted from Hospital to Contractor in a secure HIPAA compliant electronic format on a daily basis. The Billing Documents transmitted in this fashion will include, but not be limited to: ADT Registration information (patient demographics, payor information, and disposition), event times, and to the extent possible patient clinical record.

Each Hospital shall assist Contractor in obtaining patient signatures on assignment of insurance benefits and other reasonably appropriate forms supplied to the respective Hospital by Contractor. Any collection efforts by the Hospitals and Contractor will comply with all federal and state laws and regulations.

IV. EXCLUSIVITY

A. Hospital concludes that an exclusive relationship for the Services will best facilitate the delivery of efficient, effective and quality patient care. Such a relationship is expected to enhance patient services provided by Contractor and the Hospital, improve the relationships between Contractor, the Hospital's Medical Staffs and Hospital, afford effective utilization of the Hospital's equipment, provide consistent service and quality control, provide prompt availability of professional services, simplify scheduling of patients and physician coverage, enhance the efficient and effective administration of the Services – all of which enhance the quality of patient care.

B. During the Term of this Agreement, Contractor shall be the exclusive provider of the Services described in this Agreement, and therefore, Hospital will ensure does not extend medical staff privileges for the practice of the Services at Hospital to any provider not employed by or under contract with Contractor. However, nothing in the preceding sentence shall be construed to limit the rights of community-based physicians with medical staff privileges at the Hospital to provide care for their patients while they are admitted to the same.

V. TERM AND TERMINATION

A. This Agreement shall be effective as of the Effective Date, beginning at 12:00 a.m. in the applicable time zone of the Hospital and shall continue for the Initial Term. **[NOTE: The Effective Date cannot be a date that occurs before the dates that both the Hospital and Contractor signed the Agreement. If the Agreement is submitted for approval with an Effective Date that occurs before the last party (The Hospital or Contractor) signed the Agreement, the Effective Date will automatically be changed to the date that the Contractor or Hospital signed, whichever is later. Contractor will not be compensated for services provided to the Hospital prior to the Effective Date.]** Notwithstanding the foregoing, this Agreement will automatically renew for additional twelve (12) month periods following the expiration of the Initial Term, with each such additional twelve (12) month period to be called an "Additional Term", until (i) such time as a new Agreement is executed by the Parties, or (ii) this Agreement is otherwise terminated as provided herein. For purposes of this Agreement, "Term" shall mean the Initial Term and any Additional Term.

B. Either Party may terminate this Agreement at any time in the event the other Party engages in an act or omission constituting a material breach of any term or condition of this Agreement. The Party electing to terminate this Agreement shall provide the breaching Party with written notice specifying the nature of the breach. If a dispute arises regarding the materiality of a breach, then both Parties shall submit the issue to a mutually agreed upon arbitrator pursuant to Section VIII of this Agreement for resolution of the dispute. The breaching Party shall then have twenty (20) days from the date of the notice or twenty (20) days from the date of the arbitrator's decision in which to remedy the breach and conform its conduct to this Agreement. If such corrective action is not taken within the time specified, this Agreement shall terminate at the end of the twenty (20) day period without further notice or demand, provided, however, that Hospital may not terminate this Agreement if Contractor is diligently pursuing the remedy of the breach.

C. Either Party may terminate this Agreement immediately as specified in Sections I.E.2 and III.G. of this Agreement.

D. Either Party may terminate this Agreement immediately if either Party makes a general assignment for the benefit of creditors, or files a petition for relief in bankruptcy or under similar laws for the protection of debtors, or upon the initiation of such proceedings against either Party if the same are not dismissed within forty-five (45) days of service;

E. Either Party may terminate this Agreement immediately if any of the following events occur with regard to Hospital:

1. Loss of Hospital's certification as a Medicare provider;

2. Closure of Hospital;

3. Contractor's general assignment for the benefit of creditors, Contractor's petition for relief in bankruptcy or under similar laws for the protection of debtors, or upon the initiation of such proceedings against Contractor if the same are not dismissed within forty-five (45) days of service; or

4. Hospital's general assignment for the benefit of creditors, or Hospital's petition for relief in bankruptcy or under similar laws for the protection of debtors, or upon the initiation of such proceedings against Hospital if the same are not dismissed within forty-five (45) days of service; or

5. Beginning on the Effective Date and for the Term of the Agreement, Contractor's failure to achieve an overall minimum score of sixty (60) points on the "ED Physician Scorecard" or "Hospitalist Physician Scorecard", if applicable (as may be further defined in this Agreement) at Hospital for any two consecutive quarters during the Term of this Agreement or any renewal period thereof. Contractor, however, shall have the right, at its own expense, to review and audit any performance metric contained in the ED Physician Scorecard or Hospitalist Physician Scorecard, including all underlying data. Hospital agrees to resolve any discrepancy found during an audit performed by Contractor to the Parties' mutual satisfaction. If a dispute arises or the Parties are unable to resolve the discrepancy to their mutual satisfaction, then both Parties shall submit the issue to a mutually agreed upon arbitrator pursuant to Section VIII of this Agreement for resolution of the dispute.

F. This Agreement shall terminate upon termination of the Master Agreement (as defined on the cover page of this Agreement).

G. Except as provided herein, upon any termination of this Agreement, neither Party shall have further rights against, or obligations to, the other Party except with respect to any rights or obligations accruing prior to the date and time of termination and any obligations, promises or agreements which expressly extend beyond the termination, including but not limited to the terms herein related to insurance coverage, restrictive covenants, dispute resolution and confidentiality provisions. Contractor shall have reasonable access to any Hospital's information and records pursuant to Section III (H) of the Agreement for a period of six months after termination of this Agreement for Contractor's billing, risk management and/or quality/peer review purposes.

VI. RISK MANAGEMENT

A. Required Risk Reduction Education. As fair market value consideration, Hospital may reimburse or pay all actual expenses associated with the costs of any educational sessions related to the Service that Contractor and/or Contractor's Representatives are directed to attend by Hospital. All such expenses must be reasonable, and the Contractor and/or Contractor's Representatives must be authorized in advance, and in writing by the Hospital's CEO, to incur such expenses, and such expenses must be paid in accordance with Hospital's policies and procedures. All such expenses are limited to those incurred by Contractor and/or Contractor's Representatives only (e.g., expenses of spouses and other family members are excluded from reimbursement).

B. Provision of Services for Risk Management, Employment Purposes, or Other Obligations of Hospital. Contractor agrees to provide Services as requested by Hospital in response to risk management issues, employee health efforts, or other contractual obligations as reasonably requestedby Hospital. In these situations, if requested by Hospital to waive Contractor's fees after the Services have been provided, Contractor shall bill the Hospital for its professional charges rather than the patient or the patient's insurance plan. Contractor agrees to accept the then current year Medicare Physician Fee Schedule reimbursement amount, or where applicable, state workers' compensation amounts, for any such services rendered.

VII. ALTERNATIVE DISPUTE RESOLUTION. The Parties firmly desire to resolve certain disputes arising hereunder without resort to litigation in order to protect their respective business reputations and the confidential nature of certain aspects of their relationship. Accordingly, any controversy or claim arising out of or relating to this Agreement, excepting healthcare liability and/or claims sounding in negligence, and the insurance and indemnification obligations set forth in Section XI, below relating to third-party claims made by patients and/or their representatives, shall be settled by arbitration before a single arbitrator and administered by the American Health Lawyers Association in accordance with its rules, including arbitrator selection. The award or decision rendered by the arbitrator will be final, binding and conclusive, and judgment may be entered upon such award by any court of competent jurisdiction. The arbitration process itself, and any other information or disclosures revealed by either Party to the arbitrator or to the other Party during the arbitration process will be confidential. No disclosure of the award shall be made by the Parties except as required by the law or as necessary or appropriate to effectuate the terms thereof. The location of the arbitration shall be in in the city in which the Hospital is located, unless otherwise mutually agreed by the parties. The dispute shall be governed by the laws of the State. Further, the prevailing Party shall be entitled to recover all costs and expenses associated with arbitration, including reasonable attorneys' fees. If the arbitrator determines that neither Party has substantially prevailed, the Parties shall bear equally the fees and costs of the arbitrator and the related expense of arbitration. Nothing in this section shall preclude either party from maintaining or initiating an action, counterclaim or cross-complaint in tort or contract against the other related to any healthcare liability and/or claims sounding in negligence relating to third-party claims made by a patient and/or a patient's representatives.

VIII. PARTIES' RELATIONSHIP. The Parties acknowledge that Contractor is an independent contractor to Hospital for the furnishing of Contractor's Representatives who agree to render Services to patients of the Hospital. Neither Contractor nor Contractor's Representatives shall in any way be construed as employees of any of the Hospital. Neither Contractor nor any of its agents (employees or contractors) shall have the right or authority to enter into any contract in the name of the Hospital or otherwise bind the Hospital in any way without the express written consent of the Hospital designee.

IX. PERFORMANCE DATA. Hospital agrees to comply with Contractor's reasonable request for financial and performance data related to utilization at Hospital. Contractor shall make such requests no more than quarterly during the Term of this Agreement.

X. **INSURANCE AND INDEMNIFICATION.**

A. Contractor hereby agrees to indemnify and hold harmless Hospital and Hospital's officers, directors, employees, agents, successors, and assigns from and against any claim, damage, loss, expense, liability, obligation, action, or cause of action, including reasonable attorneys' fees and reasonable third party costs of investigation, which Hospital may sustain, pay, suffer, or incur by reason of any negligent act or omission of Contractor and/or its directors, employees, agents, independent contractors, contractors or subcontractors, including but not limited to Contractor's Representatives, in connection with services provided and duties undertaken under this Agreement, including any claims for personal injury, healthcare liability or wrongful death, and including, without limitation, any claims for personal injury, healthcare liability or wrongful death, and including without limitation, any claims arising from any for "cause" removal of Contractor's Representatives or Contractor's termination of its relationship with any Contractor's Representative following any for "cause" removal requested by Hospital pursuant to Section II A, above. For the avoidance of confusion, the parties hereby acknowledge that Contractor shall not be obligated to indemnify Hospital with respect to (i) any claims pursued by a Contractor's Representative arising or accruing from a "without cause" removal, or (ii) any for "cause" removal requests by Hospital that Contractor reasonably and in good faith believes may result in actual or potential violation of any applicable federal, state, or local employment, anti-retaliation and/or whistleblowing laws as set forth in writing from Contractor to Hospital. Such written notice by Contractor pursuant to clause (ii) above shall clearly articulate the relevant known or alleged facts supporting Contractor's belief, shall cite the applicable underlying law(s), shall clearly explain the rationale supporting Contractor's conclusion(s), and shall be provided to Hospital within three (3) business days after Contractor determines that such removal request may result in an actual or potential violation of law and regardless of the date of removal of the Contractor's Representative. The parties hereby acknowledge and agree that while timely and adequate notice pursuant to clause (ii) shall temporarily relieve Contractor of the obligation to indemnify Hospital, Hospital shall automatically retain all rights to challenge Contractor's refusal to indemnify pursuant to the dispute resolution procedures set forth in this Agreement. To ensure coverage in the event of an act or omission as described herein, Contractor shall (i) maintain in force at all pertinent times at Contractor's sole expense a policy of general and professional liability insurance in the minimum amount of One Million Dollars ($1,000,000.00) per occurrence, Three Million Dollars ($3,000,000.00) in the annual aggregate, naming Hospital as an additional insured thereon, or such higher amount as may be required by the laws of the State; and (ii) if applicable, participate in the appropriate state compensation fund. Contractor shall furnish, upon execution of this Agreement and annually, a copy of the policy of the insurance and a Certificate of Insurance evidencing the aforementioned coverage.

B. Hospital hereby agrees to indemnify and hold harmless Contractor from and against any claim, damage, loss, expense, liability, obligation, action or cause of action, including reasonable attorneys' fees and reasonable costs of investigation, which Contractor may sustain, pay, suffer or incur by reason of any negligent act or omission of Hospital, or its employees in connection with services provided and duties undertaken under this Agreement, including any claims for personal injury or wrongful death.

C. Contractor and Hospital each agree and it is the stated intent of each that they shall only be liable to the other party under this Section for the proportionate liability or representative share of negligence allocated to such party based on the negligent acts or omissions of each party and its directors, employees, agents, independent contractors, contractors or subcontractors, including but not limited to Contractor's Representatives. If such allocation is not determined by a court of competent jurisdiction and the parties in good faith are otherwise unable to agree to such allocations, either party hereto may bring an action, including a summary or expedited proceeding, to compel binding arbitration of such matter.

XI. **ACCESS TO BOOKS AND RECORDS.** In the event it is held that Section 1861(v)(1)(I) of the Social Security Act is applicable to this Agreement, it is agreed:

A. Until expiration of five (5) years after furnishing services and pursuant to this Agreement, Contractor shall make available upon written request of the Secretary of Health and Human Services or the U.S. Comptroller General, or any of their duly authorized representatives, this Agreement, books, documents, and records of Contractor that are necessary to verify the nature and extent of costs incurred by Hospital under this Agreement.

B. If Contractor carries out any of the duties of this Agreement through a subcontract with a related organization with a value of Ten Thousand Dollars ($10,000) or more over a twelve (12) month period, such agreement must contain a clause to the effect that until the expiration of five (5) years after the furnishing of services under the subcontract, the related organization shall make available, upon written request of the Secretary of Health and Human Services, the U.S. Comptroller General, or any of their duly authorized representatives, the subcontract, any books, documents, and records of the related organization that are necessary to verify the nature and extent of costs incurred by Hospital under this subcontract.

C. In the event said sections are found to be inapplicable to this Agreement, this article shall be deemed not to be a part of this Agreement and shall be null and void with respect thereto.

XII. **NOTICES.** Any notice required or permitted to be given hereunder shall be in writing and may be given by: (1) hand delivery and shall be deemed given on the date of delivery; (2) registered or certified mail and shall be deemed given the third day following the date of mailing; or (3) overnight delivery by reputable overnight delivery service such as Federal Express or UPS and shall be deemed given the following day. All notices to Contractor or Hospital shall be addressed to Contractor or Hospital at the addresses as set forth on the signature page, together with a required copy to: LifePoint Hospitals, 330 Seven Springs Way, Brentwood, TN 37027, Attention: Chief Legal Officer.

XIII. **CONFIDENTIALITY**. The Parties agree that this Agreement and its provisions are strictly confidential. The Parties shall not disclose any information pertaining to any provision of this Agreement to any person or entity not a party to this Agreement except for tax, legal, or accounting advisors or as otherwise required by law.

XIV. **VENDOR PROMOTION/PUBLICATION.** Hospital prohibits the use of Hospital's name by any vendor or independent contractor, or the use of any name of Hospital's subsidiaries, or affiliated hospitals in any advertisement, press statement or release, website, published customer list, or any publication or dissemination similar to the foregoing without receiving in advance the express written permission from Hospital's Chief Executive Officer or his or her designee. Any request for permission should include the complete text of the publication, statement, or document in which the name usage will appear and will be subject to edit by the Hospital.

XV. **MARKETING SERVICES/COMPENSATION OF CONTRACTOR'S REPRESENTATIVES.** Except as specifically provided in this Agreement, Contractor shall not perform and is not being compensated for marketing services with respect to the Services to be performed at the Hospital. Contractor represents and warrants that no part of the compensation paid hereunder is in exchange for the referral or arrangement for referral of any patient to of Hospital. Contractor represents and warrants that, in connection with the Services to be performed pursuant to this Agreement, each employee, independent contractor, or other entity or person performing Services pursuant to the Agreement shall be compensated in a manner that complies with the Federal Anti-Kickback Statute, an exception to the Stark law, and as applicable, an appropriate exception to any state statutes similar to either or both of the foregoing federal statutes.

XVI. **SEVERABILITY**. The invalidity or unenforceability of any provision(s) of this Agreement will not affect the validity or enforceability of any other provision(s).

XVII. **NO WAIVER**. No waiver of a breach of any provision of this Agreement shall be construed to be a waiver of any breach of any other provision.

XVIII. **ASSIGNABILITY**. Contractor may not assign any of its rights or obligations hereunder without the prior written consent of Hospital, which consent will not be unreasonably withheld. Hospital may not assign this Agreement to any successor to all or substantially all of Hospital's operating assets without the prior written consent of Contractor, which consent will not be unreasonably withheld. This Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective successors and permitted assigns.

XIX. **AMENDMENTS**. Amendments to this Agreement shall be made only in writing duly executed by both Parties hereto.

XX. **ENTIRE AGREEMENT**. This Agreement constitutes the entire agreement of the Parties with respect to the subject matter hereof, and supersedes all prior agreements, contracts and understandings, oral, written or otherwise, including but not limited to any prior agreements between Contractor and/or its affiliates and Hospital.

XXI. **THIRD PARTY BENEFICIARIES**. This Agreement is intended to, and shall be deemed and construed to create rights and/or remedies for the Hospitals, which shall be deemed third party beneficiaries to this Agreement.

XXII. **AGREEMENT CROSS-REFERENCE**. As required by 42 C.F.R. section 411.357 (d)(1)(ii), all service agreements between Company or its affiliated Hospitals and any physician (or an immediate family member of a physician) are maintained electronically in a master contract database that is maintained and updated centrally and is available for review upon request by an authorized government official.

XXIII. **FAIR MARKET VALUE CONSIDERATION.** Hospital and Contractor hereby acknowledge and agree that the compensation arrangement hereunder is established at fair market value for the Services, and the Services performed under this Agreement are needed and reasonable in scope. The Parties hereby acknowledge and agree that in the event a written fair market valuation is ordered from an independent, third-party valuation company to support the compensation methodology under this Agreement, and such fair market valuation does not support the compensation methodology under this Agreement, the Parties will enter into good faith negotiations to determine a new compensation methodology, which new compensation methodology will be evidenced in a written amendment to this Agreement that is executed by both Parties. Notwithstanding the foregoing, in the event the Parties are unable to mutually agree upon a new compensation methodology within thirty (30) days after such aforementioned good faith negotiations begin, either Party may terminate this Agreement by providing ninety (90) days' written notice to the other Party.

MEDICAL STAFF MEMBERSHIP AND PRIVILEGES AGREEMENT **ADDENDUM 1**

Contractor Representative Agreement Regarding Medical Staff Membership and Privileges

The undersigned hereby acknowledge and agrees that:

1. The undersigned is a Physician who may provide services to Hospital pursuant to Agreement between Hospital and Contractor.

2. Pursuant to the Agreement, Hospital has certain rights of approval over Physicians and others who provide services, and that; in addition, Hospital may request removal of a Physician or other provider of services under the Agreement. The undersigned understands that this will mean that Hospital may refuse to permit the undersigned to provide services under the Agreement, or request that the undersigned be removed from the permitted list of individuals providing services under the Agreement.

3. The undersigned agrees to the following: the medical staff appointment and clinical privileges of all Physicians and practitioners providing services under the Agreement shall be incident to and coterminous with the Agreement, and upon termination or expiration of the Agreement or upon removal of any Physician or practitioner by Contractor (independently or at Hospital's request) or Hospital's refusal to permit a Physician or practitioner to perform services under the Agreement, the appointment and clinical privileges of such Physician or practitioner shall automatically terminate except as otherwise provided below. Notwithstanding the foregoing, a Contractor Representative's Medical Staff Appointment and Clinical Privileges will not automatically terminate upon termination or expiration of the Agreement unless a continuation of such privileges, in Hospital's reasonable judgment, would be inconsistent with Hospital's ability to exclusively contract with a successor provider of emergency services. Any rights that the Physician or practitioner may have to any hearing or appeal procedures prior to termination of medical staff appointment or clinical privileges, pursuant to the bylaws or policies of Hospital or the Medical Staff, or any other state or federal statute, regulation or judicial decision, are hereby waived with respect to any termination of Medical Staff Appointment or Clinical Privileges at Hospital as described herein. Unless otherwise required by law, no reporting to any third party, such as the National Practitioner Data Bank, shall take place for any termination hereunder for non-clinical or non-competency issues.

ACKNOWLEDGED AND AGREED:

PHYSICIAN:

Signature _____

Name: _____

Date: _____

CONTRACTOR:

Signature 

Name: Stanley Thompson, MD

Title: CCO Teamhealth Lifepoint Group

Date: 2/25/2019

ADDENDUM TO EXCLUSIVE PROFESSIONAL SERVICES AGREEMENT **ADDENDUM 2**

This Addendum to Exclusive Professional Services Agreement (the "Addendum") is hereby entered into and made effective as of the 1st day of March, 2019, by and between RCHP-Ottumwa, LLC d/b/a Ottumwa Regional Health Center ("Hospital") and Southeastern Emergency Physicians, LLC ("Contractor").

Parties' Agreement Regarding Weatherby Healthcare Locum Tenens Providers

1 Notwithstanding anything to the contrary set forth in the Agreement, the Parties agree that the Hospital will be directly responsible for all expenses incurred by or in connection with Weatherby Healthcare locum tenens providers providing services at Hospital during the months of March and April 2019. The Parties further agree that all professional services provided by Weatherby Healthcare locum tenens providers will be billed through the current outsourced billing arrangement and shall not be billed by Contractor.

CONTRACTOR:
Southeastern Emergency Physicians, LLC

By: Stanley Thompson MD

Name: Stanley Thompson, MD

Title: CCO Teamhealth Lifepoint Group

HOSPITAL:
RCHP-Ottumwa, LLC
d/b/a Ottumwa Regional Health Center

By: Philip J. Noel III

Name: Philip J. Noel, III

Title: CEO

SCHEDULE 1

EMERGENCY DEPARTMENT AGREEMENT

TERMS AND CONDITIONS

This Schedule 1 ("Schedule 1") is attached to and made a part of the Agreement. Definitions contained herein shall have the same meaning as contained in the Agreement. Should a conflict arise between the terms contained in the Agreement and this Schedule 1, then the terms of this Schedule 1 shall control.

Contractor will be responsible for carrying out the duties identified throughout this Schedule 1 and, additionally, the duties defined hereunder (collectively referred to as the "Services"), plus any Schedules identified below, each of which constitute an integral part of this Agreement:

SCHEDULE	TITLE
1.A	Services, Coverage, and Quality Criteria
1.B	ED Physician Scorecard

SCHEDULE 1.A

SERVICES, COVERAGE, AND QUALITY CRITERIA - EMERGENCY DEPARTMENT

I. **DESCRIPTION OF SERVICES.** Hospital is engaging the services of Contractor to enter into an exclusive relationship for professional Emergency Department ("ED") services which will best facilitate efficient, effective and quality emergency medical care for patients presenting to Hospital's ED. This engagement is expected to improve the services provided at the Hospital, afford effective utilization of the Hospital's equipment and resources, provide consistent service and quality control; provide prompt availability of professional services; simplify scheduling of physician coverage, and enhance the efficient and effective administration of ED services. Contractor and Contractor's Representatives shall practice within Hospital, assuming the role of ED physician or physician extender for patients presenting to Hospital emergency department ("Program Patients"). Allied Health Practitioners, if and when utilized, shall assist Contractor with their duties and responsibilities. Contractor shall provide to Program Patients all professional emergency medicine services that are medically necessary and within the capabilities of the Contractor's Representatives. Contractor's Representatives shall not be responsible for a Program Patient's care after discharge or admission, provided however, Contractor's Representatives shall participate in the Code Team utilized at Hospital, including responses to codes and to other emergency situations involving Program Patients admitted to Hospital.

A. DUTIES OF CONTRACTOR. In addition to the coverage requirements referenced above, Hospital and Contractor agree that the following shall be required duties of Contractor with respect to the Service:

1. Drive performance and be accountable to ED Service line initiatives around quality, service, throughput and growth in coordination with Hospital.
2. Participate in all quality programs outlined by Hospital that improve patient outcomes; Improvement in Value Based Purchasing metrics including but not limited to: core measures, mortality, HCAHPS, readmissions, Medicare Spending Per Beneficiary, and other quality outcome measures.
3. Participate in development and execution of programs and/or educational programs related to service for medical personnel at Hospital, including but not limited to ED Nursing Staff and other Hospital staff, students, interns, residents, as well as Contractor's employees, subcontractors and agents.
4. Must comply with EMTALA, CMS, The Joint Commission and all regulatory agency rules and regulations.
5. Assist and participate in educating the community and creating awareness around services, as requested.
6. Provide the following program enhancement services:

    a. Participate in development and implementation of evidence-based care guidelines that are consistent with local and national standards.
    b. Lead and drive quality improvement in coordination with ED Nurse Director and appropriate Hospital personnel to ensure appropriate care by all of Contractor's Representatives.
    c. In coordination with ED service line initiatives, lead, support and drive improvement through implementation of best practices to drive improved patient outcomes around quality, service and throughput.
    d. Engage and be accountable to quality assurance and improvement initiatives by attending meetings, leading committees, measuring results and holding those accountable to established goals and objectives.
    e. Select a designee for Hospital to meet on a monthly basis with the medical director, case manager, Hospital administration, ED nurse director, and key medical staff leaders i.e. hospitalist, and other individuals necessary to provide input on enhancements for the improvement of Services at Hospital.
    f. Must remain compliant with timely completion of medical records describing the results for all the medical services performed by Contractor's Representatives in ED.
    g. Provide onsite physician supervision for outpatient services rendered at Hospital in order to meet supervision requirements under Medicare.

7. Establish expectations and hold Medical Director and Contractors' Representatives accountable to establishing effective working relationships with ED Nurse Director and personnel, other departments, the Medical Staff, and the administration.
8. Contractor's Regional Medical Directors and Regional Nursing/Clinical Directors must meet with Hospital's ED Services Team at least quarterly to review program goals and objectives around performance related to quality, service, throughput and growth.
9. Contractors support service structure; i.e. customer service and performance improvement, etc., resources; must be accountable to and establish goals consistent with Hospital's ED Service Line priorities both on priority hospitals and metrics.
10. Contractor must use the ED Physician Scorecard, as established in Schedule 1.B, attached hereto and incorporated herein by reference, to align provider and Hospital objectives through a financial withhold in the Medical Director's contract.
11. Agree to work on related projects and perform such other related duties as mutually agreed upon by both parties.

B. DUTIES OF CONTRACTOR'S REPRESENTATIVES. Hospital and Contractor agree that the following shall be required duties of each of the Contractor's Representatives assigned to the Hospitals:

1. Must be consistent with Duties outlined in Section "A" above.
2. Provide emergency department medical treatment as needed for all patients presenting to the Hospital's emergency department.
3. Participate in the Code Team utilized at the Hospital, including responses to codes.
4. Consult with other Medical Staff physicians as needed to assist with evaluations, transfers, and/or admission of program patients or unassigned patients.
5. Meet all behavior and professional conduct requirements of the medical staff bylaws and rules of regulations.
6. Meet all other requirements of the medical staff bylaws, rules and regulations.
7. Complete appropriate documentation of patient medical records and signing of final medical record within required timeframes as required by the Medical Staff Bylaws and Rules and Regulations of Hospital.
8. Work cooperatively with all medical staff and Hospital personnel.

C. MEDICAL DIRECTOR. Contractor shall designate one physician to serve as the Medical Director ("Medical Director") of the Services for the Hospital. The expectations and obligations for the Medical Director include:

1. In conjunction with the ED Nurse Director, drive performance and be accountable to the ED Service line initiative around quality, service, throughput and growth in coordination with the Hospital.
2. Lead and drive quality improvement in coordination with ED Nurse Director and appropriate Hospital personnel to ensure appropriate care by all providers in the ED.
3. In coordination with the ED service line initiative, lead, support and drive improvement through implementation of best practices to drive improved patient outcomes around quality, service and throughput.
4. Educate and hold the ED providers accountable to implement best practices supported by the Hospital around quality, throughput, service and growth and hold the ED providers accountable to meeting the goals and objectives (targets) established.
5. Engage and be accountable to quality assurance and improvement initiatives by attending meetings, leading committees, measuring results and holding those accountable to established goals and objectives (targets).
6. Serve as the professional liaison of the physicians associated with the emergency department program and work closely with Hospital and administration to solve program problems
7. Develop and implement programs to educate medical staff physicians across Hospital on the benefits of the Services to the patients and the community served by Hospital.
8. Establish a culture of safety by creating a professional atmosphere conducive to a high standard of patient care, investigate patient complains and incident reports, hold providers accountable to expectations, and provide high levels of service measured by ED patient Satisfaction.
9. Lead the monthly ED operations committee in coordination with the ED nurse director. The purpose of this multidisciplinary committee is to address key operational priorities around quality, service throughput and growth. The meetings should be data driven based on objective metrics that will drive improvement and patient outcomes in the emergency department.
10. Establish a close working relationship with the case manager of Hospital's emergency department program to ensure a high standard of patient care, proper patient care protocols are developed and maintained, coordinate work flow with the other ancillary departments within Hospital, and assist in the coordination of case management services.
11. Serve as an advisor to Hospital's quality improvement program.
12. In collaboration with the ED Nurse Director, revise existing policies and develop new policies as needed.
13. Participate in Hospital meetings, including but not limited to those related to performance improvement, quality improvement, patient experience, and utilization review.
14. Periodically review emergency department patient records to ensure the documentation, treatment, treatment plans, consults and tests ordered meet the appropriate standard of care.
15. Participate in the Hospital's peer review activities as requested/needed by Hospital.
16. Oversee the administration and management of Hospital's emergency department program and the Agreement with Hospital.
17. Ensure appropriate coverage for Hospital by scheduling coverage of the Services on a monthly basis, including on-site coverage.
18. Facilitate an evaluation process as it relates to the performance of all Contractor's Representatives that treat patients at Hospital. The performance evaluation may include input from other specialists who consult on patients presenting to Hospital's Emergency Department, Hospital personnel, etc. Performance shall be evaluated on the basis of professional attitude, professional capabilities, patient relations attitude and overall effectiveness as determined appropriate by Contractor and Hospital.

II. **COVERAGE.** In accordance with the terms of this Agreement, Contractor shall:

A. Ensure and deliver to Hospital continuous, twenty-four (24) hour on-site emergency medicine coverage, seven (7) days per week, fifty-two (52) weeks per year.

B. In order to provide the comprehensive coverage set forth above and meet patient needs, Contractor shall provide to Hospital a minimum number of qualified Physician coverage hours ("Qualified Physician Hours"), and if applicable, a minimum number of physician extender or Allied Health Practitioner coverage hours ("Allied Health Practitioner Hours).

Provider	Hours/day needed
Physician	24
NP/PA	12

C. Any adjustments to staffing requirements and hours of coverage other than those set forth in Section 2 above shall be agreed upon by Hospital and Contractor in writing.

D. In no event shall any Physician or Allied Health Practitioner providing services under the Agreement work more than twelve (12) consecutive hours in a twenty-four (24) hour period, unless prior advance written approval has been obtained from Hospital's Chief Executive Officer or his or her designee. Such advance written approval shall be waived in the case of a catastrophic event or extraordinary medical crisis.

III. **QUALITY CRITERIA.** Hospital and Contractor shall mutually agree upon an "ED Physician Scorecard" which shall be set forth in Schedule 1.B. Beginning on the Effective Date, Contractor shall cause Contractor's Representatives to meet the quality criteria set forth in the ED Physician Scorecard (the "ED Physician Scorecard") for the Hospital, which shall be effective as of the date that the ED Physician Scorecard is agreed upon by the Parties, which shall be no later than the Effective Date. The agreed upon ED Physician Scorecard shall be attached as Schedule 1.B, which may be amended from time to time by mutual agreement of the Parties. Any amendments to the ED Physician Scorecard shall be implemented prior to the commencement of a new contract year, shall be based on the prior year's trends and achievements, and shall be mutually agreed upon. The Parties further agree to use their best commercially reasonable efforts to negotiate the ED Physician Scorecard to be applicable hereunder within sixty (60) days of the Effective Date. Each of the quality criteria in the ED Physician Scorecard will be monitored quarterly during the Term of the Agreement, and Hospital will deliver the results of such assessment to Contractor thirty (30) days from the assessed quarter end. The Parties acknowledge and agree that targets identified for each of the quality criteria meet only the minimum level of performance required from Contractor and Contractor's Representatives which shall be an annual overall score of sixty (60) points (the "Minimum Score").

SCHEDULE 1.B

ED PHYSICIAN SCORECARD

Points Possible	ED Physician Scorecard Hospital Name 2016	Service Provider Goal	Quarter 1 Results	Quarter 1 Points Earned	Quarter 2 Results	Quarter 2 Points Earned	Quarter 3 Results	Quarter 3 Points Earned	Quarter 4 Results	Quarter 4 Points Earned	YTD Points Earned
	Delivering Compassionate Care										
12.5	Patient overall rating of ED	Tier Med									
12.5	Patient overall rating of ED MD	Tier Med									
25	Total Points Earned										
	Delivering High Quality Care										
10	ED Core Measure Performance (* denotes preliminary)	100%									
10	%LWOT	<1.0%									
10	% Fully Staffed	85%									
30	Total Points Earned										
	Operational Excellence										
10	Arrival Time to MSE	Tier Med									
10	MSE to Disposition	Tier Med									
10	Decision to Admit to Depart Time	Tier Med									
15	Discharges LOS	Tier Med									
45	Total Points Earned										
100	Grand Total										

Revised 12.2018

PASCAL METRICS

SUMMARY REPORT

Population: Mountain - Ottumwa Regional Health HR Company

Reportable Administrations:

- October 2020: October 26, 2020 - November 21, 2020

Report Generated on April 06, 2021

Summary Report

Domains Included in this Report

Organizational Trust & Values (OT&V)
Belief & acceptance of the values & mission of this organization.

Civility (CIVIL)
Level of respectful & courteous behaviors in the workgroup.

Exhaustion/Resilience (EXHAUST)
Extent to which emotional & physical resources are depleted.

Safety Climate (SC)
Perceived level of commitment to & focus on patient safety.

Supervisor Support (SS)
Perceived level of support & communication from one's supervisor.

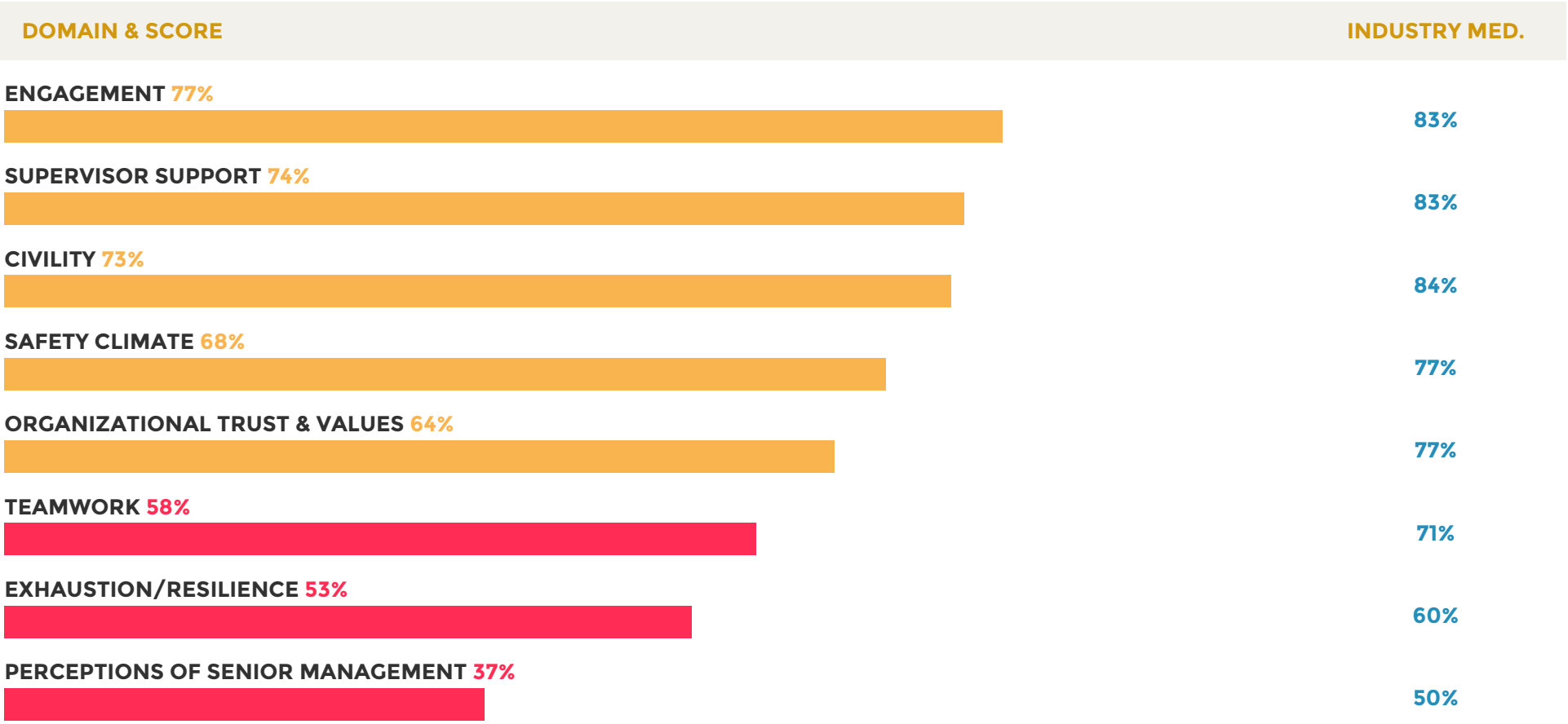
Engagement (EE)
Extent to which work provides meaning, joy, & purpose to one's life.

Teamwork (T)
Quality of teamwork & collaboration in workgroup.

Perceptions of Senior Management (PSM)
Perceptions of the support & competence of senior management.

Summary Report

Overview of Domain Scores



Summary Report

Highest to Lowest Scoring Items

ITEM	DOMAIN	% FAVORABLE
I am proud of the work I do.	EE	94%
I know where to view a copy of the Code of Conduct.	--	94%
I am familiar with my organizations Compliance Program/Code of Conduct.	--	93%
I know the proper channels to direct questions regarding patient safety in this work setting.	SC	92%
I know the name of and how to contact my organizations Compliance Officer.	--	88%
While at work, I get absorbed in my job.	EE	86%
My management team supports the goals and objectives of the Compliance Program and the Code of Conduct.	--	85%
I am encouraged by others in this work setting to report any patient safety concerns I may have.	SC	85%
I believe in the mission of this organization.	OT&V	83%
I get a sense of personal fulfillment from my work.	EE	82%
I know how to report a compliance concern anonymously using the hotline.	--	82%
My work provides me with a sense of purpose.	EE	81%
If a compliance concern comes to my attention, I would be comfortable reporting it, without fear of retaliation.	--	81%
It is easy for personnel here to ask questions when there is something that they do not understand.	T	81%
My organizations leadership sets a good example and encourages ethical behavior.	--	80%
Medical errors are handled appropriately in this work setting.	SC	80%
My interactions with coworkers are always respectful.	CIVIL	78%
Can be counted on to help deal with difficult problems.	SS	78%

Summary Report

Highest to Lowest Scoring Items

ITEM	DOMAIN	% FAVORABLE
I am treated with respect.	CIVIL	76%
Provides constructive feedback on my performance.	SS	75%
Bullying frequently occurs in my workgroup.	CIVIL	74%
I would feel safe being treated here as a patient.	SC	74%
Encourages people to talk about their concerns.	SS	74%
People in this work setting work together as a well coordinated team.	T	74%
Working all day is really a strain for me.	EXHAUST	73%
I receive appropriate feedback about my performance.	SC	73%
The culture in this work setting makes it easy to learn from the errors of others.	SC	73%
I get excited about my work.	EE	71%
I have the support I need from others in this work setting to care for patients.	T	71%
The values of this organization are consistent with my own.	OT&V	70%
Senior management doesn't knowingly compromise patient safety.	PSM	70%
In this work setting, it is difficult to speak up if I perceive a problem with patient care.	T	70%
Seeks out employee input on decisions that impact their work.	SS	69%
My input is well received in this work setting.	T	69%
In this work setting, it is difficult to discuss errors.	SC	68%
I feel burned out from my work.	EXHAUST	64%
Members of my workgroup always behave with consideration for one another.	CIVIL	63%

Summary Report

Highest to Lowest Scoring Items

ITEM	DOMAIN	% FAVORABLE
I get so involved in what I'm doing at work, I often lose track of time.	EE	63%
I look forward to each workday.	EE	62%
Disagreements in this work setting are resolved appropriately (i.e., not who is right, but what is best for the patient).	T	60%
Senior management supports my daily efforts.	PSM	56%
This organization consistently demonstrates its written values.	OT&V	54%
I get adequate, timely info about events that might affect my work from senior management.	PSM	54%
I feel tired when I get up in the morning and have to face another day on the job.	EXHAUST	52%
I trust the direction this organization is going in.	OT&V	50%
I feel used up at the end of the workday.	EXHAUST	40%
I feel emotionally drained from my work.	EXHAUST	37%
The staffing levels in this work setting are sufficient to handle the number of patients.	PSM	31%

Glint Results Review

Glint Quarterly Engagement Program 5pt

Let’s set the stage.

For today’s conversation, we’ll use a simple framework called ACT.

Acknowledge where we are.

Collaborate on where we want to go.

Take one step forward.

This is an opportunity for the team to give each other feedback, collaborate on solutions, and commit to small changes we all can make to improve our experience at work.

Acknowledge where we are.

Acknowledge Conversation Prompts

What are some things we have learned from reviewing the results (include some positives and some opportunities)?

What are the strengths we shouldn't lose sight of? What is our most important strength?

What are the biggest opportunities we see in the results? What are we missing?

Filters

View Exec Summary

Culture of Safety and Engagement:
Culture of Safety and Engagement: June 2022 CoSE

33 / 33 Questions

FILTER BY

Hospital Name: Ottumwa Regional ×

314 / 466 respondents

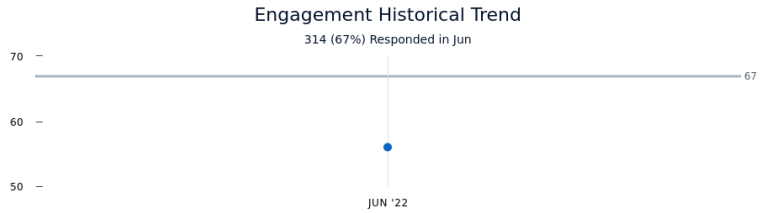
Pulse Overview

Jun '22 Engagement

56

Company 67

Change --



June 2022 CoSE Results

Response Rate

67%

314 of 466 responded

Comments

672

View all Comments

Engagement Favorability 42%

Questions

33

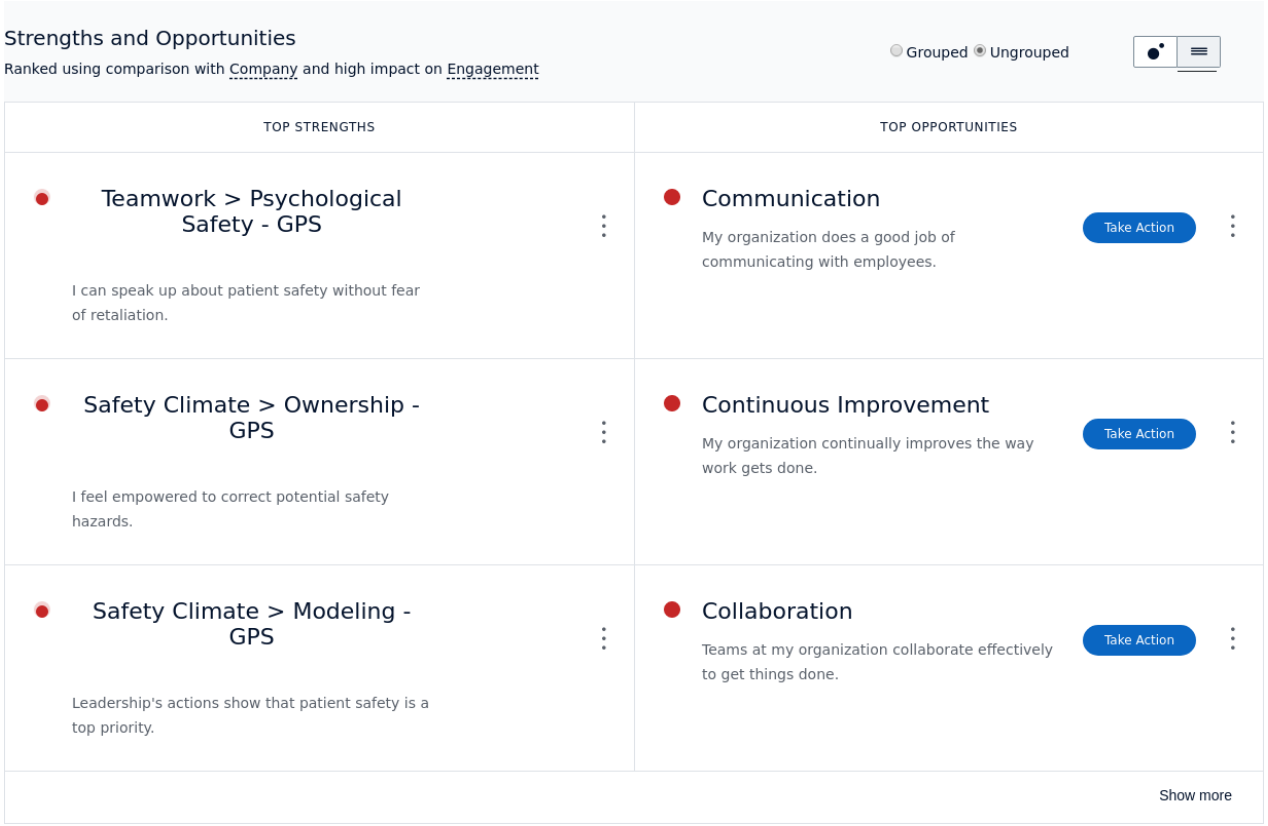
0	Scores Increased
0	Scores Decreased
0	Scores Above Company
35	Scores Below Company

Alert Summary

685 Populations

0 Teams

View All Alerts



Scores

Grouped | Ungrouped

Name	Score ↓	vs Company	Change	Impact	% Favorable	Comments	Question
GPS	65	-7	--	Very High	57%	20	2 Questions Jun 15, 2022
Compliance	65	-5	--	High	59%	5	I feel I can report compliance concerns without fear of retaliation. Jun 15, 2022
Feedback	64	-10	--	High	56%	12	My manager provides me with feedback that helps me improve my performance. Jun 15, 2022
Teamwork	62	-7	--	Very High	53%	48	8 Questions Jun 15, 2022
Safety Climate	61	-7	--	Very High	52%	42	8 Questions Jun 15, 2022
Empowerment	60	-8	--	Very High	53%	6	I feel empowered to make decisions regarding my work. Jun 15, 2022
Belonging	58	-10	--	Very High	49%	9	I feel a sense of belonging at my organization. Jun 15, 2022
Engagement	56	-11	--	--	42%	30	2 Questions Jun 15, 2022
Resources	55	-8	--	Very High	44%	11	I have the resources I need to do my job well. Jun 15, 2022

Resources	55	-8	--	Very High	44%	11	I have the resources I need to do my job well. Jun 15, 2022
Care	55	-10	--	Very High	49%	8	At work, I feel cared about as a person. Jun 15, 2022
Values	53	-11	--	Very High	35%	9	People at my organization live the company values. Jun 15, 2022
Growth	53	-10	--	Very High	41%	9	I have good opportunities to learn and grow within my organization. Jun 15, 2022
Recognition	52	-10	--	Very High	42%	10	I feel satisfied with the recognition or praise I receive for my work. Jun 15, 2022
Collaboration	52	-12	--	Very High	37%	10	Teams at my organization collaborate effectively to get things done. Jun 15, 2022
Continuous Improvement	45	-13	--	Very High	26%	11	My organization continually improves the way work gets done. Jun 15, 2022
Communication	41	-16	--	Very High	26%	11	My organization does a good job of communicating with employees. Jun 15, 2022
Action Taking	41	-11	--	Very High	27%	7	I believe meaningful action will be taken as a result of this survey. Jun 15, 2022

Department Hierarchy

Department Hierarchy	Engagement ↓	vs Company	Change	% Favorable	Responses
Ottumwa Regional	56	-11	--	42%	314 (67%)
All	56	-11	--	42%	314 (67%)

C Collaborate on where we want to go.

Collaborate Conversation Prompts

What is one thing we should focus on improving in the next few weeks?

What should we start doing to improve in this area? What should we continue doing? What should we stop doing?

What is the top simple change we can begin trying as a team over the next few weeks?

Take one step forward.

Take one step forward Conversation Prompts

Here’s one change I will commit to trying when we leave today. What’s one small thing each of you will do as a result of our discussion?

We’ll check in on how we’re doing during next month’s meeting. Thank you for your openness and commitment to improving together.

Next steps

- Create an Action Plan in Glint outlining key actions for the team.
- Schedule time during a recurring team meeting for ongoing ACT check-ins.

Thank You

Appendix

Tips for a great conversation

- Incorporate the ACT conversation as 15 minutes on the agenda of a standing team meeting.
- Create safety for sharing stories of successes, surprises and misses.
- Encourage candid feedback, while acknowledging we can't solve for everything right away.
- Be comfortable with being uncomfortable. These conversations may feel hard at first but will get easier over time with more repetition.

Commit to listen

Be curious

Share openly & constructively

Your role in the feedback process is **not to own all of the action items independently,** but to **own the ongoing conversations** about feedback and action that fuels progress

Your Role as a Manager:

- Show confidence in team's abilities, provide direction, role modeling and recognize the right behaviors.
- Provide guidelines for prioritization and decision-making, seek out differing opinions and ensure all voices are heard.
- Navigate larger organizational constraints and serve as first point of escalation to help overcome roadblocks.
- Foster a continuous improvement mindset by Check in frequently and adjust as needed.

Let's have an A C T Conversation!

(Post-Survey ACT Conversation Team Worksheet)

A Acknowledge where we are.

- Key insights from Glint results
- Most important strength not to lose sight of
- Biggest opportunity to get after

C Collaborate on where we want to go.

- One thing to focus on improving in the next few weeks
- Stop doing to improve
- Start doing to improve
- Continue doing to improve
- Top simple change to try in the next few weeks

T Take one step forward.

- Your commitment over the next few weeks
- Any barriers to success
- Next check-in

Let's have an  Conversation!

(Ongoing ACT Conversation Team Worksheet)

A Acknowledge where we are.

- How did you do on your commitment?
- Success story
- Learning

C Collaborate on where we want to go.

- One thing to focus on improving in the next few weeks
- Stop doing to improve
- Start doing to improve
- Continue doing to improve
- Top simple change to try in the next few weeks

T Take one step forward.

- Your commitment over the next few weeks
- Any barriers to success
- Next check-in

Glint Results Review

Glint Quarterly Engagement Program 5pt

Let’s set the stage.

For today’s conversation, we’ll use a simple framework called ACT.

Acknowledge where we are.

Collaborate on where we want to go.

Take one step forward.

This is an opportunity for the team to give each other feedback, collaborate on solutions, and commit to small changes we all can make to improve our experience at work.

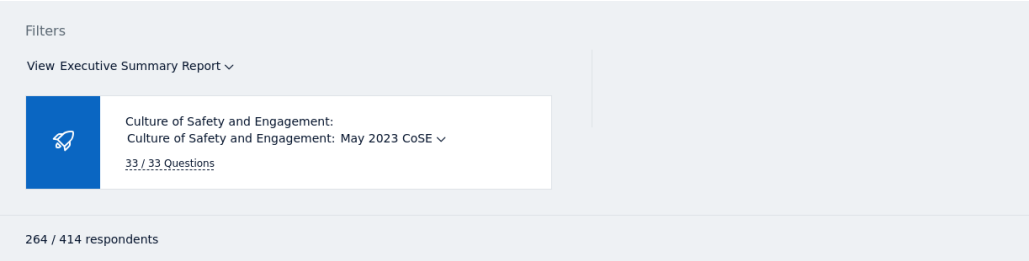
Acknowledge where we are.

Acknowledge Conversation Prompts

What are some things we have learned from reviewing the results (include some positives and some opportunities)?

What are the strengths we shouldn't lose sight of? What is our most important strength?

What are the biggest opportunities we see in the results? What are we missing?

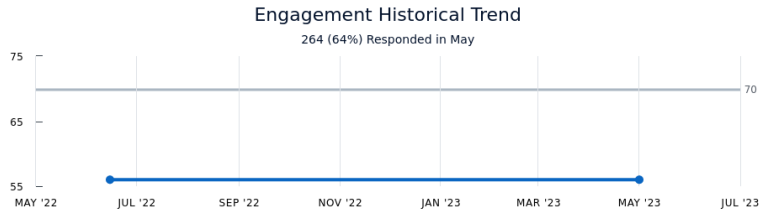


Pulse Overview

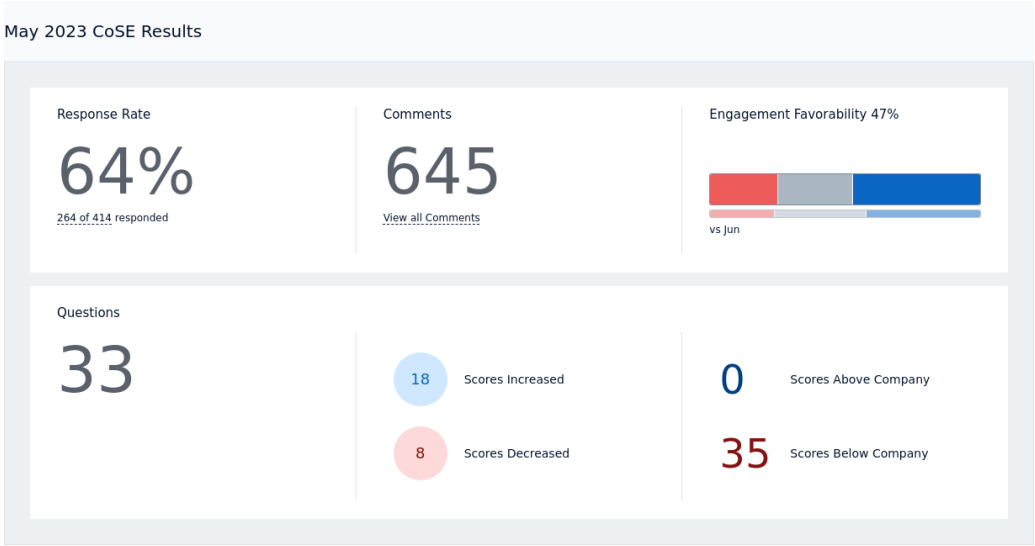
May '23 Engagement

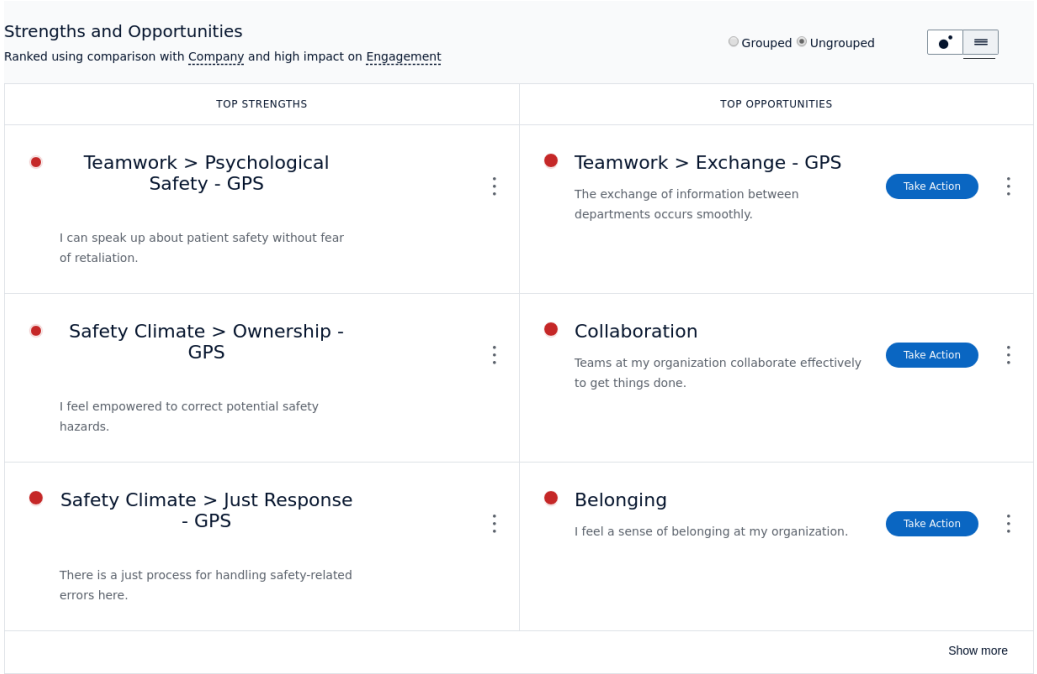
56

Company	vs Jun
70	0



May 2023 CoSE Results





Scores

Grouped | Ungrouped

Name	Score ↓	vs Company	Change	Impact	% Favorable	Comments	Question
Compliance	66	-5	↑ 1	Very High	62%	7	I feel I can report compliance concerns without fear of retaliation. May 1, 2023
Feedback	65	-10	↑ 1	Very High	64%	9	My manager provides me with feedback that helps me improve my performance. May 1, 2023
> Teamwork	63	-8	↑ 1	Very High	55%	59	8 Questions May 1, 2023
> GPS	63	-10	↓ 2	Very High	55%	27	2 Questions May 1, 2023
> Safety Climate	62	-8	↑ 1	Very High	54%	63	8 Questions May 1, 2023
Empowerment	58	-12	↓ 2	Very High	49%	4	I feel empowered to make decisions regarding my work. May 1, 2023
Belonging	57	-14	↓ 1	Very High	48%	10	I feel a sense of belonging at my organization. May 1, 2023
> Engagement	56	-14	0	--	47%	31	2 Questions May 1, 2023
Care	55	-13	0	Very High	48%	12	At work, I feel cared about as a person. May 1, 2023

Care	55	-13	0	Very High	48%	12	At work, I feel cared about as a person. May 1, 2023
Values	54	-13	↑ 1	Very High	38%	9	People at my organization live the company values. May 1, 2023
Growth	54	-11	↑ 1	Very High	43%	10	I have good opportunities to learn and grow within my organization. May 1, 2023
Resources	53	-12	↓ 2	Very High	45%	10	I have the resources I need to do my job well. May 1, 2023
Recognition	53	-11	↑ 1	Very High	45%	6	I feel satisfied with the recognition or praise I receive for my work. May 1, 2023
Collaboration	52	-14	0	Very High	40%	7	Teams at my organization collaborate effectively to get things done. May 1, 2023
Continuous Improvement	51	-10	↑ 6	Very High	36%	14	My organization continually improves the way work gets done. May 1, 2023
Action Taking	47	-7	↑ 6	Very High	34%	5	I believe meaningful action will be taken as a result of this survey. May 1, 2023
Communication	46	-13	↑ 5	Very High	34%	18	My organization does a good job of communicating with employees. May 1, 2023

Department Hierarchy

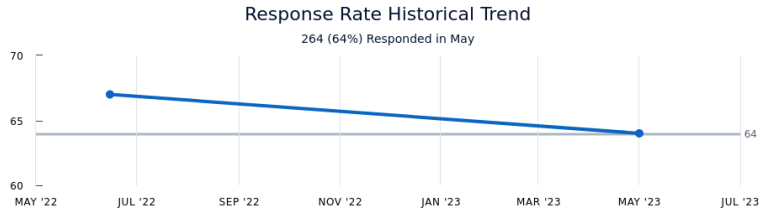
Department Hierarchy	Engagement ↓	vs Company	Change	% Favorable	Responses
Ottumwa Regional	56	-14	0	47%	264 (64%)
All	56	-14	0	47%	264 (64%)

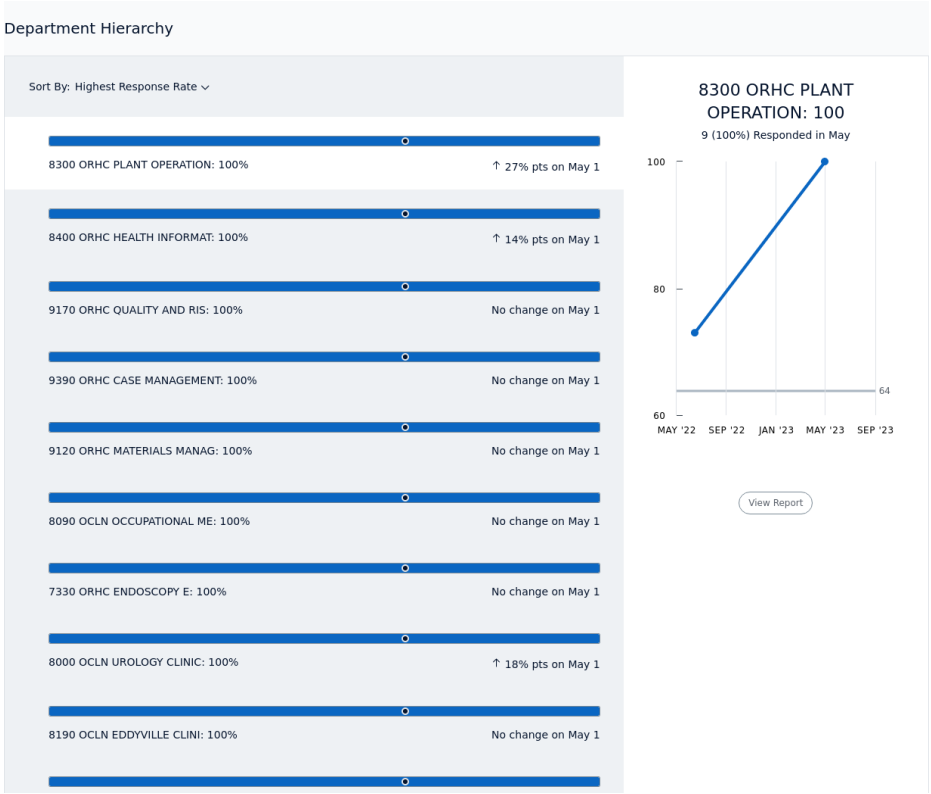
May Response Rate

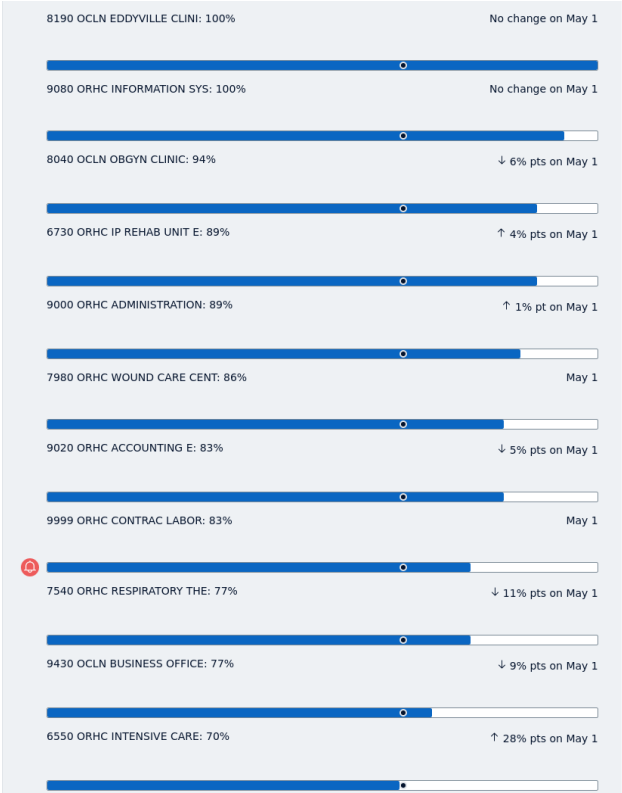
64%

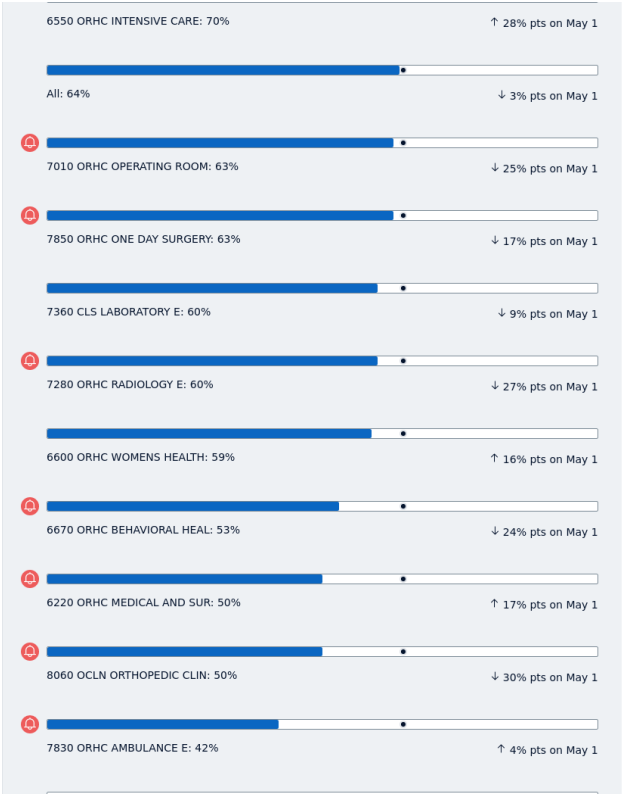
Company 64%

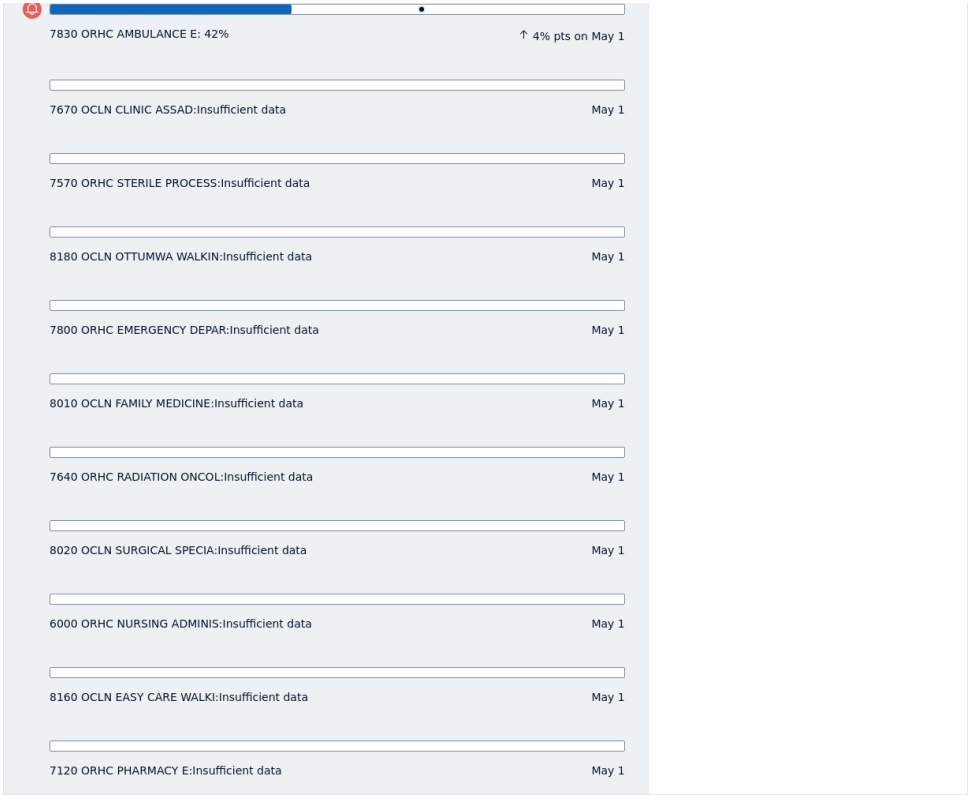
vs Jun ↓3%











7120 ORHC PHARMACY E:Insufficient data	May 1

Overview

Comments
221 commenters (84%) of respondents

645

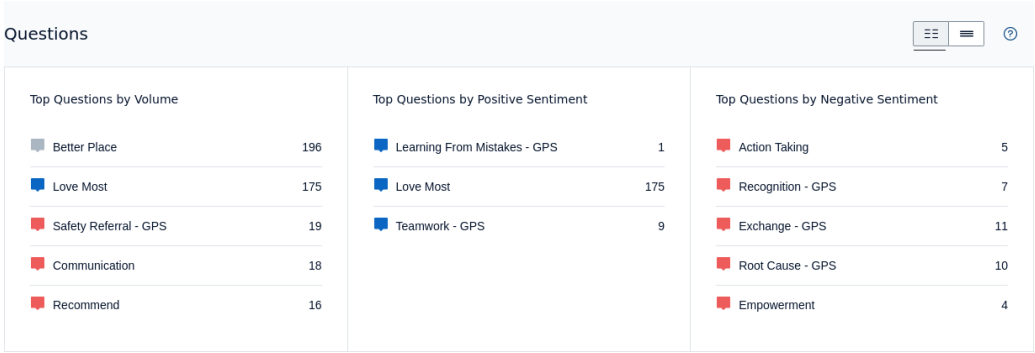
↓ 4% vs Jun

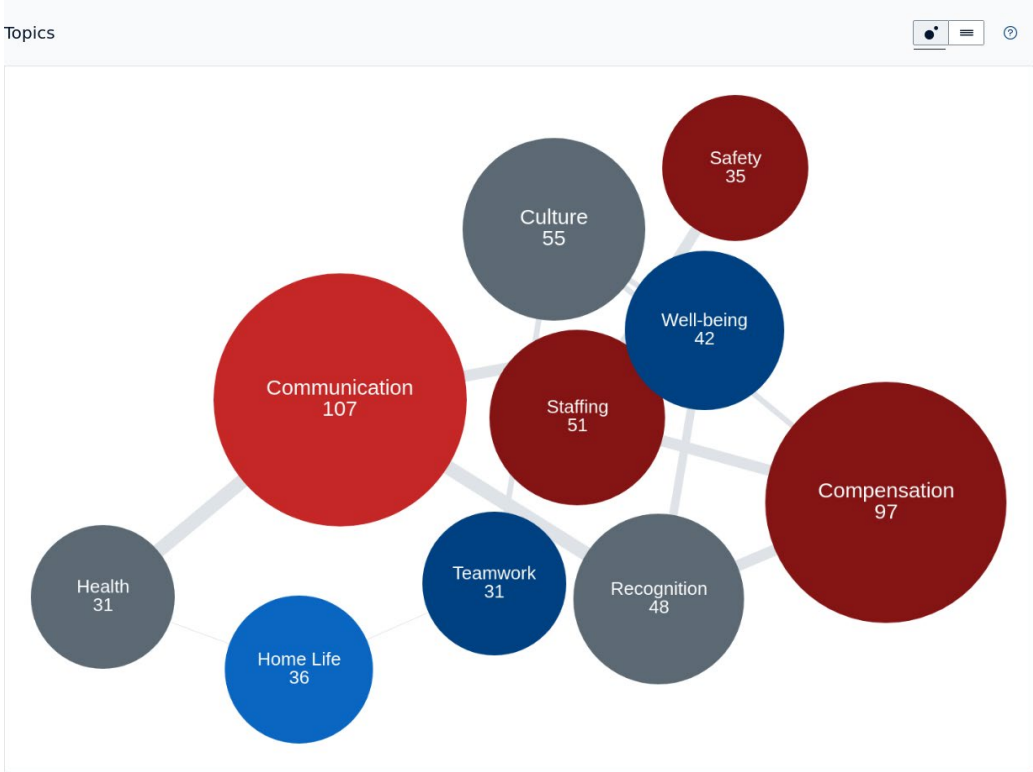
Comment Sentiment
Overall sentiment is mixed and trending negative

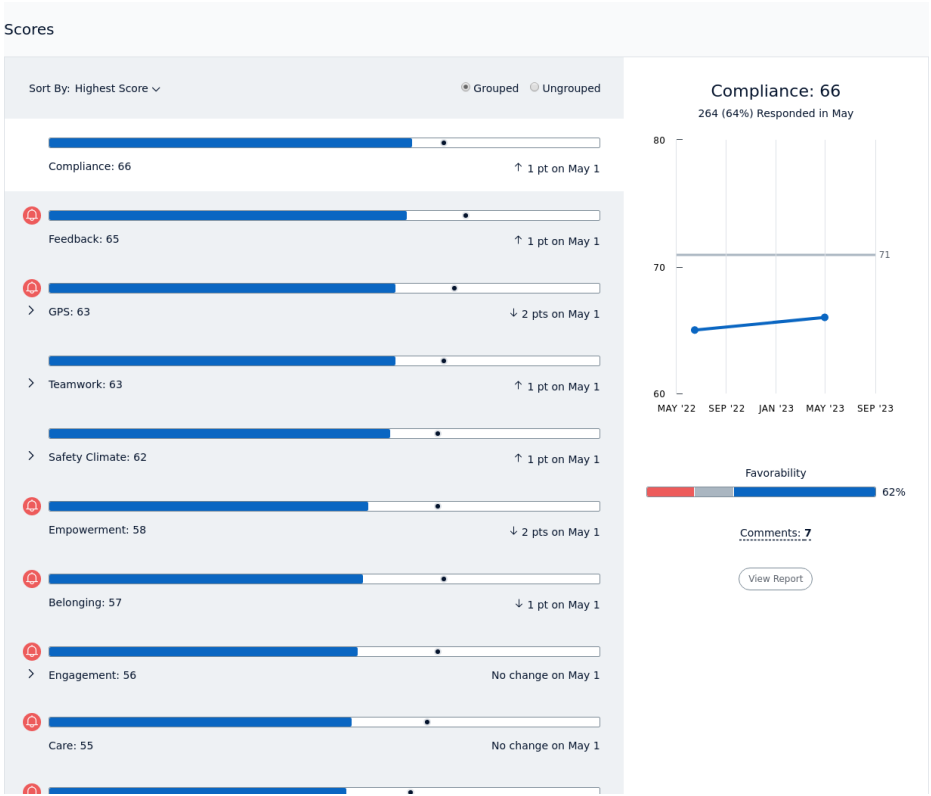
Topics
These topics are mentioned most in the comments

Communication(107) Compensation(97) Culture(55) Staffing(51) Recognition(48)

Explore More Topics

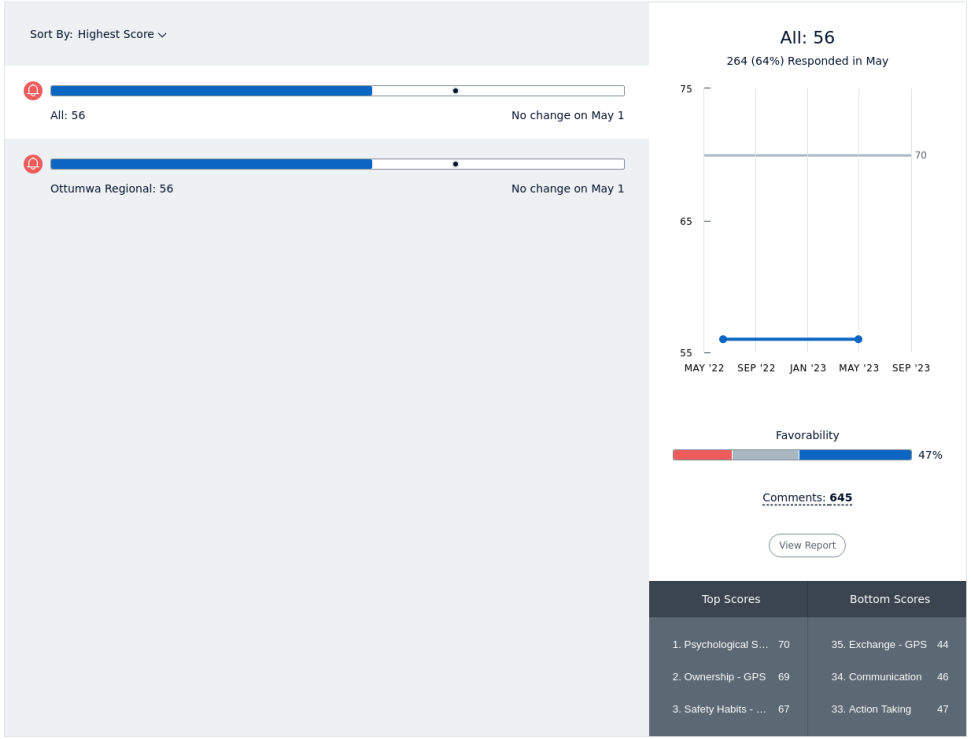


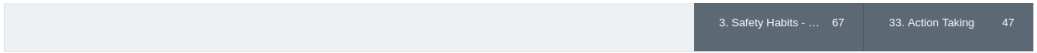




Top Teams	Bottom Teams
1. Ottumwa Regional 66	1. Ottumwa Regional 66

Engagement by Department Hierarchy





C Collaborate on where we want to go.

Collaborate Conversation Prompts

What is one thing we should focus on improving in the next few weeks?

What should we start doing to improve in this area? What should we continue doing? What should we stop doing?

What is the top simple change we can begin trying as a team over the next few weeks?

Take one step forward.

Take one step forward Conversation Prompts

Here’s one change I will commit to trying when we leave today. What’s one small thing each of you will do as a result of our discussion?

We’ll check in on how we’re doing during next month’s meeting. Thank you for your openness and commitment to improving together.

Next steps

- Create an Action Plan in Glint outlining key actions for the team.
- Schedule time during a recurring team meeting for ongoing ACT check-ins.

Thank You

Appendix

Tips for a great conversation

- Incorporate the ACT conversation as 15 minutes on the agenda of a standing team meeting.
- Create safety for sharing stories of successes, surprises and misses.
- Encourage candid feedback, while acknowledging we can't solve for everything right away.
- Be comfortable with being uncomfortable. These conversations may feel hard at first but will get easier over time with more repetition.

Commit to listen

Be curious

Share openly & constructively

Your role in the feedback process is **not to own all of the action items independently,** but to **own the ongoing conversations** about feedback and action that fuels progress

Your Role as a Manager:

- Show confidence in team's abilities, provide direction, role modeling and recognize the right behaviors.
- Provide guidelines for prioritization and decision-making, seek out differing opinions and ensure all voices are heard.
- Navigate larger organizational constraints and serve as first point of escalation to help overcome roadblocks.
- Foster a continuous improvement mindset by Check in frequently and adjust as needed.

Let's have an  Conversation!

(Post-Survey ACT Conversation Team Worksheet)

A Acknowledge where we are.

- Key insights from Glint results
- Most important strength not to lose sight of
- Biggest opportunity to get after

C Collaborate on where we want to go.

- One thing to focus on improving in the next few weeks
- Stop doing to improve
- Start doing to improve
- Continue doing to improve
- Top simple change to try in the next few weeks

T Take one step forward.

- Your commitment over the next few weeks
- Any barriers to success
- Next check-in

Let's have an  Conversation!

(Ongoing ACT Conversation Team Worksheet)

A Acknowledge where we are.

- How did you do on your commitment?
- Success story
- Learning

C Collaborate on where we want to go.

- One thing to focus on improving in the next few weeks
- Stop doing to improve
- Start doing to improve
- Continue doing to improve
- Top simple change to try in the next few weeks

T Take one step forward.

- Your commitment over the next few weeks
- Any barriers to success
- Next check-in

Glint Results Review

Glint Quarterly Engagement Program 5pt

Let’s set the stage.

For today’s conversation, we’ll use a simple framework called ACT.

Acknowledge where we are.

Collaborate on where we want to go.

Take one step forward.

This is an opportunity for the team to give each other feedback, collaborate on solutions, and commit to small changes we all can make to improve our experience at work.

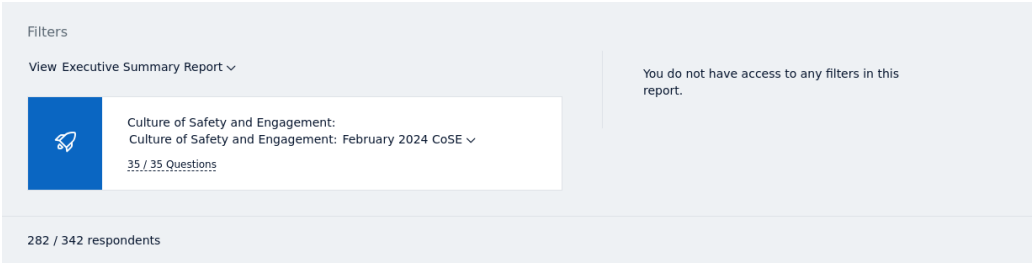
Acknowledge where we are.

Acknowledge Conversation Prompts

What are some things we have learned from reviewing the results (include some positives and some opportunities)?

What are the strengths we shouldn't lose sight of? What is our most important strength?

What are the biggest opportunities we see in the results? What are we missing?



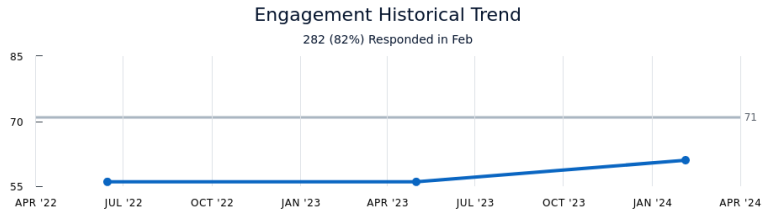
Pulse Overview

Feb '24 Engagement

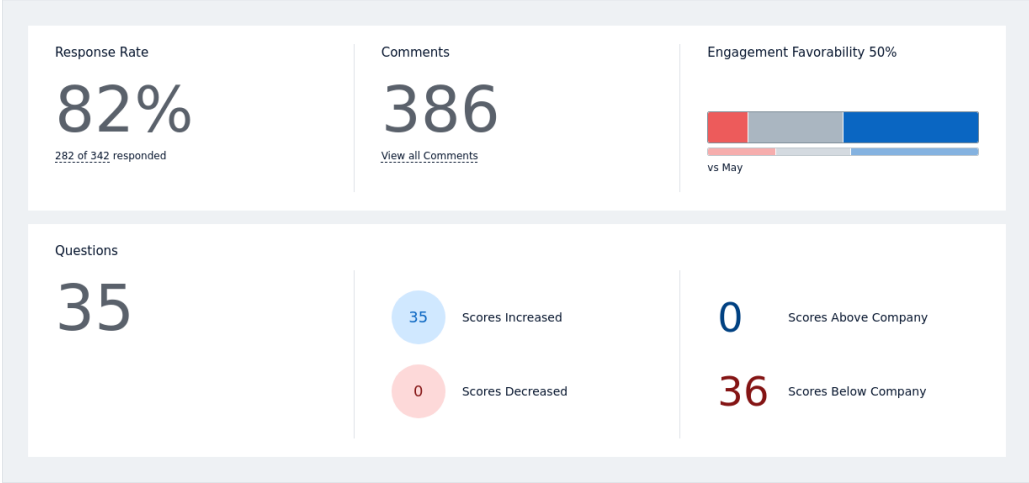
61

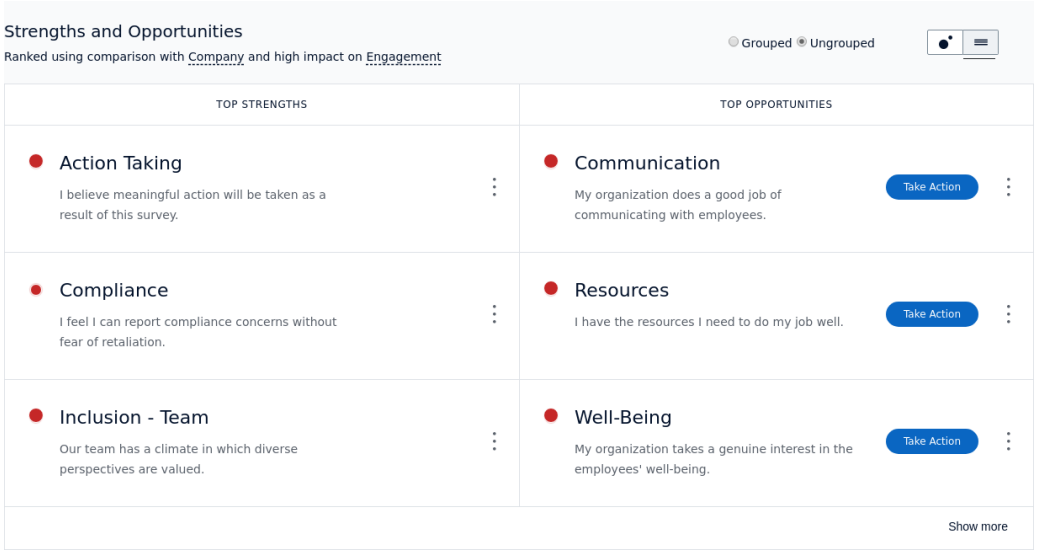
Company 71

vs May ↑5



February 2024 CoSE Results

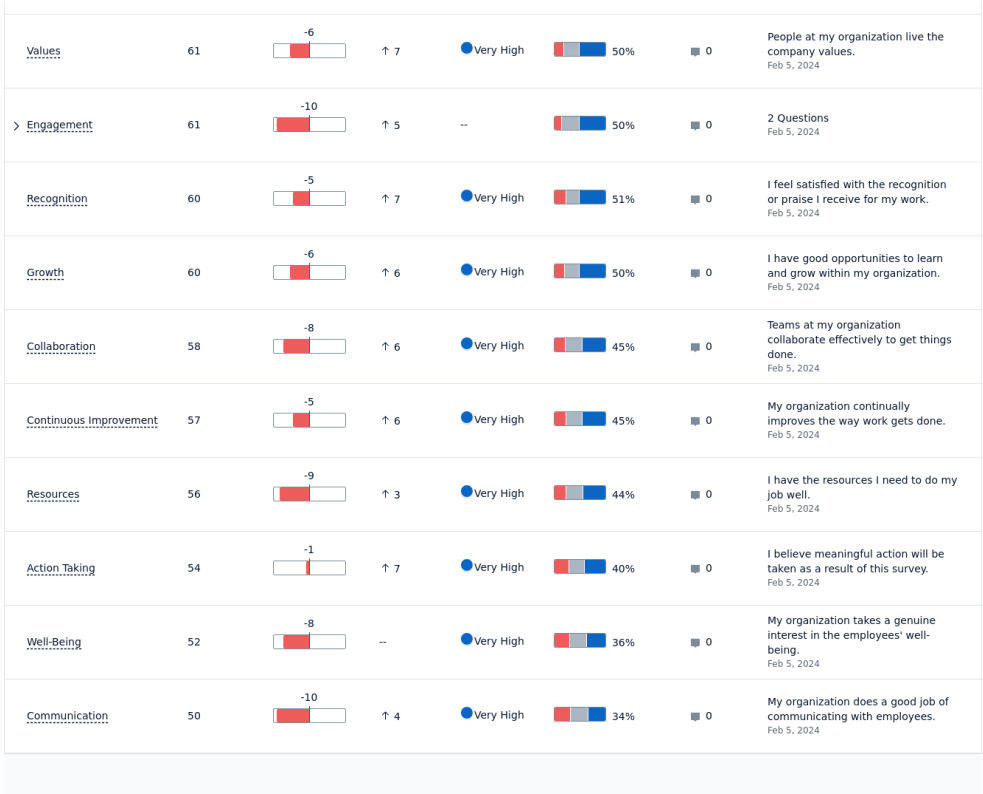




Scores

Grouped | Ungrouped

Name	Score ↓	vs Company	Change	Impact	% Favorable	Comments	Question
Feedback	71	-5	↑ 6	High	68%	0	My manager provides me with feedback that helps me improve my performance. Feb 5, 2024
Compliance	68	-3	↑ 2	High	62%	0	I feel I can report compliance concerns without fear of retaliation. Feb 5, 2024
Teamwork	67	-4	↑ 4	Very High	60%	0	8 Questions Feb 5, 2024
Inclusion - Team	67	-4	--	Very High	60%	0	Our team has a climate in which diverse perspectives are valued. Feb 5, 2024
Safety Climate	66	-4	↑ 4	Very High	58%	0	8 Questions Feb 5, 2024
GPS	66	-8	↑ 3	Very High	59%	0	2 Questions Feb 5, 2024
Empowerment	66	-4	↑ 8	Very High	58%	0	I feel empowered to make decisions regarding my work. Feb 5, 2024
Belonging	65	-6	↑ 8	Very High	56%	0	I feel a sense of belonging at my organization. Feb 5, 2024
Care	62	-7	↑ 7	Very High	54%	0	At work, I feel cared about as a person. Feb 5, 2024
Values	61	-6	↑ 7	Very High	50%	0	People at my organization live the company values. Feb 5, 2024



Values	61	-6	↑ 7	Very High	50%	0	People at my organization live the company values. Feb 5, 2024
Engagement	61	-10	↑ 5	--	50%	0	2 Questions Feb 5, 2024
Recognition	60	-5	↑ 7	Very High	51%	0	I feel satisfied with the recognition or praise I receive for my work. Feb 5, 2024
Growth	60	-6	↑ 6	Very High	50%	0	I have good opportunities to learn and grow within my organization. Feb 5, 2024
Collaboration	58	-8	↑ 6	Very High	45%	0	Teams at my organization collaborate effectively to get things done. Feb 5, 2024
Continuous Improvement	57	-5	↑ 6	Very High	45%	0	My organization continually improves the way work gets done. Feb 5, 2024
Resources	56	-9	↑ 3	Very High	44%	0	I have the resources I need to do my job well. Feb 5, 2024
Action Taking	54	-1	↑ 7	Very High	40%	0	I believe meaningful action will be taken as a result of this survey. Feb 5, 2024
Well-Being	52	-8	--	Very High	36%	0	My organization takes a genuine interest in the employees' well-being. Feb 5, 2024
Communication	50	-10	↑ 4	Very High	34%	0	My organization does a good job of communicating with employees. Feb 5, 2024

Department Hierarchy

Department Hierarchy	Engagement ↓	vs Company	Change	% Favorable	Responses
Ottumwa Regional	61	-10	↑ 5	50%	282 (82%)
All	61	-10	↑ 5	50%	282 (82%)

C Collaborate on where we want to go.

Collaborate Conversation Prompts

What is one thing we should focus on improving in the next few weeks?

What should we start doing to improve in this area? What should we continue doing? What should we stop doing?

What is the top simple change we can begin trying as a team over the next few weeks?

Take one step forward.

Take one step forward Conversation Prompts

Here’s one change I will commit to trying when we leave today. What’s one small thing each of you will do as a result of our discussion?

We’ll check in on how we’re doing during next month’s meeting. Thank you for your openness and commitment to improving together.

Next steps

- Create an Action Plan in Glint outlining key actions for the team.
- Schedule time during a recurring team meeting for ongoing ACT check-ins.

Thank You

Appendix

Tips for a great conversation

- Incorporate the ACT conversation as 15 minutes on the agenda of a standing team meeting.
- Create safety for sharing stories of successes, surprises and misses.
- Encourage candid feedback, while acknowledging we can't solve for everything right away.
- Be comfortable with being uncomfortable. These conversations may feel hard at first but will get easier over time with more repetition.

Commit to listen

Be curious

Share openly & constructively

Your role in the feedback process is **not to own all of the action items independently,** but to **own the ongoing conversations** about feedback and action that fuels progress

Your Role as a Manager:

- Show confidence in team's abilities, provide direction, role modeling and recognize the right behaviors.
- Provide guidelines for prioritization and decision-making, seek out differing opinions and ensure all voices are heard.
- Navigate larger organizational constraints and serve as first point of escalation to help overcome roadblocks.
- Foster a continuous improvement mindset by Check in frequently and adjust as needed.

Let's have an  Conversation!

(Post-Survey ACT Conversation Team Worksheet)

A Acknowledge where we are.

- Key insights from Glint results
- Most important strength not to lose sight of
- Biggest opportunity to get after

C Collaborate on where we want to go.

- One thing to focus on improving in the next few weeks
- Stop doing to improve
- Start doing to improve
- Continue doing to improve
- Top simple change to try in the next few weeks

T Take one step forward.

- Your commitment over the next few weeks
- Any barriers to success
- Next check-in

Let's have an  Conversation!

(Ongoing ACT Conversation Team Worksheet)

A Acknowledge where we are.

- How did you do on your commitment?
- Success story
- Learning

C Collaborate on where we want to go.

- One thing to focus on improving in the next few weeks
- Stop doing to improve
- Start doing to improve
- Continue doing to improve
- Top simple change to try in the next few weeks

T Take one step forward.

- Your commitment over the next few weeks
- Any barriers to success
- Next check-in

ANNUAL REPORT

OF

LIFEPOINT HEALTH, INC.

FOR THE

FISCAL YEAR ENDED DECEMBER 31, 2018

PREPARED IN ACCORDANCE WITH

ANNUAL REPORT ON FORM 10-K
(AS MODIFIED UNDER DEBT AGREEMENTS)

LifePoint Health, Inc.
(Exact Name of Company as Specified in Its Charter)

RegionalCare Hospital Partners Holdings, Inc.
(Former Name of Company)

Delaware	**27-0500485**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**
330 Seven Springs Way Brentwood, Tennessee	**37027**
(Address of Principal Executive Offices)	**(Zip Code)**

(615) 920-7000
(Company's Telephone Number, Including Area Code)

103 Continental Place, Suite 200, Brentwood, Tennessee 37027
(Former Address of Company)

At March 28, 2019, there were 100 outstanding shares of common stock of LifePoint Health, Inc.

LifePoint Health, Inc.

Annual Report

For the fiscal year ended December 31, 2018

TABLE OF CONTENTS

DISCLOSURE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report for the fiscal year ended December 31, 2018 (this "***Report***") contains forward-looking statements that involve risks and uncertainties. Forward-looking statements include any statements that address future results or occurrences. In some cases you can identify forward-looking statements by terminology such as "may," "might," "will," "would," "should," "could" or the negatives thereof. Generally, the words "anticipate," "believe," "continue," "expect," "intend," "estimate," "project," "plan" and similar expressions identify forward-looking statements. In particular, statements about our expectations, beliefs, plans, objectives, assumptions or future events or performance contained elsewhere in this Report are forward-looking statements. These forward-looking statements include statements that are not historical facts, including statements concerning our possible or assumed future actions and business strategies. We have based these forward-looking statements on our current expectations, assumptions, estimates and projections. While we believe these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks, uncertainties and other factors, many of which are outside of our control, which could cause our actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. Such forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. Such factors include, among others, the following:

- the significant costs and substantial indebtedness that were incurred in connection with the closing of the LifePoint/RCCH Merger (as defined herein) and the integration of the businesses of Legacy LifePoint (as defined herein) and RCCH (as defined herein);
- payment changes, including policy considerations and changes resulting from federal and state budgetary restrictions;
- impact from or likelihood of the repeal, replacement or material modification to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "***Affordable Care Act***"), as a result of legislative or court action;
- potential impact from the repeal of the "individual mandate" to purchase health insurance under the Affordable Care Act, included in the Tax Cuts and Jobs Act of 2017 (the "***Tax Act***");
- impact from changes to Medicaid supplemental payment programs;
- our compliance with new and existing laws and regulations as well as costs and benefits associated with compliance;
- any potential action brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the "qui tam" or "whistleblower" provisions of the federal False Claims Act (the "***False Claims Act***");
- impact from the changes in payer mix marked by a shift of patients from private insurance to Medicare and Medicaid programs;
- our acquisition strategy, including integration risks relating to recent historical acquisitions and integration risks relating to future acquisitions that are in addition to those associated with the LifePoint/RCCH Merger;
- the potential material obligations if we acquire facilities with unknown or contingent liabilities;
- claims and legal actions relating to professional liabilities and other litigation risks;
- delayed payments and repayments resulting from reviews of claims to Medicare and Medicaid for our services;
- impact of controls imposed by payers designed to reduce inpatient services;
- our relationships with our joint venture partners, including our Duke LifePoint Healthcare joint venture with Duke University Health System;
- changes in physician employment regulations;
- increases in the amount and risk of collectability of patient accounts receivable;
- our need to make investments continually in our processes and information systems to protect the privacy of patients, employees and other persons and reduce the risk of successful cybersecurity attacks;
- damage to our reputation, regulatory penalties, legal claims and liability under state and federal laws that we could suffer upon any cybersecurity or privacy breaches;
- effects of competition in a facility's market;
- effects of union organizing activities;
- potential recoupment of previously recognized income from electronic health record ("***EHR***") incentive programs;
- anticipated capital expenditures, including routing projects, investments in information systems and capital projects related to acquisitions, construction of new facilities and construction projects and the expectation that capital commitments could be a component of future acquisitions;
- timeframes for completion of capital projects;
- changes in depreciation and amortization expenses;
- costs of providing care to our patients;
- implementation of supply chain management and revenue cycle functions;

- accounting estimates and the impact of accounting methodologies and new accounting pronouncements;
- changes in industry and general economic trends;
- consolidation of commercial insurance companies and patient shifts to lower cost healthcare plans, including association health plans and short term limited duration health insurance plans, which generally provide lower payment for services provided;
- participation in the healthcare exchanges and the impact of increasing enrollment by patients in insurance plans with narrow networks, tiered networks, high deductibles or high co-payments;
- uncertainty of patient volumes and related revenues;
- governmental or third-party investigations, legal actions and voluntary self-disclosures relating to overpayments or other regulatory compliance matters;
- recruitment and retention of senior executives, providers and other healthcare employees;
- our ability to acquire facilities on favorable terms and successfully complete asset sales and divestitures;
- the ability of our local management teams to identify and meet the needs of our patients, medical staffs and their communicates;
- the efforts of insurers, healthcare providers and others to contain healthcare costs;
- our ability to obtain adequate levels of general and professional liability insurance;
- our ability to implement initiatives promoting cost reductions and operational efficiencies;
- possible future indebtedness that may be incurred; and
- other factors referenced under the caption "Risk Factors" contained in this Report.

Given these uncertainties, readers are cautioned not to place undue reliance on such forward-looking statements. We disclaim any obligation to update any such factors or to announce the result of any revisions to any of the forward-looking statements contained herein to reflect future results, events or developments.

Statements in this Report are made as of the date hereof. New factors emerge from time to time that could cause our actual results to differ, and it is not possible to predict all such factors.

EXPLANATORY INFORMATION REGARDING THIS REPORT

This Report has been prepared in accordance with the obligations of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.) (the "***Company***") under (i) Section 4.02 of the Indenture, dated as of April 29, 2016 (the "***8.25% Secured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 8.25% Secured Notes due 2023 (the "***8.25% Secured Notes***"), (ii) Section 4.02 of the Indenture, dated April 29, 2016 (the "***11.5% Unsecured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 11.5% Unsecured Notes due 2024 (the "***11.5% Unsecured Notes***"), (iii) Section 4.02 of the Indenture, dated November 16, 2018 (the "***9.75% Unsecured Notes Indenture***" and, together with the 8.25% Secured Notes Indenture and the 11.5% Unsecured Notes Indenture, the "***Indentures***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 9.75% Unsecured Notes due 2026 (the "***9.75% Unsecured Notes***" and, together with the 8.25% Secured Notes and the 11.5% Unsecured Notes, the "***Notes***"), (iv) Section 5.04 of the Asset-Based Revolving Credit Agreement, dated as of November 16, 2018 (the "***ABL Agreement***"), among the Company, as Lead Borrower, DSB Acquisition, LLC, a Delaware limited liability company ("***Holdings***"), the lenders party thereto from time to time and Citibank, N.A., as administrative agent and collateral agent, and (v) Section 5.04 of the First Lien Credit Agreement, dated as of November 16, 2018 (the "***Term Loan Agreement***" and, together with the ABL Agreement, the "***Credit Agreements***"), among the Company, as Lead Borrower, Holdings, the lenders party thereto and Citibank, N.A., as administrative agent and collateral agent. This Report has been prepared in all material respects in accordance with the rules and regulations of the Securities and Exchange Commission (the "***SEC***") applicable to an Annual Report on Form 10-K for the fiscal year ended December 31, 2018, except to the extent permitted to be excluded by the Indentures and the Credit Agreements.

USE OF NON-GAAP FINANCIAL INFORMATION

In this Report, we have provided EBITDA and Adjusted EBITDA (collectively, the "***Non-GAAP Measures***") because we believe they provide the Holders with additional information to measure our performance and evaluate our ability to service our indebtedness. We believe that the presentation of Non-GAAP Measures is appropriate to provide additional information to the Holders about certain material non-cash items and about unusual items that we do not expect to continue or to continue at the same level in the future as well as other items. Further, we believe the Non-GAAP Measures provide a meaningful measure of operating profitability because we use them for evaluating our business performance and understanding certain significant items.

The Non-GAAP Measures are not presentations made in accordance with United States ("***U.S.***") generally accepted accounting principles ("***GAAP***"), and our use of these terms may vary from others in our industry. EBITDA and Adjusted EBITDA should not be considered as alternatives to operating income or any other performance measures derived in accordance with GAAP as measures of operating performance or cash flows as measures of liquidity. EBITDA and Adjusted EBITDA have important limitations as analytical tools, and you should not consider them in isolation or as substitutes for analysis of our results as reported under GAAP. Because of these limitations, we rely primarily on our GAAP results and use EBITDA and Adjusted EBITDA only as a supplement. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" for a description of the calculation and limitations of these measures.

DOCUMENT SUMMARIES AND REQUESTS

This Report contains summaries believed to be accurate with respect to certain documents, but reference is made to the actual documents for complete information. All such summaries, which do not purport to be complete, are qualified in their entirety by such reference. Copies of the documents referred to herein will be made available without cost to Holders of the Notes by making a written or oral request to us. Any such request may be made to us at the following address and telephone number:

LifePoint Health, Inc.
330 Seven Springs Way
Brentwood, Tennessee 37027
Attn: General Counsel
Tel. (615) 920-7000

FISCAL YEAR

All references to "fiscal year" are to the twelve months ended December 31 of the year referenced.

OTHER ITEMS

This Report is prepared by LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.), a Delaware corporation, which, along with each of its consolidated subsidiaries, is referred to herein as the "***Company***," "***LifePoint***," "***we***," "***our***," "***us***," and, before giving effect to the LifePoint/RCCH Merger (as defined below), "***RCCH***," in each case, unless the context otherwise requires.

References in this Report to the "***LifePoint/RCCH Merger***" refer to the merger, which was effective on November 16, 2018, of Legend Merger Sub, Inc., a Delaware corporation and wholly-owned subsidiary of RCCH ("***Legend Merger Sub***"), with and into LifePoint Health, Inc., a Delaware corporation ("***Legacy LifePoint***"), with Legacy LifePoint surviving the LifePoint/RCCH Merger as a subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

References in this Report to the "***RegionalCare/Capella Merger***" refer to the merger of Crimson Merger Sub, LLC ("***Crimson Merger Sub***"), a Delaware limited liability company and wholly-owned subsidiary of RegionalCare Hospital Partners Inc. ("***Regional Care***"), with and into Capella Health Holdings, LLC ("***Capella***"), with Capella surviving the RegionalCare/Capella Merger as a wholly-owned subsidiary of RegionalCare, which began to do business as RCCH HealthCare Partners. The RegionalCare/Capella Merger was consummated on April 29, 2016; however, for accounting purposes, the RegionalCare/Capella Merger became effective on May 1, 2016.

References in this Report to the "***Apollo/RegionalCare Acquisition***" refer to the merger, which was effective on December 3, 2015, of DSB Merger Sub Inc., a Delaware corporation and wholly-owned subsidiary of Holdings, with and into RegionalCare with RegionalCare surviving such merger as a direct wholly-owned subsidiary of Holdings, which is indirectly controlled by our Sponsor.

References in this Report to the "***Sponsor***" refer to certain funds that are affiliates of the Company (the "***Apollo Funds***") that are ultimately controlled and/or managed by Apollo Management VIII, L.P. ("***Apollo Management***" and, when acting on behalf of the Apollo Funds, "***Apollo***"), which is an affiliate of Apollo Global Management LLC.

PART I

Item 1. *Business*.

Our Company

We own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. As of December 31, 2018, we operated 89 hospital campuses in 30 states throughout the U.S., having a total of 11,876 licensed beds. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a network of hospitals and outpatient facilities.

We seek to fulfill our mission of Making Communities Healthier® by (1) delivering high quality patient care, (2) supporting our physicians, (3) creating excellent workplaces for our employees, (4) taking a leadership role in our communities and (5) ensuring fiscal responsibility. We strive to create places where people choose to come for healthcare, physicians want to practice and employees want to work.

Our Business Strategy

The key elements of our business strategy include:

- *Continue to Grow in Existing Markets by Expanding Services and Access Points to Care*. We regularly conduct in-depth strategic reviews of the major service lines offered at each of our facilities and evaluate additional services through which we could profitably grow in our markets and better serve our communities. We leverage our local market knowledge together with input and guidance from our local physician and community leaders to prioritize the healthcare services our communities are seeking. Focus areas include expansion of specialty service lines to meet unserved patient needs, expansion of access points to care, including outpatient, ancillary and retail health services, and investment in technology and equipment. We invest strategically in our markets in order to increase the quality and scope of services we provide, meet the needs of our communities and maintain our strong reputation as the healthcare provider of choice. This in turn helps us to continue recruiting physicians and growing the revenue and profitability of our facilities.

- *Continue to Recruit and Retain Leading Physicians*. Our physician engagement strategies drive our ability to enhance and expand our services to meet the healthcare needs of our communities. We have a comprehensive recruiting program that is directed by an experienced corporate department and is supported at the local level by our hospital system chief executive officers ("***CEOs***") and Boards of Trustees. We supplement our local teams with experienced corporate office specialists and several third party recruiting firms to assist us in identifying candidates that match the profile of our physician needs. We maintain a flexible approach to aligning our goals with our physician partners, including our willingness to recruit physicians through multi-year employment and/or income guarantee arrangements. In addition, we believe our physicians are attracted to our facilities because of several factors, including our commitment to quality care, our focus on employing and developing high quality nurses and support staff and our integration into, and support of, the communities we serve.

- *Routinely Optimize Our Portfolio to Strengthen Our Position in Existing Markets and Expand into New Markets*. We evaluate and selectively pursue acquisitions of hospitals, outpatient and ancillary clinics and other healthcare facilities in new and existing markets, with the goal of improving our operating performance and better meeting the healthcare needs of our communities. We employ a rigorous and disciplined approach to new market acquisitions and focus on a range of criteria, including expected financial returns and strategic benefits, to evaluate a target's suitability and fit within our portfolio. We seek to operate health systems that are, or have the potential to become, market leaders in non-urban communities with favorable demographic trends. We often acquire underperforming and/or undermanaged facilities where we can drive operating efficiencies in order to realize significant upside potential following an acquisition to generate attractive effective purchase multiples and strong returns on our investment. The recent market trend toward health system consolidation, particularly among underperforming not-for-profit hospital operators without the scale and/or operating discipline to compete, has benefited us and we believe will continue to support our acquisition strategy. Furthermore, we routinely evaluate our existing portfolio to assess whether we are meeting our strategic and financial objectives in our markets. We evaluate and may seek to opportunistically divest assets that do not meet our strategic and/or financial objectives and which may deliver more value to our stakeholders through a sale.

- *Commitment to the Delivery of Exceptional Quality Patient Care*. We believe providing high quality patient care is critical to attracting patients, physicians and employees to our facilities. In addition, providing high quality patient care is increasingly vital to achieving our operating and financial success, including receiving full payment from governmental and commercial payers. We believe several factors contribute to providing high quality patient care, including instilling leadership and accountability at all levels of our organization, aligning ourselves with quality physicians and medical staff, and providing a clinical environment that is satisfactory to our patients, physicians and employees. Furthermore, we strive continually to improve physician and employee satisfaction, which we believe is critical to delivering quality patient care. In addition, we also seek to partner with academic medical centers and regionally significant health systems to better serve our communities and to ensure we are delivering high quality care.

- *Continue to Engage in Strategic Relationships with Local Partners*. We partner with several academic medical centers and regionally significant health systems to better serve our communities. We have established partnerships with Duke University Health System ("***Duke***"), Norton Healthcare, Inc. ("***Norton***"), LHC Group, Inc. ("***LHC***"), University of Washington Health, the University of Alabama at Birmingham, and Billings Clinic. We formed Duke LifePoint Healthcare, a joint venture between us and a wholly-controlled affiliate of Duke, with a mission to own and operate community hospitals and other facilities as well as improve the delivery of healthcare services. We own a controlling interest in Duke LifePoint Healthcare. We believe this partnership, which combines our operational resources and experience with Duke's expertise in the development of clinical services and quality systems, further strengthens our ability to acquire well-positioned facilities. Since its formation in 2011 through December 31, 2018, we have completed the acquisition of 14 acute care hospitals and ancillary facilities through Duke LifePoint Healthcare.

- *Continue to Focus on Cost Reduction and Operational Efficiency*. We strive to improve our operating performance by making our revenue cycle processes more efficient, making an even higher level of purchases through our group purchasing organization, operating more efficiently and effectively, and working to appropriately standardize our policies, procedures and practices across all of our affiliated facilities. As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have partnered with a third party to provide certain nonclinical business functions, including payroll processing, supply chain management and revenue cycle functions. We believe this model is the most cost effective and efficient approach to managing these nonclinical business functions across multi-facility enterprises. Additionally, in connection with our efforts to responsibly manage purchasing costs, we participate along with other healthcare companies in a group purchasing organization, HealthTrust Purchasing Group ("***HPG***"), which makes certain national supply and equipment contracts available to our facilities. As of December 31, 2018, we owned an approximate 7.2% equity interest in HPG. We also implement this operating discipline when we enter a new market through acquisitions, where we focus on optimizing staffing levels to reduce labor costs, leveraging our national scale and group purchasing organizations to reduce supply costs and standardizing revenue cycle and information technology ("***IT***") systems. We have made substantial progress implementing these initiatives consistently across our network and we believe that opportunity exists for continued improvement in the near term, particularly among our recently acquired facilities.

- *Experienced Executive Management and Leadership Teams.* Our senior management team has an average of more than 20 years of healthcare industry experience with a proven record of achieving strong operating results. The senior management team is highly respected in the hospital management industry and has significant experience in managing and acquiring hospitals. Our executive management team is led by David Dill, who serves as our Chief Executive Officer. Mr. Dill has more than 20 years of operational and financial leadership experience in the healthcare industry, most recently as President and Chief Operating Officer of Legacy LifePoint.

Our Background

LifePoint/RCCH Merger

Summary

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

Equity Contribution

In connection with the LifePoint/RCCH Merger, the Apollo Funds, together with certain other co-investors investing through a co-investment vehicle controlled by our Sponsor or its affiliates, indirectly contributed $1,000.0 million of newly invested capital to DSB Parent L.P., a Delaware limited partnership ("***DSB Parent***"), which is our indirect parent and is owned by the Apollo Funds, such co-investment vehicle and certain current or former directors, members of management, employees and consultants of the Company, and the $1,000.0 million of newly invested capital was further contributed to the Company to be used to partially fund the LifePoint/RCCH Merger.

Financing Transactions

Concurrently with the closing of the LifePoint/RCCH Merger, we (1) issued the 9.75% Unsecured Notes, (2) entered into the ABL Agreement, which provides a senior secured asset-based revolving credit facility (the "***ABL Facility***") in an aggregate principal amount of $800.0 million with a maturity of five years, (3) terminated our existing senior secured asset-based revolving credit facility, which we entered into on April 29, 2016 (the "***Prior ABL Facility***"), (3) entered into the Term Loan Agreement, which provides a senior secured term loan credit facility (the "***Term Loan Facility***") in an aggregate principal amount of $3,550.0 million with a maturity of seven years, and (4) repaid in full our $150.0 million term loan facility, which we entered into on April 25, 2018 (the "***Prior Term Facility***").

RegionalCare/Capella Merger and Apollo/RegionalCare Acquisition

On March 21, 2016, RegionalCare and Capella entered into an agreement and plan of merger, pursuant to which, effective on April 29, 2016 (and effective May 1, 2016 for accounting purposes), Crimson Merger Sub, merged with and into Capella, with Capella continuing as the surviving company in the merger as a wholly-owned subsidiary of RegionalCare. After the RegionalCare/Capella Merger was consummated we began to do business as RCCH HealthCare Partners. Concurrently with the closing of the RegionalCare/Capella Merger, we (i) issued the 8.25% Secured Notes and the 11.5% Unsecured Notes, (ii) entered into the Prior ABL Facility and (iii) refinanced certain indebtedness of DSB Holdings, RegionalCare and Capella.

On November 11, 2015, RegionalCare entered into an agreement and plan of merger with Holdings and the other parties thereto, in which RegionalCare became a direct wholly-owned subsidiary of Holdings on December 3, 2015. Holdings is an indirect wholly-owned subsidiary of DSB Parent, which is controlled by our Sponsor.

In connection with the Apollo/RegionalCare Acquisition and the RegionalCare/Capella Merger, certain Apollo Funds directly or indirectly managed by the Sponsor contributed in the aggregate approximately $380.0 million of invested capital to DSB Parent.

Our Operations

Services

We operate health systems that provide a range of medical, surgical and behavioral health services across inpatient and outpatient settings, including general surgery, internal medicine, cardiology, radiology, oncology, orthopedics, women's services, neurology, rehabilitation services, pediatric services, emergency services and, primarily through our joint venture with LHC, home health and hospice services. In some of our health systems, we offer specialized services such as open heart surgery, skilled nursing, psychiatric care and neurosurgery. In many markets, we also provide outpatient services such as same day surgery, clinical laboratory services, diagnostic imaging services, respiratory therapy services, sports medicine services, urgent care services and lithotripsy. The services provided in any specific health system depend on many factors, including the community need for the service, whether physicians necessary to safely operate the service line are members of the medical staff of that hospital and the existence of any contractual or certificate of need restrictions.

Management and Oversight

Our executive management team has extensive experience in operating multi-facility hospital networks and plays a vital role in the strategic planning for our facilities. A hospital's local management team is typically composed of a CEO, chief operating officer, chief financial officer and a chief nursing officer. Local management teams and the hospital's Board of Trustees and our corporate management teams, develop annual operating plans setting forth growth strategies through the expansion of current services, implementation of new services and the recruitment and retention of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the needs of our patients, medical staffs and the community as a whole is critical to the success of our facilities. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including quality of care, patient satisfaction and financial measures.

The Board of Trustees at each facility, consisting of local community leaders, members of the medical staff and the facility CEO, advises the local management teams and helps develop the strategic operating plan for their facility. In addition, it plays a key role in providing the patient care excellence that we demand. Members of each Board of Trustees are identified and recommended by our local management teams. The Boards of Trustees oversee policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

The majority of our facilities have a physician engagement group ("***PEG***") or a physician leadership group ("***PLG***") comprised of key physicians and members of the facility's administrative team. The mission of the PEG or PLG is to provide ongoing dialogue between hospital facility administration and members of the medical staff and community physicians primarily in the areas of operations, quality patient care, employee satisfaction and community relations.

We also provide support to the local management teams through our corporate resources in areas such as revenue cycle, business office, legal, managed care, clinical efficiency, physician services and other administrative functions. These resources allow for sharing best practices and standardization of policies and processes among all of our facilities.

Cost Management

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

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

Attracting Patients

We believe that the most important factors affecting a patient's choice in facilities are the reputation of the facility, the availability and expertise of physicians and nurses and the location and convenience of the facility. Other factors that affect utilization include local demographics and population growth, local economic conditions and the facility's success in contracting with a wide range of local payers.

Outpatient Services

The healthcare industry has experienced an accelerated shift during recent years from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology also have supported the shift to outpatient utilization. However, we expect the decline in inpatient admission use rates to moderate over the long term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through expanding service offerings and increasing the throughput and convenience of our emergency departments, outpatient surgery facilities and other ancillary units in our facilities.

Sources of Revenues

General

Our facilities generate revenues by providing healthcare services to our patients. Depending upon the patient's medical insurance coverage, we are paid for these services by governmental Medicare and Medicaid programs, commercial insurance, including health maintenance organizations ("***HMOs***"), preferred provider organizations ("***PPOs***") and other private insurers, and directly by the patient. The amounts we are paid for providing healthcare services to our patients vary depending upon the payer. Governmental payers generally pay significantly less than the hospital's customary charges for the services provided. Insured patients are generally not responsible for any difference between customary hospital charges and the amounts received from commercial insurance payers. However, insured patients are responsible for payments not covered by insurance, such as exclusions, deductibles and co-payments.

The following table summarizes our revenues by payer as approximate percentages of our net patient revenues before the provision for doubtful accounts for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
Medicare	37.6 %	40.4 %	36.4 %
Medicaid	13.1	12.2	12.8
HMOs, PPOs and other private insurers	41.3	40.7	42.5
Self-pay	8.0	6.7	8.3
	100.0 %	100.0 %	100.0 %

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

Medicare

Our revenues from Medicare were approximately 37.6% of our net patient revenues before the provision for doubtful accounts for the year ended December 31, 2018. Medicare provides hospital and medical insurance benefits, regardless of income, to persons age 65 and over, some disabled persons and persons with end-stage renal or Lou Gehrig's disease. All of our hospitals are currently certified as providers of Medicare services.

Over the years, Congress and the Centers for Medicare and Medicaid Services ("***CMS***") have made several sweeping changes to the Medicare program and its reimbursement methodologies, such as the implementation of the prescription drug benefit that was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "***MMA***") and the numerous changes contained in the Affordable Care Act. Many of these changes have resulted in decreased reimbursement to healthcare providers. For example, the Budget Control Act of 2011 ("***BCA***") imposed a 2% reduction in Medicare spending which began on April 1, 2013. The Bipartisan Budget Act of 2015 ("***BBA***") and the Bipartisan Budget Act of 2018 (the "***2018 Act***") extended the 2% reduction in Medicare spending through 2027. Additional reductions in Medicare reimbursement could result from changes to, or the repeal of, the Affordable Care Act, or as a result of the enactment of Medicare reform, deficit reduction, or other legislation.

Medicare Inpatient Prospective Payment System

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

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor each federal fiscal year ("***FFY***"), which begin on October 1 (for example, FFY 2019 began on October 1, 2018). The index used to adjust the base MS-DRG payment rate, which is known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. For FFYs 2019, 2018 and 2017, the hospital market basket index increased 2.9%, 2.7% and 2.7%, respectively. Generally, however, the percentage increase in the MS-DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the hospital market basket increases for FFYs 2019, 2018 and 2017 were reduced by CMS by 0.75%, 0.75% and 0.75%, respectively. As also mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the Bureau of Labor Statistics' 10-year moving average of changes in annual economy-wide productivity. For FFYs 2019, 2018 and 2017, the productivity adjustment equated to a 0.8%, 0.6% and 0.3% reduction in the market basket increase, respectively. As a result of these reductions and other changes implemented by CMS, the MS-DRG-rate increased by 1.85% for FFY 2019.

On October 1, 2007, CMS replaced the previously existing 538 diagnosis related groups with 745 MS-DRGs. The MS-DRGs are intended to more accurately reflect the cost of providing inpatient services and eliminate any incentives that hospitals may have to only treat the healthiest and most profitable patients. The American Taxpayer Relief Act of 2012 ("***ATRA***") required CMS to recoup $11 billion from IPPS payments in FFYs 2014 through 2017 to offset an additional increase in aggregate payments to hospitals that Congress believes occurred from FFY 2008 through 2013 solely as the result of the transition to the MS-DRG system. In FFYs 2014, 2015 and 2016, CMS applied negative 0.8% adjustments as part of the recovery process required by ATRA, and it applied a negative 1.5% adjustment in FFY 2017 to recover the remaining outstanding amount. CMS had previously indicated that the reductions required by ATRA would be fully restored in FFY 2018. However, under the Medicare Access and CHIP Reauthorization Act of 2015 ("***MACRA***"), those reductions will be restored in 0.5% increments over a six year period from FFYs 2018 through 2023, which will result in a cumulative 3.0% increase in rates, which is less than the 3.9% reduction that was imposed by CMS in FFYs 2014 through 2017. In addition, the 21st Century Cures Act (the "***Cures Act***") further reduced the restoration for FFY 2018 from 0.5% to 0.4588%.

CMS has implemented a number of programs and requirements that are intended to promote value based purchasing and to link payments to quality and efficiency. For example, the MMA required all acute care hospitals to participate in CMS' Hospital Inpatient Quality Reporting Program (the "***IQR Program***") in order to receive the full hospital market basket update. Hospitals that do not participate in the IQR Program receive a one-fourth reduction in their IPPS annual payment update for the applicable FFY. Our hospitals reported all quality measures required by CMS related to the IQR Program and will receive the full market basket update through FFY 2019. In addition, hospitals that are not meaningful EHR users are also subject to an additional 75% reduction of the hospital market basket increase.

In addition, the Affordable Care Act requires United States Department of Health and Human Services ("***HHS***") to implement a value-based purchasing program for inpatient hospital services. This program rewards hospitals based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period. As part of the program, the Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by 2.0% each FFY. HHS pools the amount collected from these reductions to fund payments to reward hospitals that meet and exceed certain quality performance standards established by HHS. Under the program, each hospital's performance is evaluated during a specified performance period, and hospitals receive points on each of a number of pre-determined measures based on the higher of (i) their level of achievement relative to an established standard or (ii) their improvement in performance from their performance during a prior baseline period. Each hospital's combined scores on all the measures are translated into value-based incentive payments. Hospitals that receive higher total performance scores receive higher incentive payments than those that receive lower total performance scores. Because the Affordable Care Act provides that the funds pooled and otherwise set aside for the value-based purchasing program will be fully distributed, hospitals with high scores may receive greater reimbursement under the value-based purchasing program than they would have otherwise, and hospitals with low scores may receive reduced Medicare inpatient hospital payments.

Medicare also does not allow an inpatient hospital discharge to be assigned to a higher paying MS-DRG if certain designated hospital acquired conditions ("***HACs***") were not present on admission and the identified HAC is the only condition resulting in the assignment of the higher paying MS-DRG. In those situations, the case is paid as though the secondary diagnosis was not present. In addition, hospitals that fall into the top 25.0% of national risk-adjusted HAC rates for all hospitals in the previous year receive a 1.0% reduction in their total Medicare payments.

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

Medicare Hospital Outpatient Prospective Payment System and Other Outpatient Services

CMS reimburses hospital outpatient services under the Medicare hospital outpatient prospective payment system ("***OPPS***"), and uses fee schedules to pay for durable medical equipment and physical, occupational and speech therapy, clinical diagnostic laboratory and independent diagnostic testing facility services. Under the OPPS, hospital outpatient services are classified into groups called ambulatory payment classifications ("***APCs***"). Services in each APC are clinically similar and are similar in terms of the resources they require. Depending on the services provided, a hospital may be paid for more than one APC for an encounter. CMS establishes a payment rate for each APC by multiplying the scaled relative weight for the APC by a conversion factor. The payment rate is further adjusted to reflect geographic wage differences. The APC conversion factors for calendar years ("***CYs***") 2019, 2018 and 2017 were $79.490, $78.636 and $75.001, respectively, after the inclusion of the productivity adjustments and other reductions (1.55% for CY 2019, 1.35% for CY 2018 and 1.05% for CY 2017), that were required by the Affordable Care Act. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Reporting Program (the "***OQR Program***"). Hospitals that do not satisfy the reporting requirements of the OQR Program are subject to a reduction of 2.0% in their annual payment update under the OPPS. Our hospitals reported all quality measures required by CMS for the OQR Program and will receive the full market basket update through CY 2019.

Effective as of January 1, 2017, Section 603 of the BBA limits reimbursement for items and services that are furnished by certain off-campus outpatient provider-based departments ("***off-campus PBDs***") of hospitals. CMS included several provisions implementing Section 603 in the OPPS final rule for CY 2017. Under the final rule, CMS will continue to make OPPS payments to off-campus PBDs that were billing Medicare as hospital departments under the OPPS prior to November 2, 2015 ("***grandfathered PBDs***"). However, grandfathered PBDs will generally not be able to relocate, and CMS has indicated that it may adopt limitations on the expansion of the service lines provided at grandfathered PBDs in the future. In addition to grandfathered PBDs, CMS will also continue to reimburse all items and services that are furnished in a "dedicated emergency department" of a hospital, as such term is defined for the purposes of the Emergency Medical Treatment and Active Labor Act ("***EMTALA***"), regardless of whether the items and services are emergency items and services, and all items and services that are furnished in off-campus PBDs that are located within 250 yards of a remote location of a hospital, which is a facility that is either created or acquired by a hospital for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the hospital, under the OPPS. For CY 2019, all items and services not provided at a grandfathered or otherwise excepted off-campus PBD will generally be paid by CMS under Medicare physician fee schedule ("***PFS***") rates that are approximately 40% of the applicable OPPS rate (the "***PFS Adjusted Rate***"). In addition, in 2018, CMS issued a final rule that will generally reimburse clinic visit services provided at all off-campus PBDs, including grandfathered PBDs, at a reduced Medicare PFS-equivalent payment rate. The payment reduction for clinic visit services provided at off-campus PBDs will be phased in over a two year period beginning in FFY 2019.

As part of the OPPS final rule for CY 2018, CMS finalized a change to the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B Drug Pricing Program (the "***340B Program***"). The 340B Program allows certain non-profit and governmental hospitals and other healthcare providers to obtain substantial discounts on covered outpatient drugs (prescription drugs and biologics other than vaccines) from drug manufacturers. Under the final rule, CMS pays for separately reimbursable, non-pass through drugs and biologicals (other than vaccines) purchased through the 340B Program at the average sales price ("***ASP***") minus 22.5% rather than ASP plus 6%. CMS estimated that this change reduced Medicare payments for drugs and biologicals by $1.6 billion in CY 2018. To maintain budget neutrality, CMS implemented an offsetting increase in the conversion factor, and, as a result, reimbursement rates for non-drug items and services provided by all hospitals, including those not eligible to participate in the 340B program, that are reimbursed under the OPPS. In connection with the OPPS final rule for CY 2019, CMS expanded the 340B Drug Pricing Program payment reductions to drugs that are obtained through the 340B Drug Pricing Program and furnished by non-excepted, off-campus PBDs.

In September 2018, a lawsuit was filed challenging the authority of CMS to make the 340B Program payment reductions set forth in the OPPS final rule for CY 2018. On December 27, 2018, the U.S. District Court for the District of Columbia held that the payment reductions exceeded CMS's statutory authority and entered a permanent injunction against the reductions. However, because the 340B Program payment reductions were made in a budget-neutral manner and the savings derived from the reductions were used to increase reimbursement for all of the other items and services provided under the OPPS, the Court ordered the parties to submit briefs as to how the issue should be remedied. CMS has appealed the Court's ruling. We cannot predict the outcome of CMS's appeal or the remedies, if any, that may be imposed in connection with the 340B Program payment reduction litigation or whether CMS will appeal the Court's ruling. If OPPS payments to hospitals are reduced (either retroactively or prospectively) as a result of the 340B Program payment reduction litigation, we would be materially adversely affected.

Medicare Disproportionate Share Hospital Payments

Hospitals may also qualify for Medicare disproportionate share hospital ("***DSH***") payments, if they treat a high percentage of low-income patients (Medicaid and Medicare patients eligible to receive Supplement Security Income). DSH payments are determined annually based on certain statistical information specified by HHS and are paid as an addition to MS-DRG payments. The Affordable Care Act requires Medicare DSH payments to providers to be reduced by 75% beginning in FFY 2014, subject to adjustment if the Affordable Care Act does not decrease uncompensated care to the extent anticipated. The amount that is withheld is reduced by the percentage change in uninsured individuals under the age of 65, and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. The IPPS final rule for FFY 2019 established the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2019 at approximately $8.3 billion, up from $6.8 billion in FFY 2018.

Medicare Dependent and Low Volume Hospital Programs

On April 16, 2015, MACRA was enacted. Among other things, MACRA extended the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by Medicare, and the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located a certain distance from another general acute care hospital and have less than a certain number of Medicare discharges each fiscal year, through September 30, 2017. The 2018 Act extended both of these programs through FFY 2022.

Cost Reports

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

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

Medicare Bad Debt Reimbursement

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

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

Physician Services

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

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

Medicaid

Our revenues under the various state Medicaid programs were approximately 13.1% of our net patient revenues before the provision for doubtful accounts for the year ended December 31, 2018. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. Medicaid programs are funded by both the federal government and states to provide healthcare benefits to limited categories of low-income individuals under 65 years of age. These programs and the reimbursement methodologies are administered by the states under approved plans and vary from state to state and from year to year. Amounts received under the Medicaid programs are often significantly less than the hospital's customary charges for the services provided. Most state Medicaid payments are made under a prospective payment system, fee schedule, cost reimbursement program, or some combination of these three methods. All of our hospitals are currently certified to participate in their respective state Medicaid programs.

The Affordable Care Act essentially requires states to expand medical coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level ("***FPL***"). However that portion of the Affordable Care Act was held to be unconstitutional by the U.S. Supreme Court, and, as a result, states may opt out of the expansion without losing their existing Medicaid funding. Therefore, the income level required for individuals to qualify for Medicaid varies widely from state to state. To offset the cost of the Medicaid program's expansion, the Affordable Care Act authorized the federal government to provide states with "matching funds" (referred to as "***Enhanced FMAP***") to cover the costs of covering the newly eligible individuals. The Enhanced FMAP was 100% for CYs 2014 through 2016; 95% in 2017; 94% in 2018; is 93% in 2019; and will be 90% in 2020 and thereafter.

In recent years, we have benefited from the expansion of Medicaid under the Affordable Care Act, and effective as of January 1, 2019, Virginia, an additional state in which we operate, expanded its Medicaid program. However, a number of states in which we operate have not expanded their Medicaid programs, and several states have adopted or are considering legislation designed to reduce or control their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs, and imposing additional taxes on hospitals to help finance such states' Medicaid systems. Given the reductions in the Enhanced FMAP and in light of the possible repeal, replacement or modification of the Affordable Care Act, we are unable to predict how many, if any, additional states in which we operate will expand their Medicaid programs or how many, if any, of the states in which we operate that have expanded their Medicaid programs will keep their expansions in place in the future.

The Affordable Care Act also included a number of provisions that are intended to improve the quality of care that is provided to Medicaid beneficiaries. Among other things, the Affordable Care Act prohibits federal funds from being used to reimburse providers for services related to provider preventable conditions, such as HACs, wrong site surgeries and other provider preventable conditions that may be designated by each state Medicaid program.

Work Requirements

In addition to implementing value-based purchasing and quality-driven reimbursement requirements, CMS also recently issued new guidance permitting states to impose work and/or community engagement on certain Medicaid beneficiaries. In response to the guidance, a number of states, including several in which the Company has facilities, have requested demonstration waivers from CMS that would allow those states to impose work requirements on their Medicaid beneficiaries. CMS has approved the requests that have been made by Arizona, Arkansas, Indiana, Kentucky, Michigan, New Hampshire and Wisconsin, and the remaining requests are still pending. The approved waivers and work requirements have already been implemented in Arkansas and Indiana, and the other waivers that have been approved are scheduled to take effect in the upcoming months. However, lawsuits have been filed in the U.S. District Court for the District of Columbia challenging the authority of CMS to allow the Arkansas and Kentucky Medicaid programs to impose work requirements on their respective beneficiaries. We cannot predict whether CMS will grant additional waivers that allow for the imposition of work and community engagement requirements on Medicaid beneficiaries or the impact that any such waivers will have on coverage for patients seeking care at our facilities. We also cannot predict whether the legal challenges that have been initiated against the Arkansas and Kentucky demonstration waivers will be successful or whether any legal challenges will be initiated against any other similar demonstration waivers that have been or may be granted by CMS in the future.

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

Medicaid Disproportionate Share Hospital Payments

In addition to Medicare DSH funding, hospitals that provide care to a disproportionately high number of low-income patients may receive Medicaid DSH payments. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. Although federal Medicaid law defines some level of hospitals that must receive Medicaid DSH funding, states have broad discretion to define additional hospitals that also may qualify for Medicaid DSH payments and the amount of such payments.

Pursuant to the Affordable Care Act, as amended by subsequent legislation, funding for Medicaid DSH programs is to be reduced by $4 billion in FFY2020 and $8 billion per year from FFY 2021 through 2025. Because many of the states in which we operate have not expanded Medicaid programs as intended under the Affordable Care Act, the reduction in Medicaid DSH payments may take place without a coupled increase in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

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

Recovery Audit and Other Review Contractors

Recovery audit contractors ("***RACs***") are used by CMS and state agencies to detect Medicare and Medicaid overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare and Medicaid claims filed by healthcare providers. RACs perform post-discharge audits of medical records to identify overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services and are paid on a contingency basis. Any claims identified as overpayments are subject to a RAC program appeals process. In 2016, in connection with the procurement of the new recovery audit contracts, CMS made a number of enhancements to the RAC program, including the establishment of a RAC program Provider Relations Coordinator, requiring RACs to maintain an overturn rate of less than 10% at the first level of appeal, requiring RACs to maintain an accuracy rate of at least 95%, and establishing additional documentation request limits based on a provider's compliance with Medicare rules, that are intended to address provider and other stakeholder concerns. CMS has also limited the number of claims that RACs may audit by limiting the number of records that RACs may request from hospitals based on each hospital's claim denial rate for the previous year.

In addition to RACs, CMS employs Unified Program Integrity Contractors ("***UPICs***"), which integrate the functions of the former Zone Program Integrity Contractors, Program Safeguard Contractors, and Medicaid Integrity Contractors, to perform post-payment audits of Medicare and Medicaid claims and identify overpayments. A number of state Medicaid agencies and other contractors have also increased their review activities.

Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our hospitals have had Medicare claims audited by the RAC program. While our hospitals have successfully appealed many of the adverse determinations raised by Medicare RAC audits, we cannot predict if this trend will continue or the results of any future audits. We cannot predict the volume or outcome of any future audits conducted by the various RAC and other review programs to which our hospitals will be subject.

Utilization and Claim Review

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

In addition to utilization reviews, CMS has also adopted a nationwide claim review and provider education program known as the Targeted Probe and Educate ("***TPE***") program, which is intended to reduce errors in the claims submission process and focuses on items and services that pose the greatest risk to the Medicare program or that have a high national error rate, such as short inpatient stays. Under the TPE program, Medicare administrative contractors ("***MACs***", and each individually, a "***MAC***") use data analysis to identify providers who, for a particular item or service, have high claim denial rates or billing practices that vary significantly from their peers. Once a provider has been identified, the MAC reviews between 20 and 40 of the provider's claims for the item or service and, if issues are noted, offers the provider an individualized education session that is based on the results of the review. The provider is then generally given 45 days to improve its systems and processes, and, after that period has ended, the MAC conducts another review of the provider's claims. If additional issues are identified, the provider is given the opportunity for another education session. Providers are typically given three rounds of review and education before being referred to CMS for further action, such as pre-payment or RAC review.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payers including HMOs, PPOs and other private insurers. Also included in this category are the patient responsibility portions for co-payment and deductible obligations under these programs. Our revenues from HMOs, PPOs and other private insurers were approximately 41.3% of our net patient revenues before the provision for doubtful accounts for the year ended December 31, 2018. Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services or accept fixed, pre-determined fees for our services. These discounted arrangements often limit our ability to increase charges or revenues in response to increasing costs. We actively negotiate with these payers in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payer with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. Additionally, plans purchased through the Affordable Care Act health insurance marketplace exchanges (the "***Exchanges***") are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when we are not a participating provider in the network, it can result in higher patient responsibility amounts that a patient may not have the ability to pay or may choose not to pay. We expect these trends to continue in the coming years.

Self-Pay Patients

Self-pay revenues are derived from patients who do not have any form of healthcare coverage. Our revenues from self-pay patients were approximately 8.0% of our net patient revenues before the provision for doubtful accounts for the year ended December 31, 2018. The revenues associated with self-pay patients are generally reported at our gross charges. We evaluate these patients, after the patient's medical condition is determined to be stable, for qualifications of Medicaid or other governmental assistance programs, as well as our local hospital's policy for charity care. We do not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is our policy not to pursue collection of amounts related to these patients. Our ability to collect self-pay revenues is dependent on a combination of broad economic factors, including unemployment levels in our markets.

Health Care Reform

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, requiring most Americans to obtain health insurance (the "***individual mandate***"), providing additional funding for Medicaid in states that choose to expand their programs, reducing IPPS, OPPS and Medicare and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and instituting certain private health insurance reforms. The Affordable Care Act has, however, been subject to a number of legislative and regulatory changes and court challenges and its future is uncertain.

For example, on January 20, 2017, President Trump issued an executive order that, among other things, stated that it was the intent of his administration to repeal the Affordable Care Act and, pending that repeal, instructed the executive branch of the federal government to defer or delay the implementation of any provision or requirement of the Affordable Care Act that would impose a fiscal burden on any state or a cost, fee, tax or penalty on any individual, family, health care provider, or health insurer. On October 12, 2017, President Trump issued another executive order related to the Affordable Care Act that resulted in the issuance of regulations that are intended to encourage the formation of association health plans and increase the maximum duration of and access to short-term limited duration health insurance plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. In addition, a number of bills have been introduced in Congress that would repeal the Affordable Care Act and would replace it with varying health coverage plans, including plans that would allow insurers to sell health insurance across state lines, allow the use of health savings accounts ("***HSAs***") without a high-deductible plan, or give states the option to either keep the coverage framework created by the Affordable Care Act (e.g., expanded Medicaid, individual subsidies, and insurance exchanges) or utilize the increased federal funding that was intended for Medicaid expansion to be provided by the federal government under the Affordable Care Act to create HSAs that can be used by low-income individuals to purchase health insurance. Also, the Tax Act repealed the penalties associated with the individual mandate effective January 1, 2019. We cannot predict whether the Affordable Care Act will be repealed, replaced, or materially modified by Congress or the impact that the repeal of the penalties associated with the individual mandate will have on our facilities.

In addition to the administrative actions and legislative efforts to repeal, replace or modify the Affordable Care Act, there have been and will likely continue to be a number of legal challenges to various provisions of the Affordable Care Act. For example, in 2014, the U.S. House of Representatives (the "***House***") filed a lawsuit challenging the use of federal funds to pay insurance companies for cost sharing reductions that are provided to certain individuals who purchase insurance through the Exchanges. The House lawsuit was ultimately settled after HHS stopped making cost sharing reduction payments to insurance companies based on the determination that these payments had not been appropriated by Congress. A number of insurers have, however, filed litigation against HHS to recover the cost sharing reduction payments that have not been made. In addition, on December 14, 2018, the U.S. District Court for the Northern District of Texas held that, in light of the repeal of the penalties associated with the individual mandate, the entire Affordable Care Act was unconstitutional. The Court did not, however, issue an injunction against the continued enforcement of the Affordable Care Act, and seventeen states and the House have appealed the Court's ruling. We cannot predict the outcome of the litigation that has been filed by insurers relating to the cessation of HHS's cost sharing reduction payments, the impact that the cessation of HHS's cost sharing reduction payments will have on the premiums that are charged by insurers or the outcome of the appeal regarding the constitutionality of the Affordable Care Act.

Unless specifically stated otherwise, our summary of provisions of the Affordable Care Act throughout the remainder of this section and elsewhere in this Report are based on the law as currently in effect. Additionally, refer to the section below captioned "Impact of the Affordable Care Act on the Company" for further discussion about the uncertainty surrounding the Affordable Care Act.

Expanded Coverage

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

Public program expansion has been driven primarily by expanding the categories of individuals who are eligible for Medicaid coverage and allowing individuals with relatively higher incomes to qualify for Medicaid coverage.

The Affordable Care Act essentially made the expansion of the Medicaid program mandatory, but, in 2012, the U.S. Supreme Court held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that chose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. Based on the U.S. Supreme Court's ruling, a number of states, including several in which the Company has facilities, have opted not to expand their Medicaid programs. Public program expansion has also occurred through provisions of the Affordable Care Act that authorize the federal government to subsidize states that create non-Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL and allow Medicaid participating hospitals to make presumptive determinations of Medicaid eligibility for certain categories of individuals, such as pregnant women, infants, children, and parents and other caretaker relatives and their spouses. If an individual is found to be presumptively eligible for Medicaid benefits, the hospital will get paid for the services it provides during the temporary presumptive eligibility period, just as though the patient were already enrolled in the Medicaid program.

The expansion of health coverage through the private sector as a result of the Affordable Care Act has occurred through new requirements on health insurers, employers and individuals. For example, commencing January 1, 2014, health insurance companies were prohibited from imposing annual coverage limits, dropping coverage, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. In addition, since January 1, 2011, each health plan has been required to keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. Also, since September 23, 2010, health insurers have not been permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old. Larger employers are subject to new requirements and incentives to provide health insurance benefits to their full time employees, and, effective January 1, 2016, all employers subject to the requirement are required to offer health insurance coverage to 95% of their full-time employees and their dependents in order to avoid penalties.

To facilitate the purchase of health insurance by individuals and small employers, each state was required to establish an Exchange by January 1, 2014. For individuals and families below 400% of the FPL, the cost of obtaining health insurance through the Exchanges is subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. Health insurers participating in the Exchange must offer a set of minimum benefits to be defined by HHS and may offer more benefits. Any benefits to us from the expansion of private sector coverage depend in large part on our success in contracting with payers whose policies are listed on the Exchanges. We currently have contracts with Exchange payers in every state in which we operate, and the reimbursement rates paid under those contracts generally are comparable to that paid to us by other private payers.

Beginning in 2014 and continuing throughout 2018, primarily as a result of the expansion of health insurance coverage, we experienced an increase in revenues from providing care to certain previously uninsured individuals. Although we expect this trend to continue, the future impact and timing of such expansion remains difficult to predict for the reasons discussed above, will be gradual and may not offset scheduled decreases in reimbursement. Additionally, we cannot predict the impact of the cessation of cost sharing reduction payments, the repeal of the individual mandate or any other modifications to the Affordable Care Act that may be adopted.

Public Program Spending

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

Accountable Care Organizations

The Affordable Care Act requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("***ACOs***"). ACOs are groups of hospitals, physicians and other designated professionals and suppliers who come together voluntarily to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS are eligible to share in a portion of the amounts saved by the Medicare program. There are several types of ACO programs, and as of January 2018, approximately 560 ACOs had been established to participate in the Medicare Shared Savings Program, and additional ACOs are being established by private payers. A few of our facilities currently participate in ACOs.

Bundled Payment Pilot Programs

The Affordable Care Act created the Center for Medicare & Medicaid Innovation ("***CMMI***") and made it responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs while improving quality of care. Under these projects and initiatives, participating providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care and accept accountability for costs and the quality of care that is provided. By rewarding providers for quality, cost-effective care and penalizing providers when costs exceed a certain amount, these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. In connection with these programs, CMMI has developed a voluntary Bundled Payment for Care Improvement initiative to test innovative payment and service delivery models that have the potential to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care for beneficiaries. Participation in bundled payments programs is generally voluntary, but CMS does currently require hospitals in certain geographic areas to participate in the Comprehensive Care for Joint Replacement model which covers certain extremity joint replacement procedures. CMS has indicated that it expects to increase opportunities for providers to participate in voluntary bundled payment models initiatives and that it may create additional mandatory bundled payment models in the future. Several of our facilities currently participate in bundled payment programs.

Specialty Hospital Limitations

Over the last decade, we have faced competition from hospitals that have physician ownership. The Affordable Care Act prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand. As of December 31, 2018, we operate four hospitals through joint ventures with physicians in which we own a controlling interest.

Impact of the Affordable Care Act on the Company

The expansion of health insurance coverage under the Affordable Care Act has resulted in an increase in the number of patients using our facilities who have either private or public program coverage. It is difficult to predict with great precision the timing or size of positive or negative impacts on revenue as a result of the Affordable Care Act, because of uncertainty surrounding a number of material factors, including the following:

- the elimination of the penalties associated with the individual mandate;
- the cessation of cost sharing reduction payments to insurers;
- the possibility that the Affordable Care Act will be repealed and/or replaced or further modified by Congress;
- even if the Affordable Care Act is not repealed, replaced or further modified, the level of disruption that may be caused by continuing legal challenges and other efforts to delay, block or eliminate specific provisions of the Affordable Care Act, including the outcome of litigation relating to the continued constitutionality of the Affordable Care Act;
- how many previously uninsured individuals will ultimately obtain coverage as a result of the Affordable Care Act;
- what percentage of the future newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states impose work and community engagement and/or premium requirements on their Medicaid beneficiaries;
- the number of states that ultimately elect to expand their Medicaid programs and when that expansion occurs;
- whether any states that have expanded their Medicaid programs will scale back such expansion through the imposition of work or premium requirements or otherwise as the Enhanced FMAP is reduced;
- the extent to which states will enroll any new Medicaid participants in managed care programs;
- the rates charged by private payers for insurance purchased on the Exchanges;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the future rates paid to hospitals by private payers for newly covered individuals under different plans, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- increasing self-pay as a result of individuals in the Exchanges who select high deductible plans, and risks presented by their ability to pay such deductibles;
- whether or not private insurers will participate in the Exchanges, and whether such participation is through the use of narrow networks that restrict the number of participating providers or tiered networks that impose significantly higher cost sharing obligations on patients that obtain services from providers in a disfavored tier; and

- whether the net effect of the Affordable Care Act, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business.

Additionally, since approximately 50.7% of our net patient revenues before the provision for doubtful accounts in 2018 were from Medicare and Medicaid, collectively, the reductions in Medicare and Medicaid reimbursement and in the growth of spending by the Medicare and Medicaid programs that are contemplated by the Affordable Care Act will significantly impact us and could offset any positive effects of the Affordable Care Act. It is difficult to predict with great precision the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from Medicare and Medicaid business when the reductions are fully implemented;
- whether reductions required by the Affordable Care Act will be changed by statute;
- whether efforts to reform Medicaid funding into block grants or per capita caps will be successful, and, if implemented, the impact such changes may have on the Medicaid programs of states in which we operate;
- the size of the Affordable Care Act's annual productivity adjustment to the market basket in future years;
- the amount of the Medicare DSH reductions that are made;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in FFY 2020;
- what the losses in revenues will be, if any, from the Affordable Care Act's quality initiatives;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and
- reductions to Medicare payments CMS may impose for "excessive readmissions."

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

Competition for Patients

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

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

In addition, tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, exemptions from sales, property and income taxes, and participation in the 340B Program. In certain states, some not-for-profit hospitals are permitted by law to directly employ physicians while for-profit hospitals are prohibited from doing so.

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

Competition for Professionals

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

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

Many physicians today prefer to be employed, rather than operating their own practices or joining existing medical groups. Our hospitals and affiliated entities had more employed physicians at the end of 2018 than at the end of 2017. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians and incur additional expenses as a result. We expect this trend to continue.

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

Employees

At December 31, 2018, we had approximately 56,000 employees, including approximately 12,500 part-time employees. The majority are hospital-based employees, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our facilities. Approximately 2,500 of our employees across ten different facilities are unionized. While some of our non-unionized facilities experience union organizing activity from time to time, currently we do not expect these efforts to affect our future operations materially. Our facilities, like most facilities, have experienced rising labor costs. Our labor costs also may increase at higher rates among unionized employees. Unionized employees also may have rights under their collective bargaining agreements that restrict the ability of a facility to take certain actions with respect to these employees.

Government Regulation

Overview

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

Acute care hospitals are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing, certification and accreditation. All of our hospitals are currently licensed under appropriate state laws and are qualified to participate in the Medicare and Medicaid programs. In addition, as of December 31, 2018, with the exception of Bluegrass Community Hospital and Saline Memorial Hospital, all of our hospitals were accredited by the Joint Commission.

Fraud and Abuse Laws

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

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

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

Anti-kickback Statute

The Anti-kickback Statute prohibits the payment, receipt, offer or solicitation of anything of value, whether in cash or in kind, with the intent of generating referrals or orders for services or items covered by a federal or state healthcare program. Violations of the Anti-kickback Statute are punishable by, among other things, criminal fines of up to $100,000 for each violation, substantial civil monetary penalties for each violation that are subject to annual adjustments for inflation, damages equal to three times the total remuneration and/or possible exclusion from participating in Medicare, Medicaid or other governmental healthcare programs.

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

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

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

Stark Law

The Stark law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship if those entities provide certain "designated health services" unless an exception applies. The Stark law also prohibits entities that provide designated health services reimbursable by Medicare and Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires entities to refund amounts received for items and services provided pursuant to a prohibited referral on a timely basis. "Designated health services" include, among other things, inpatient and outpatient hospital services, laboratory services and radiology services. A violation of the Stark law may result in (i) a denial of payment, (ii) substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation or circumvention scheme and (iii) exclusion from participation in the Medicare and Medicaid programs and other governmental healthcare programs. In addition, violations of the Stark law could also result in penalties under the False Claims Act.

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

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

False Claims Act

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

Changes in the Regulatory Environment

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

In addition to the changes mentioned above, the Affordable Care Act created False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. On February 11, 2016, CMS published a final rule that provides clarification around the meaning of overpayment identification and generally establishes a six year lookback period for Medicare Part A and Part B providers and suppliers. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments, accurately prepare cost reports and timely resolve credit balances. In light of the provisions of FERA and the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law, including technical violations of certain fraud and abuse laws, and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

State Laws

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

Emergency Medical Treatment and Active Labor Act

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

Administrative Simplification Provisions and Privacy and Security Requirements

We are subject to the administrative simplification provisions of HIPAA which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. Additionally, we are subject to the privacy, security and breach notification regulations promulgated under HIPAA and the Health Information Technology for Economic and Clinical Health Act (the "***HITECH Act***"), which are designed to protect the confidentiality, availability and integrity of protected health information ("***PHI***") and establish an array of patient rights with respect to such information. The HIPAA privacy, security and breach notification regulations apply to covered entities, which include health plans, health care clearinghouses, and health care providers that conduct certain standard transactions (such as billing insurance) electronically. In addition, certain provisions of the privacy, security and breach notification regulations apply to business associates, which are entities that perform certain functions or activities on behalf of covered entities that require access to or the use or disclosure of protected health information. In certain circumstances, a covered entity may be held liable for the actions of its business associate if HHS determines an agency relationship exists between the covered entity and the business associate under federal agency law.

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

Violations of the HIPAA regulations may result in criminal penalties and substantial civil monetary penalties subject to a limit for violations of the same requirement in a calendar year. The civil monetary penalties are also subject to annual inflation adjustments. In addition, state attorneys general are authorized to bring civil actions seeking either injunction or damages up to $25,000 for violations of the same requirement in a calendar year in response to HIPAA violations that affect their state residents. HHS has the discretion in many cases to resolve HIPAA violations through informal means without the imposition of penalties. However, the HIPAA privacy, security and breach notification regulations have and will continue to impose significant costs on our facilities in order to comply with these standards. We expect increased enforcement of the HIPAA regulations.

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

Corporate Practice of Medicine and Fee-Splitting

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

Certificates of Need

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

Not-for-Profit Hospital Conversion Legislation

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

State Hospital Rate-Setting Activity

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

Environmental Regulation

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

Compliance Program

We maintain a company-wide ethics and compliance program designed to ensure that we maintain high standards of ethical conduct in the operation of our business, and to meet or exceed applicable federal guidance and industry standards. We continually implement written policies and procedures for all of our employees to promote compliance with all applicable laws, regulations and Company policies, and to encourage a "culture of compliance" within the Company and its facilities. The organizational structure of our ethics and compliance program includes oversight by our Board of Directors and compliance committees at the Company and facility levels. We have compliance officers and personnel at the Company level and at our facilities. Other features of our compliance program include initial and periodic ethics and compliance training, systems for identifying and tracking compliance issues (including databases and hotlines for employees to report, without fear of retaliation, any suspected legal or ethical violations), regular auditing and monitoring of compliance issues, including coding audits and reviews of our financial relationships with physicians, and prompt review and resolution of identified issues.

Our compliance program also oversees the implementation and monitoring of the standards set forth by HIPAA for privacy. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and oversight by at the Company level.

Risk Management and Insurance

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("***SIR***") and deductible levels. At December 31, 2018, our SIR for professional liability claims is $5.0 million per claim, with a $5.0 million inner aggregate, at the majority of our facilities, and $2.0 million per claim at certain of our facilities. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2018, our deductibles for workers' compensation claims range from $0.5 million to $1.0 million per claim in all states in which we operate except for Montana, Oklahoma, Ohio, Washington and Wyoming. We participate in state-specific programs for our workers' compensation claims arising in these states. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

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

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

Item 1A. ***Risk Factors.***

Any of the following risks could materially and adversely affect our business, financial condition or results of operations. In addition, the risks described below are not the only risks that we face. The following information should be read in conjunction with Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations." Additional risks and uncertainties not currently known to us or those that we currently view to be immaterial could also materially and adversely affect our business, financial condition or results of operations.

We may be unable to achieve some or all of the expected benefits of the LifePoint/RCCH Merger.

We may not be able to achieve projected benefits or cost savings in connection with the LifePoint/RCCH Merger. The success of the LifePoint/RCCH Merger will depend, in part, on our ability to integrate Legacy LifePoint's and RCCH's businesses and operations as well as fully realize the anticipated benefits and synergies from combining these businesses. Mergers inherently involve risks, including those associated with assimilating and integrating different business operations, corporate cultures, personnel, infrastructure and technologies or products and increasing the scope, geographic diversity and complexity of our operations. There may be additional costs or liabilities that are not currently anticipated, including costs resulting from the unexpected loss of key employees or patients of the combined company, the hiring of additional management and other critical personnel, or unknown obligations or liabilities of facilities acquired in the LifePoint/RCCH Merger. The LifePoint/RCCH Merger may also be disruptive to our ongoing business, may divert the attention of our management and may cause patients, payers, joint venture partners, suppliers and employees that deal with us to seek changes to existing business relationships with us. Any of these risks could adversely affect our business, financial condition and results of operations.

Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments on the Notes.

We are a highly leveraged company. As of December 31, 2018, we had total outstanding debt of approximately $6,148.0 million, excluding capital and financing leases and unamortized debt issuance costs.

Our substantial indebtedness could have important consequences for the lenders and holders of our indebtedness. For example, it could:

- limit our ability to borrow money for our working capital, capital expenditures, debt service requirements, strategic initiatives or other purposes;
- make it more difficult for us to satisfy our obligations with respect to our indebtedness, including the Notes, and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the indentures governing the Notes and the agreements governing other indebtedness;
- require us to dedicate a substantial portion of our cash flow from operations to the payment of interest and the repayment of our indebtedness, thereby reducing funds available to us for other purposes;
- limit our flexibility in planning for, or reacting to, changes in our operations or business;
- make us more highly leveraged than some of our competitors, which may place us at a competitive disadvantage;
- make us more vulnerable to downturns in our business, our industry or the economy;
- restrict us from making strategic acquisitions, engaging in development activities, introducing new technologies or exploiting business opportunities;
- cause us to make non-strategic divestitures;
- limit, along with the financial and other restrictive covenants in our indebtedness, among other things, our ability to borrow additional funds or dispose of assets;
- prevent us from raising the funds necessary to repurchase all Notes tendered to us upon the occurrence of certain changes of control, which failure to repurchase would constitute an event of default under the Indentures; or
- expose us to the risk of increased interest rates, as certain of our borrowings, including borrowings under the ABL Facility and the Term Loan Facility, are at variable rates of interest.

In addition, the ABL Agreement, the Term Loan Agreement and the Indentures contain restrictive covenants that limit or will limit our ability to engage in activities that may be in our long-term best interest. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of substantially all of our existing and future indebtedness.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.

Our ability to pay principal and interest and to satisfy our other debt obligations will depend upon, among other things:

- our future financial and operating performance (including the realization of any cost savings described herein), which will be affected by prevailing economic, industry and competitive conditions and financial, business, legislative, regulatory and other factors, many of which are beyond our control; and
- our future ability to borrow under the ABL Facility, the availability of which depends on, among other things, our complying with the covenants in the ABL Agreement.

We cannot assure you that our business will generate cash flow from operations, or that we will be able to draw under the ABL Facility or otherwise, in an amount sufficient to fund our liquidity needs, including the payment of principal and interest on the ABL Facility, the Term Loan Facility and the Notes.

If our cash flows and capital resources are insufficient to service our indebtedness, we may be forced to reduce or delay capital expenditures, sell assets, seek additional capital or restructure or refinance our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. In addition, the terms of existing or future debt agreements, including the ABL Agreement, the Term Loan Agreement and the Indentures, may restrict us from adopting some of these alternatives. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to dispose of material assets or operations to meet our debt service and other obligations. We may not be able to consummate those dispositions for fair market value or at all. Furthermore, any proceeds that we could realize from any such dispositions may not be adequate to meet our debt service obligations then due. The Sponsor and its affiliates have no continuing obligation to provide us with debt or equity financing. Our inability to generate sufficient cash flow to satisfy our debt obligations, or to refinance our indebtedness on commercially reasonable terms or at all, could result in a material adverse effect on our business, results of operations and financial condition and could negatively impact our ability to satisfy our obligations under our indebtedness.

If we cannot make scheduled payments on our indebtedness, we will be in default, and the lenders under the Term Loan Facility and the holders of the Notes could declare all outstanding principal and interest to be due and payable, the lenders under the ABL Facility could terminate their commitments to loan money, our secured lenders (including the lenders under the ABL Facility and the Term Loan Facility and the holders of the 8.25% Secured Notes) could foreclose against the assets securing their loans and the Notes and we could be forced into bankruptcy or liquidation. All of these events could cause you to lose all or part of your investment in the Notes.

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

In 2018, we derived approximately 50.7% of our net patient revenues before the provision for doubtful accounts from Medicare and Medicaid programs, collectively. Numerous factors could materially decrease, or delay timing of, Medicare and Medicaid payments to our facilities. These factors include statutory and regulatory changes, administrative rulings and determinations concerning patient and provider eligibility and requirements for utilization review. Furthermore, the Affordable Care Act and related federal laws provide for material scheduled reductions in the growth rate of Medicare and Medicaid program spending, including reductions in market basket updates and Medicare and Medicaid DSH funding.

Medicaid programs, which are jointly funded by federal and state governments and are administered by states, provide healthcare benefits to qualifying individuals who are unable to afford care. A number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs. States may also impose additional taxes on hospitals to help finance such states' Medicaid systems. Some states have also taken steps to implement work and/or community engagement requirements for Medicaid beneficiaries, which could have the effect of reducing the number of individuals eligible for Medicaid in those states.

Recent executive and legislative actions to amend or impede the implementation of the Affordable Care Act and ongoing efforts to repeal, replace or further modify the Affordable Care Act may adversely affect our business, financial condition and results of operations.

The Affordable Care Act dramatically altered the U.S. healthcare system, and we have expended substantial cost and effort to prepare for and comply with the Affordable Care Act. Since its adoption into law in 2010, the Affordable Care Act has been challenged before the U.S. Supreme Court, and several bills have been and continue to be introduced in Congress to delay, defund or repeal implementation of or amend significant provisions of the Affordable Care Act. In addition, there continues to be ongoing litigation over the interpretation, implementation and constitutionality of the law. The net effect of the Affordable Care Act, as currently in effect, on our business is subject to a number of variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. Additional variables of the Affordable Care Act impacting our business will be how states, providers, insurance companies, employers, and other market participants respond during this period of uncertainty surrounding the future of the Affordable Care Act.

In 2017, President Trump issued executive orders that, among other things, expressed the administration's intent to repeal the Affordable Care Act, instructed the executive branch of the federal government to defer or delay the implementation of any provisions of the Affordable Care Act that would impose a fiscal burden on any state or a cost, fee, tax or penalty on any individual, family, health care provider, or health insurer. On October 12, 2017, President Trump issued another executive order related to the Affordable Care Act that resulted in the issuance of regulations that are intended to encourage the formation of association health plans, and increase the maximum duration of and access to short-term limited duration health insurance plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. In 2017, the United States Department of Justice ("***DOJ***") also announced that HHS was immediately ceasing its cost sharing reduction payments to insurance companies based on a determination that those payments had not been appropriated by Congress, and Congress enacted the Tax Act that, in addition to overhauling the federal tax system, repealed the penalties associated with the individual mandate effective as of January 1, 2019. In addition, in December 2018, the U.S. District Court for the Northern District of Texas found that, as a result of the repeal of the penalties associated with individual mandate, the entire Affordable Care Act is unconstitutional.

We cannot predict the impact that the President's executive orders and other administrative actions will have on the implementation and enforcement of the provisions of the Affordable Care Act or the current or pending regulations adopted to implement the law. In addition, we cannot predict the impact that the repeal of the penalties associated with the individual mandate and the cessation of cost sharing reduction payments to insurers will have on the availability and cost of health insurance and the overall number of uninsureds. We also cannot predict the outcome of litigation challenging the constitutionality of the Affordable Care Act or whether the Affordable Care Act will be repealed, replaced, or modified. If the Affordable Care Act is found to be unconstitutional or if it is repealed, replaced or modified, we cannot predict what, if any, the replacement plan or modifications would be, when any such replacement plan or modifications would become effective, or whether any of the existing provisions of the Affordable Care Act would remain in place.

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

Medicaid supplemental payments ("***MSPs***") are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and Upper Payment Limit ("***UPL***") payments. Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating these patients. The total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law. Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars.

The Affordable Care Act called for significant reductions in Medicaid DSH funding to account for decreases in uncompensated care anticipated under the health insurance coverage expansion. Subsequent changes in the law have delayed the implementation of these reductions, but they are scheduled to take effect in FFY 2020. Reductions in Medicaid DSH payments may take place without increases in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

UPL programs have expanded in recent years and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs. We cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease.

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

All participants in the healthcare industry are required to comply with numerous overlapping laws and regulations at the federal, state and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to relationships with providers and other referral sources, the adequacy and quality of medical care, inpatient admission criteria, privacy and security of health information, standards for equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, compliance with building codes and environmental protection, among other matters. Many of the laws and regulations applicable to the healthcare industry are complex and may be violated inadvertently, and there are numerous enforcement authorities, including CMS, the OIG, the DOJ, state attorneys general, and contracted auditors, as well as private plaintiffs.

There are also heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. Recent enforcement actions have focused on, among other things, financial arrangements between hospitals and providers, billing for services without adequately documenting the medical necessity for such services and billing for services outside the coverage guidelines for such services. Hospitals continue to be one of the primary focal areas of the OIG and other governmental fraud and abuse programs, as described in the OIG Work Plan. Dealing with investigations can be time and resource consuming and can divert management's attention from the business. Any such investigation or settlement could increase our costs or otherwise have an adverse effect on our business. In addition, because of the potential for large monetary exposure under the False Claims Act, which provides for treble damages and substantial civil monetary penalties for each separate false claim or statement, healthcare providers often resolve allegations without admissions of liability for significant and material mounts to avoid the uncertainty of damages and penalties that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree, settlement agreement or corporate integrity agreement. These additional requirements can result in significant additional and ongoing expenditures. Given the significant size of actual and potential settlements, it is expected that the government will continue to devote substantial resources to investigating healthcare providers' compliance with the healthcare payment rules and fraud and abuse laws. Certain of our facilities have received inquiries and subpoenas from various governmental agencies regarding these matters, and we are also subject to various claims and lawsuits relating to these and other matters.

The laws and regulations with which we must comply continually change. In the future, different interpretations or enforcement of these laws and regulations could subject our business practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws and regulations, many of these laws and regulations are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable laws and regulations. If we fail to comply with applicable laws and regulations, we could suffer substantial civil or criminal penalties, including the loss of our licenses to operate our facilities or loss of our ability to participate in the Medicare, Medicaid and other governmental programs.

Additionally, we are subject to a variety of different federal, state and local employment and wage and hour laws. While we strive to comply with those laws, if we fail to do so, we may be subject to lawsuits by governmental authorities or private plaintiffs. In addition, the Internal Revenue Service ("***IRS***") and/or state taxing authorities may successfully challenge positions taken on our tax returns.

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

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

The False Claims Act prohibits healthcare facilities and providers, as well as other entities or individuals from, among other things, knowingly submitting false claims for payment to the federal government, or knowingly causing the submission of such claims. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. We are required to provide information to our employees and certain contractors about state and federal false claims laws and whistleblower provisions and protections. Defendants found to be liable under the False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus substantial civil monetary penalties, that are subject to annual inflation adjustments, for each separate false claim.

There are many potential bases for liability under the False Claims Act, including reckless or intentional acts or omissions. The government has used the False Claims Act to prosecute Medicare and other government healthcare program violations such as coding errors, billing for services not provided, submitting false cost reports, and providing care that is not medically necessary or that is substandard in quality. The Affordable Care Act also (i) created potential False Claims Act liability for failing to report and repay identified overpayments within sixty (60) days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later, and (ii) provided that claims submitted in connection with patient referrals that result from violations of the Anti-kickback Statute constitute false claims for the purposes of the False Claims Act. Some courts have held that a violation of the Stark law can result in False Claims Act liability as well. In addition, a number of states have adopted their own false claims and whistleblower provisions whereby a private party may file a civil lawsuit in state court.

Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws, many of these laws are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable fraud and abuse laws.

Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may limit our revenues and profitability.

The amounts we receive for services provided to patients are determined by a number of factors, including the payer mix of our patients and the reimbursement methodologies and rates utilized by our payers. In recent years, we have seen shifts of patients from commercial and private insurance to Medicare and Medicaid programs and from "traditional" fee-for-service Medicare and Medicaid programs to "managed" Medicare and Medicaid programs. Some members of Congress have also recently proposed measures that would expand government-sponsored coverage, including "Medicare-for-all" or other single-payer proposals. Reimbursement rates generally are lower for (i) Medicare and Medicaid beneficiaries than they are for patients whose care is covered by commercial and private insurance and (ii) managed Medicare and Medicaid beneficiaries than they are for traditional Medicare and Medicaid beneficiaries. We also experience demographic pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs. Our revenues and results of operations may be adversely affected by these shifts.

In addition, our revenues from negotiated rates with HMOs, PPOs, insurance companies, employers and other private payers may decline based on renegotiations and the respective bargaining power of the parties. There is a general trend towards further consolidation among private payers, which may increase their bargaining power over fee structures. As a result, payers increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk related to paying for care provided. These changes include moving away from a percent of charge payment structure to a fixed payment for an episode of care, which typically reduces our payment rate and limits our ability to raise prices going forward. Furthermore, low cost plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices, restrict or exclude our facilities or impose significantly higher cost sharing obligations for care provided by our facilities if they are classified in a disfavored tier. In addition, other healthcare providers, including some with greater financial resources, greater geographic coverage or a wider range of services, may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care plans to contract with us.

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

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

We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations or it could diminish the anticipated value of the acquired facility.

We may be unable to timely and effectively integrate facilities that we acquire with our ongoing operations. Many of the facilities we have acquired had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced delays in improving the operating margins or effectively integrating the operations of our acquired facilities and we may experience such delays in implementing operating procedures and systems in newly or future acquired facilities. Integrating an acquired facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel. Additionally, we may experience delays in reimbursement from governmental and third-party payers as a result of the change of ownership of our acquired facilities.

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

Facilities we have acquired, including in connection with the LifePoint/RCCH Merger, or facilities we acquire in the future, may have unknown or contingent liabilities for historical activities or conditions, including liabilities for failure to comply with laws and regulations, retroactive payment adjustments or recoupments from payer audits, medical and general professional malpractice liabilities, unfunded pension liabilities, workers' compensation or other employee-related liabilities, previous tax or environmental liabilities, regulatory and compliance related liabilities, and unacceptable business or accounting practices. Although we endeavor to obtain contractual indemnification from sellers covering these matters in connection with some acquisitions, we have not obtained contractual indemnifications in connection with all of them, and any indemnification obtained from sellers may be insufficient to cover material claims or liabilities for past activities of acquired businesses and the sellers may have insufficient funds to satisfy any claims or liabilities for which we may otherwise be entitled to be reimbursed.

We typically retain and rely on existing local management teams at newly acquired facilities to implement changes to operating procedures and systems. Integrating local management teams can involve cultural and systems challenges that may demand a disproportionate share of our resources and senior management's attention, and we may experience turnover of providers and other key personnel. Our acquisitions have become, and may continue to become larger, and may occur in communities with competing facilities. As a result, the issues surrounding integration may become more complex, expensive and time-consuming and may have a greater impact on our financial performance when we experience delays or difficulties.

If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.

As of December 31, 2018, we had approximately $2,642.1 million of goodwill and other intangible assets and approximately $4,317.1 million of long-lived assets, net of accumulated depreciation. We expect to recover the carrying values of both our goodwill as well as our long-lived assets through our future cash flows. We evaluate the carrying value of our goodwill at least annually, based on our fair value, to determine whether it is impaired. We evaluate our long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows. If the carrying value of our goodwill or our long-lived assets is impaired, we may incur a material non-cash charge to earnings.

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

We will be subject to medical malpractice lawsuits and other legal actions arising out of the operations of our facilities and the activities of our employed or affiliated providers. As a matter of policy, we typically notify patients of any potential harms they may have suffered at our facilities, regardless of whether such notifications are required by law and notwithstanding our uncertainty as to the severity of such harms or whether they even took place. This may lead to class actions or other multi-plaintiff lawsuits or whistleblower reports. These actions may involve large claims and significant defense costs and, if we or our facilities are found liable, any judgments against us may be material. Furthermore, some states in which we operate do not impose caps on non-economic malpractice damages and, even in the states that have imposed caps on such damages, litigants may seek recoveries under alternative theories of liability that might not be subject to such caps. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement whether or not we believe we are liable. Amounts we pay to settle any of these matters also may be material.

Although we maintain professional and general liability insurance with unrelated commercial insurance carriers, each individual plaintiff's claim is generally subject to an SIR insurance program administered in-house by our risk department with assistance from our insurance brokers. Any successful claim against us that is within our SIR amounts could have an adverse effect on our results of operations or liquidity. Some of these claims could exceed the scope of the excess coverage in effect, or coverage of particular claims could be denied, and any amounts not covered by insurance could be material.

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

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

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare and Medicaid for payment for our services. These post-payment reviews may increase as a result of government cost-containment initiatives, including enhanced medical necessity reviews for patients admitted as inpatients to general acute care hospitals for certain procedures and audits of claims under the RAC programs to detect overpayments not identified through existing claims review mechanisms. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those claims most likely to contain overpayments, such as incorrectly coded services, short stays, incorrect payment amounts, non-covered services and duplicate payments. The claims review strategies used by the RACs generally include a review of high dollar claims, including inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals.

In addition, CMS and the states use UPICs to perform post-payment audits of claims and identify Medicare and Medicaid overpayments. Third party audits or investigations of Medicare or Medicaid claims could result in increases or decreases in operating revenues to be recognized in periods subsequent to when the related services were performed, which may have a material adverse effect on our results of operations.

Controls designed to reduce inpatient services may reduce our revenues.

Over the last several years, payers have instituted policies and procedures to reduce or limit the use of inpatient services. Controls imposed by Medicare, Medicaid, and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for payment are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by QIOs, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of the MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. QIOs may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider that is in substantial noncompliance with quality standards be excluded from participation in the Medicare program.

Utilization review is also a requirement of most non-governmental managed care organizations and other third-party payers. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Additionally, in some states in which we operate, commercial third-party payers and Medicaid managed care plans have instituted policies that retroactively limit or deny patient coverage for emergency department and certain other services provided at hospitals if the payers believe the services could have been provided in less expensive settings. For example, such payers are increasingly seeking to pay relatively low "triage fees" for patients seen in emergency departments when the payers retrospectively determine the patients' treatment did not qualify as an emergency service. Significant limits on the scope of services reimbursed or on the amounts paid for such services could have a material adverse effect on our revenues and results of operations.

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

We outsource selected business functions to third parties. We take steps to monitor and regulate the performance of independent third parties to whom we delegate selected functions, including revenue cycle management, patient access, billing, cash collections, payment compliance and support services, project implementation, supply chain management, payroll system services and parts of cybersecurity. Arrangements with third party service providers may make our operations vulnerable if vendors fail to satisfy their obligations to us as a result of their performance, changes in their own operations, financial condition, or other matters outside of our control. We may also face legal, financial or reputational harm for the actions or omissions of such providers, including for violations of HIPAA and other privacy and security laws applicable to healthcare providers, and we may not have effective recourse against the providers for those harms. The expanding role of third party providers may also require changes to our existing operations and the adoption of new procedures and processes for retaining and managing these providers, as well as redistributing responsibilities as needed. Effective management, development and implementation of our outsourcing strategies are important to our business and strategy. If there are delays or difficulties in enhancing business processes or our third party providers do not perform as anticipated, we may not fully realize on a timely basis the anticipated economic and other benefits of the outsourcing projects or other relationships we enter into with key vendors, which could result in substantial costs, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us. Terminating, transitioning or renegotiating arrangements with key vendors or failure to renegotiate on favorable terms could result in additional costs and a risk of operational delays, potential errors and possible control issues as a result of the termination or during the transition or renegotiation phase.

We conduct a significant portion of our operations through joint ventures. We cannot provide assurances that relationships with our joint venture partners will remain strong, which could negatively affect our joint ventures, affiliations and other strategic alliances as well as our overall business.

We have completed a number of joint ventures, affiliations and other strategic alliances as part of our business strategy. We expect to enter into similar transactions in the future, including joint ventures where we may have a minority or non-controlling interest. We believe our relationships with our joint venture partners are strong; however, any changes in these relationships could disrupt ongoing business, negatively affect cash flow and distract management and other key personnel.

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

As a general matter, our joint venture partners may have investment and operational goals that are not consistent with our company-wide objectives, including the timing, terms and strategies for future growth and development opportunities, and we could reach an impasse on certain decisions, which may hinder our ability to pursue preferred strategies for growth and development, could require significant resources and attention from management and key employees to resolve and could have an adverse effect on our operations, cash flow and revenue growth. In addition, our joint venture relationships with not-for-profit partners and the agreements that govern these relationships are structured based on current provisions of the Internal Revenue Code of 1986, as amended (the "***Code***") (and the Treasury Regulations thereunder), published rulings by the IRS, as well as case law relevant to joint ventures between for-profit and not-for-profit entities. Material changes in these legal authorities could adversely affect our relationships with not-for-profit partners and related joint venture arrangements.

Furthermore, joint ventures in which we have a minority equity interest and minority investments inherently involve a lesser degree of control over business operations, thereby potentially increasing the financial, legal, operational and compliance risks associated with the joint venture or minority investment. We may be dependent on joint venture partners or management who may have business interests, strategies or goals that are inconsistent with ours. Business decisions or other acts or omissions of the joint venture partner or management may adversely affect the value of our investment, result in litigation or regulatory action against us, result in reputational harm to us or adversely affect the value of our investment or partnership. To the extent another party makes decisions that negatively impact the joint venture or internal control issues arise within the joint venture, we may have to take responsive or other actions or we may be subject to penalties, fines or other related actions for these activities.

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

We employ a large number of physicians. Physician employment by acute care facilities, where permissible, is a trend in the industry and has become more common as a result of actual and potential reductions in payment amounts for physician services and increasing costs to physicians, such as EHR implementation and professional liability insurance expenses. Employed physicians generally present more direct risks to us than those presented by independent members of our hospitals' medical staffs, such as risks of unsuccessful physician integration, challenges associated with physician practice management and compliance risks arising from the increased billing and coding activities associated with the employment of physicians, the possibility of legal claims under federal and state employment law, and governmental scrutiny of physician employment arrangements. Employed physicians also require us to incur additional expenses, such as increased salary and benefit costs, medical malpractice expense and rent expense. Payments received by us for services provided by our employed physicians, the physicians to whom our facilities have provided recruitment assistance, and the physician members of our medical staffs could be adversely affected as physician payment methodologies move toward pay-for-performance as hospital payment models are doing. The combination of payment cuts, potential liabilities and increased expenses could have an adverse effect on our results of operations.

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

The primary collection risks associated with our accounts receivable relate to uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (exclusions, deductibles and co-payments) remain outstanding. The provision for doubtful accounts relates primarily to amounts due directly from patients. The amount of our provision for doubtful accounts is based on management's assessment of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage, the rate of growth in uninsured patient admissions and other collection indicators. While we have experienced a reduction in uninsured patients as a result of the Affordable Care Act, the risk of collection from insured patients, and the amounts due, have increased, and will likely continue to increase, as more individuals are enrolled in insurance plans with larger deductibles and/or co-payments, including those purchased on insurance exchanges.

If we experience growth in self-pay volume and revenue, including increased acuity levels for uninsured patients and increases in co-payments and deductibles for insured patients, our revenues and results of operations could be adversely affected. Although we have experienced a reduction in uninsured patients since 2014 as a result of the Affordable Care Act and the expansion of state Medicaid programs, we are unable to predict whether that trend will continue in light of the repeal of the penalties associated with the individual mandate, the cessation of the cost sharing reduction payments to insurers, and the decision by some states not to expand their Medicaid programs. In addition, the risk of collection from insured patients (and the amounts due) has increased, and will likely continue to increase, as a result of more individuals being enrolled in insurance plans with high deductibles and high co-payments. Furthermore, our ability to improve co-insurance collections and collections from self-pay patients may be limited by legislative developments, such as federal and state legislation designed to reduce "surprise billing," or by other regulatory or investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

An increase in the proportion of our accounts receivable being comprised of uninsured accounts and a deterioration in the collectability of these both insured and uninsured accounts could adversely affect our results of operations and revenues. Even if the Affordable Care Act remains implemented in its current form, we may continue to experience bad debts and be required to provide uninsured discounts and charity care for patients who choose not to purchase coverage, are undocumented immigrants who are not permitted to enroll in the Exchanges or government healthcare programs or live in states that do not expand or maintain the expansion of their Medicaid programs.

We are subject to potential legal and reputational risk as a result of our access to personal information of our patients and employees.

HIPAA and numerous other federal and state laws and regulations govern the collection, dissemination, use, privacy, security, confidentiality, integrity, and availability of personally identifiable information ("***PII***") and PHI. HIPAA imposes privacy and security requirements on healthcare providers who are covered entities such as us, including to implement reasonable and appropriate administrative, physical and technical safeguards to protect PHI, including PHI maintained, used and disclosed in electronic form, and data breach notification requirements for certain unauthorized access, acquisition, use or theft of PHI. The safeguards include employee training, identifying "business associates" with whom we need to enter into HIPAA-compliant contractual arrangements, and various other measures. We are required to develop and adopt a comprehensive set of policies and procedures to comply with HIPAA and other privacy and information security laws. Ongoing implementation and oversight of these measures involves significant time, effort and expense. In the ordinary course of our business, we, and vendors acting on our behalf, collect, transmit, share and store sensitive data, including PHI and PII of our patients and employees. Such information is at risk of accidental or intentional misuse or disclosure, and is often targeted by criminal organizations. The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. If, in spite of our security and compliance efforts we or any of our business associates were to experience a breach, loss, or other compromise of PHI or PII, such event could disrupt our operations, result in increased data protection costs, damage our reputation, or result in regulatory penalties, legal claims and civil or criminal liability under HIPAA and other state and federal laws, which could have a material adverse effect on our results of operations.

HHS requires covered entities to report breaches of unsecured PHI to affected individuals without unreasonable delay and in no case later than 60 days after the discovery of the breach by the covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HIPAA creates a presumption that all non-permitted uses or disclosures of unsecured PHI are breaches unless the covered entity establishes that there is a low probability the information has been compromised. HHS has imposed substantial mandatory civil and criminal penalties for violations of HIPAA's requirements, with potential civil penalties exceeding $1.7 million in a calendar year for multiple violations of the same requirement in a single year. Moreover, because a single breach incident can result in multiple violations of multiple requirements, potential penalties can range much higher. We are also subject to state breach notification laws which may differ from HIPAA. In addition, state attorneys general and private plaintiffs have brought civil actions seeking injunctions and damages in response to violations of state or federal privacy laws or HIPAA's privacy, security and breach notification rules, as applicable. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA's requirements, its standards have been used as a basis for the duty of care in state civil suits, such as those for negligence or recklessness in the handling of PHI. In addition, HIPAA mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities such as us, and has reserved the right to initiate enforcement actions where it discovers noncompliance.

In addition, many states in which we operate may impose laws that are more protective of the privacy and security of PII than HIPAA. Where these state laws are more protective of individual privacy than HIPAA, we have to comply with their stricter provisions. Not only may some of these state laws impose fines and penalties upon violators, but some may also afford private rights of action to individuals who believe their PII has been misused. Both state and federal laws are subject to modification or enhancement of privacy protection at any time. Our facilities will continue to remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These statutes vary and could impose additional requirements on us and more severe penalties for disclosures of confidential health information. New health information standards could have a significant effect on the manner in which we do business, and the cost of complying with new standards could be significant. We may not remain in compliance with the diverse privacy requirements in all of the jurisdictions in which we do business. If we fail to comply with HIPAA or similar state laws, we could incur substantial civil monetary or criminal penalties.

A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

We rely extensively on our information systems and certain systems operated by us and third-parties to manage clinical, financial and employee data, communicate with our patients, payers, vendors and other third parties and summarize and analyze operating results. These systems are at risk from cybersecurity attacks and other intrusions, including attempts to gain unauthorized access to and theft of our confidential data, misuse, corruption or destruction of confidential data and damage, disruptions or shutdowns of these systems due to viruses, malware, ransomware, employee error or malfeasance, and other electronic security breaches. Our systems, which transmit and store sensitive and confidential data, including PHI and other PII of our patients, employees and others, and our proprietary and confidential business performance and other data, will continue to be a target for attempts to gain unauthorized access and data theft due to the valuable nature of the information they contain, as well as at risk for accidental exposure. In addition, certain third-party medical devices and equipment are used at our facilities, and may be vulnerable to cybersecurity attacks or other breaches which could negatively impact our systems or our patients.

Cybersecurity breaches and other unauthorized access to our data can sometimes be difficult to discern, and any delays in detection may lead to increased harm. Such attacks or breaches are common in the healthcare sector and could result in the compromise of health information or other data subject to protection by HIPAA and other laws and regulations, or disrupt our IT systems or business. While we are not aware of having experienced a material cybersecurity breach, there can be no assurance that we will not be subject to material cyber-attacks or security breaches in the future, or that the preventive actions we take to reduce the risk of such incidents and protect our IT and data will be sufficient. We continue to prioritize cybersecurity and the development of practices and controls to protect our systems. However, regardless of the nature, extent and timing of our actions, these measures may not prevent security breaches. If our services are subject to cyber-attacks that impair or deny the ability of patients to access our services, current and potential patients may become unwilling to provide us the information necessary for them to become users of our services or may curtail or stop using our services. As cyber-threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures and to investigate and remediate any information security vulnerabilities. As we are subjected to cyber-attacks and possible security breaches in the future, this could have an adverse impact on our business, reputation, financial condition and results of operations. See "—We are subject to potential legal and reputational risk as a result of our access to personal information of our patients and employees" for more information.

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

We require substantial capital resources to fund our growth strategy and ongoing capital expenditure programs, including capital expenditure programs for renovation, expansion and construction at our facilities and the addition of equipment and technology at our facilities. We often commit to significant capital expenditures well in advance of the time these expenditures will be made. Our cash flows and available capital resources may be insufficient to fund our capital expenditure programs and commitments, and we may be forced to reduce or delay planned and required capital expenditures. Additionally, we may experience delays or impediments in satisfying the schedule for capital expenditure commitments because of a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions. The failure to satisfy our capital expenditure commitment obligations could also damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions.

At December 31, 2018, we estimated our total remaining capital expenditure commitments to be approximately $1,436.3 million, which generally have remaining terms of three to seven years. Of this amount, approximately one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time. The failure to satisfy our capital expenditure commitment obligations could damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions. As a result, if our cash flows and available capital resources are not sufficient to fund all of our anticipated capital expenditures, it may be necessary for us to give priority to contractual capital expenditure commitment obligations over other elective capital expenditure programs.

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

Competition among hospitals and other healthcare service providers, including outpatient facilities, has intensified in recent years. We also have acquired, and may continue to acquire, larger facilities in more concentrated population centers, which experience greater competition for healthcare services. We compete with other facilities, including larger tertiary and quaternary care centers located in metropolitan areas. Although the facilities with which we compete may be a significant distance away from our facilities, patients in our markets may migrate on their own to, may be referred by local providers to, or may be required by their health plan to travel to these facilities. Furthermore, some of the facilities with which we compete may offer more or different services than those available at our facilities, may have more advanced equipment or technology or may have a medical staff that is perceived to be better qualified. We also compete with facilities and health systems that are implementing physician and other provider alignment strategies, such as employing providers, acquiring physician practice groups and participating in ACOs or other clinical integration models, which may impact our competitive position. Also, many of the facilities that compete with our facilities are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions and are eligible to participate in the 340B Program. These facilities, in most instances, are also exempt from paying sales, property and income taxes and have the ability to issue tax-exempt bonds for financing.

Quality of care and value-based purchasing have also become significant trends and competitive factors in the healthcare industry. CMS makes public the performance data relating to multiple quality measures that facilities submit in connection with their Medicare payment. CMS also requires every Medicare participating hospital to establish and update annually a public online listing of the hospital's standard charges for items and services. If the publicly-available performance and charge data become a primary factor in where patients choose to receive care, and if competing facilities have lower charges or better results than our facilities on those measures, our revenues and/or patient volumes could decline.

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

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

There is a trend in the healthcare industry toward value-based purchasing of healthcare services and bundled payment arrangements. Value-based purchasing programs include both public reporting of quality data and payment limitations tied to the incidence of preventable adverse events or the quality and efficiency of care provided by facilities. For example, Medicare, Medicaid and many large commercial payers may require facilities to report certain quality data to receive full payment updates or avoid payment reductions. They may also impose payment reductions in connection with HACs and excessive readmissions for certain conditions designated by HHS. Our revenue may be negatively impacted by the application of one or more of these measures. Bundled payment arrangements generally set target payment amounts for all healthcare services provided to patients during particular episodes of care. They are intended to create incentives for physicians, hospitals and other providers to work together to provide higher quality and more coordinated care at a lower cost. We currently participate in a few ACOs as well as a number of bundled payment programs, and we expect value-based purchasing programs, including programs that condition payment on patient outcome measures, to become more common and to involve a higher percentage of payment amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively affect our revenues.

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

The success of our business operations depends on the number and quality of the physicians and other healthcare providers who perform services at our facilities. Our ability to recruit and retain quality providers in turn depends on several factors, including the actual and perceived quality of services furnished by our facilities, our ability to meet demands for new technology, our ability to identify and communicate with providers who want to practice in our communities and our ability to provide competitive financial compensation packages. Our ability to attract and retain providers is increasingly dependent on the ability of our facilities to offer and sustain employment arrangements. In particular, we face intense competition in the recruitment and retention of specialists and primary care providers. We may not be able to recruit all of the providers we target. In addition, we may incur increased malpractice, compliance or insurance expense depending on the quality of providers' clinical outcomes.

Additionally, our ability to recruit and employ providers is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the Stark law, the Anti-kickback Statute, state anti-kickback and self-referral statutes, and related regulations. The Stark law requires, among other things, that recruitment assistance can only be provided to physicians who meet certain geographic and practice requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit physicians currently in practice in the community beyond recruitment costs actually incurred by them. All arrangements with physicians must also be fair market value and commercially reasonable.

In addition to these legal requirements, there is competition from other communities and facilities for these providers, and this competition continues after the provider is practicing in one of our communities. For example, integrated ACOs and other kinds of "narrow" provider networks or organizations may exclude our providers from their plans' networks of healthcare providers. These contracting networks often organize hospitals, providers and ancillary healthcare providers into exclusive networks involving fewer healthcare providers. If our affiliated providers are excluded from such networks, we may have difficulty recruiting new providers or retaining existing providers.

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

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

We may have difficulty acquiring facilities on favorable terms. Furthermore, our business could be negatively affected if acquisitions are not successfully completed or if contingent liabilities materialize in connection with such transactions.

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

The cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired facility's results of operations, allocation of purchase price, effects of subsequent legislation and limitations on rate increases. As part of our acquisition strategy, we may commit to making significant capital improvements at acquired facilities. Such improvements may be difficult to achieve in the anticipated timeframe, if at all, due to a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions.

Our ability to engage in certain acquisitions in several states may be limited due to exclusivity, non-competition and non-solicitation provisions that we have agreed to in connection with our joint ventures (including Duke LifePoint Healthcare) and previous acquisitions and divestiture transactions. Additionally, certain acquisitions may require the consent of and collaboration with our joint venture partners based upon the applicable governing documents. If we cannot obtain the cooperation of our joint venture partners in certain instances, we may not be able to pursue these opportunities.

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

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

Many of the non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies intended to generate organic growth and improve operating results at our facilities.

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

- defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for facilities; or
- purchase a high-deductible insurance plan or no insurance at all, which increases a facility's dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms.

Additionally, non-urban communities are experiencing a much slower rate of growth, if any, as compared to more concentrated population centers. As a result, we may experience payer mix pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs.

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

If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results could be negatively impacted.

We have initiated a multi-year business initiative to standardize certain processes, policies and systems throughout our facilities, including migrating our multiple IT platforms to a smaller number of enterprise-wide systems solutions. If we do not allocate and effectively manage the resources necessary to build and sustain the proper IT infrastructure and implement standardized systems, or if we fail to achieve the expected benefits from this initiative, it may impact our ability to operate profitably and efficiently, and comply in a timely manner with changing regulatory requirements and with the requests of patients, payers and business partners. The failure to transition to these systems on time, or anticipate necessary readiness and training needs, could lead to business disruption and loss of revenue. In addition, the operating results of newly acquired facilities could be impacted if such facilities are not integrated on a timely basis into our new systems. The actions we take to resolve compliance or regulatory issues within acquired facilities may affect our revenue or results of operations.

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

If access to our information systems or those provided by our third party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

Our business depends heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and to develop new systems in order to keep pace with continuing changes in information processing technology. In addition to our own systems, we rely on multiple third party providers of financial, clinical, supply chain, patient accounting and network information services and, as a result, we face operational challenges in maintaining multiple provider platforms and facilitating the interface of such systems with one another. The third party providers may not have appropriate controls to protect confidential information. We do not control the information systems of third party providers, and in some cases we may have difficulty accessing information archived on third party systems, which could subject us to liability for failure to respond to legal, regulatory or payer obligations or information requests. Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, flood, hurricane, telecommunications failure, terrorist attack or other catastrophic event. If these systems fail or are interrupted, if our access to these systems is limited in the future or if providers develop systems more appropriate for more urban healthcare markets and not suited for our facilities, our operations could suffer.

We intend to expand our operations, including by acquiring more facilities, which will require us to integrate and transition certain existing information systems. In addition, as new information systems are developed in the future, we will need to integrate them into our existing systems. Evolving industry and regulatory standards, such as the HITECH Act, HIPAA and EHR meaningful use regulations, also may require changes to our information systems in the future. System conversions are costly, time consuming and disruptive for providers, staff and, in some cases, patients. If such conversions occurred on a large scale or if we are unable to properly integrate other information systems or expand or update our current information systems, the costs and disruptions could have a material adverse effect on our revenues or results of operations.

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

In addition to depending on our physicians and other providers, the operations of our facilities are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians. We compete with other healthcare facilities in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our facilities, including physician assistants, nurses and other non-physician healthcare professionals. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue and the competition for experienced and talented hospital management personnel is intense. This may result in employee turnover, require us to enhance wages and benefits to recruit and retain management, nurses and other medical support personnel, recruit personnel from foreign countries (which may be limited by changes in immigration law, regulation and policy), and hire more expensive temporary or contract personnel. In addition, the states in which we operate could adopt mandatory nurse staffing ratios or could increase mandatory nurse-to-patient staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. Some of the employees at some of our facilities are represented by a union, and others may be in the future, which can also increase the cost of labor. If our labor costs increase, we may not be able to raise rates to offset these increased costs. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs could have a material adverse effect on our revenues or results of operations.

Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and subject to the terms of collective bargaining agreements.

Increased or ongoing labor union activity is another factor that could adversely affect our labor costs or otherwise adversely impact us. Several of our facilities have unionized employees. When a new collective bargaining agreement with a union must be negotiated, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur, and our operations could be disrupted or our labor costs increased as a result of these disruptions. Our labor costs also could increase significantly if a substantial number of other employees at our facilities unionize.

If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained.

The terms of the collective bargaining agreements also set forth certain requirements related to the respective facility's employment practices, seniority, hours of work, overtime, holidays, use and redemption of paid time off, extended illness bank, vacation scheduling, compensation, pay practice, health and non-health benefits, leaves of absence, grievance procedures, disability accommodations and the facility's drug and alcohol policies. If these facilities fail to fulfill any of these requirements, it could result in discussions with union representatives or the filing of a grievance that could be costly and time-consuming for those facilities. Furthermore, the terms of the collective bargaining agreements constrain our flexibility with respect to these and other employee issues. The inability to negotiate future collective bargaining agreements on favorable terms with these employees or with other unionized employees could have a material adverse effect on our business, results of operations and financial condition.

If we fail to implement and maintain certified electronic health record and coding systems in an effective and timely manner, our operations could be adversely affected.

The Medicare and Medicaid Promoting Interoperability Programs (formerly known as the Medicare and Medicaid EHR Incentive Programs for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals, and formerly referred to as "***Meaningful Use***") was established in 2011 to encourage eligible professionals, eligible hospitals, and critical access hospitals to adopt, implement, upgrade and demonstrate meaningful use of certified health information technology ("***Certified HIT***") for the purposes of advancing care coordination and improving the quality of care. In 2018, CMS merged the Meaningful Use program into the programs that are being created under MACRA, included this technology requirement as one of the four components of MIPS, and changed the name of the Meaningful Use program to the Promoting Interoperability Program. Each year, HHS and CMS revise standards required for use of Certified HIT, and they periodically revise standards required for a technology's designation as a Certified HIT. In order to meet the requirements for the Promoting Interoperability Program, we must implement, maintain and use technology that meets the Certified HIT standards. In addition, use of Certified HIT is required for reporting under other CMS payment programs, such as ACOs and bundled payment programs. Certain of our EHR's will require software upgrades in the future in order to continue being categorized as Certified HIT as designated by HHS. Failure to effectively comply with the new requirements of the Promoting Interoperability Program, implement EHR systems or maintain current requirements for EHR systems effectively and in a timely manner could have a material adverse effect on our revenue generated from Medicare Part B claims and other CMS QPPs in which we participate.

Under Meaningful Use, we received certain incentive payments related to our efforts to implement our EHR. Incentive payments we have received in prior years for EHR implementation were materially reduced over the program's life to immaterial amounts in 2017 and 2018. EHR incentive payments that we have previously recognized are subject to audit and potential recoupment if it is determined that we did not meet the applicable Meaningful Use standards required in connection with such incentive payments.

Under Meaningful Use, we received certain incentive payments related to our efforts to implement our EHR. Incentive payments we have received in prior years for EHR implementation were materially reduced over the program's life to immaterial amounts in 2017 and 2018. EHR incentive payments that we have previously recognized are subject to audit by CMS and potential recoupment for up to the past six years if it is determined that we did not meet the applicable Meaningful Use standards required in connection with such incentive payments. To the extent a CMS audit determines that we did not meet the reporting requirements for Meaningful Use, the Company would be subject to the potential recoupment of the incentive and other payments previously received in connection with the Meaningful Use program. In addition, reporting under MIPS results in either a negative or positive per claim payment adjustment by CMS and potential bonus payments, as well. To the extent a CMS audit determines that we did not meet the reporting requirements of the Promoting Interoperability Program, the Company would be subject to potential recoupment of any positive adjustments or bonus payments that were previously made. A determination by CMS that the Company has made a false attestation regarding its Meaningful Use or Promoting Interoperability Program participation could also potentially be grounds for prosecution under the False Claims Act or other applicable federal fraud and abuse laws.

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

Some states require prior approval for the purchase, construction and expansion of healthcare facilities, based on the state's determination of need for additional or expanded healthcare facilities or services. Certain states in which we operate facilities require a certificate of need for the purchase, construction or expansion of hospital facilities, capital expenditures exceeding a prescribed amount, changes in bed capacity or services, or for other hospital-related activities. We may not be able to obtain certificates of need required for expansion activities or to effectively compete with competing healthcare providers in the future. In addition, all of the states in which we operate facilities require hospitals, other healthcare facilities, and most healthcare providers to maintain one or more licenses. If we fail to obtain any required certificate of need or license, our ability to operate or expand operations in those states could be impaired.

In the states in which we operate that do not require certificates of need for the purchase, construction and expansion of hospital facilities, competing healthcare facilities face lower regulatory barriers to entry and expansion. If competing healthcare entities are able to purchase, construct or expand healthcare facilities without the need for regulatory approval, we may face decreased market share and revenues in those markets.

The implementation of participation and quality measurement requirements under the MACRA's Merit-Based Incentive Payment System may affect our revenues.

Under MACRA, CMS updates payment rates for physician services based on inflation, and implements the QPP that rewards value and outcomes through participation in MIPS or an APM program. Beginning in 2017, MIPS started measuring provider performance under four categories: quality, improvement activities, promoting interoperability and cost, and annually establishes a point threshold for each category and overall performance. In 2019, MIPS began rewarding or penalizing providers based on performance reported in CY 2017 and subsequent years. The MIPS adjustment has a more significant impact on claims' payment than the annual inflationary update to the Medicare PFS.

Although CMS estimates that less than half of all clinicians, which includes physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists, who bill Medicare Part B are eligible for MIPS, physicians are required to participate unless they are participants of an APM, are newly enrolled in Medicare, or see a low volume of Medicare patients (i.e., no more than 200 patients in a calendar year or $90,000 in charges for professional services). MIPS eligible clinicians are subject to a payment adjustment of plus or minus 4% in CY 2019 (based on CY 2017 performance) with the payment adjustment increasing each year until it reaches plus or minus 9% in CY 2022 and beyond. MIPS eligible clinicians with exceptional performance may receive up to 10% bonus payment. However, for CY 2019, CMS projects that only 1.5% of participating MIPS eligible clinicians will receive a bonus, with this amount only increasing to 3.6% of MIPS eligible providers in CY 2021 (based on 2019 performance). Providers participating in an APM may be eligible for more advantageous adjustments under MIPS (or avoid any negative adjustment) and receive a 5% bonus. At this time, we have limited participation in APMs.

If an eligible clinician has not been satisfactorily participating in MIPS, his or her claims for Medicare Part B services are likely to be subject to negative payment adjustments in CY 2019 (which is based on 2017 performance), CY 2020 (which is based on CY 2018 performance) and CY 2021 (which will be based on CY 2019 performance). For participating eligible clinicians that meet or exceed the MIPS threshold or APM requirements, claims for payment are likely to be subject to positive adjustments as well as a share of an additional pool of bonus payments. At this time, and as CMS continues to modify MIPS payment policies, it is unclear how MIPS will impact our overall physician payments under the Medicare program. If we have not timely and effectively implemented policies and procedures, quality programs and appropriate clinician contracting to ensure compliance with MACRA and other QPP requirements, we would experience a negative effect on future revenues related to Medicare Part B claims.

MACRA requires that CMS publish each eligible clinician's MIPS score and performance category scores on its Physician Compare website. CMS has stated that it will report scores based on CY 2017 performance in early 2019. Publishing of MIPS scores could have an adverse reputational effect on us if our employed physicians have low scores or scores that are lower than those of the other clinicians in the relevant communities.

If current or future laws or regulations force us or cause us to restructure our arrangements with physicians and other providers, we may incur additional costs, lose contracts and suffer a reduction in net revenue under existing contracts, and we may need to refinance our debt or obtain consent from our lenders.

A number of laws bear on our relationships with our physicians and other providers. There is a risk that state authorities in some jurisdictions may find that our contractual relationships with our physicians violate laws prohibiting the corporate practice of medicine and fee-splitting. These laws generally prohibit the practice of medicine by lay entities or persons and are intended to prevent unlicensed persons or entities from interfering with or inappropriately influencing the physician's professional judgment. They may also prevent the sharing of professional services income with non-professional or business interests. In states that have enacted corporate practice of medicine and fee-splitting prohibitions, we believe that we have structured our physician contracts in an effort to remain compliant with such laws. A regulatory agency, however, could still make a determination that our arrangements constitute a corporate practice of medicine or fee splitting violation. A review or action by regulatory authorities or the courts could force us to terminate or modify our contractual relationships with physicians and affiliated medical groups or revise them in a manner that could be materially adverse to our business.

In addition, we have also entered into a number of joint venture arrangements with physicians and other providers (e.g., hospitals and hospital operators) that are subject to state and federal fraud and abuse laws, including the Anti-kickback Statute and False Claims Act. See "We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may reduce our revenues and profitability." To the extent applicable, regulatory agencies may view these transactions as prohibited arrangements that must be restructured, or discontinued, or for which we could be subject to other significant penalties, including debarment, suspension or exclusion from state and federal government healthcare programs. Although compliance programs can mitigate the risk of investigation and prosecution for violations of these laws, the risks cannot be entirely eliminated. Any action against us for violation of these laws, even if we successfully defend against it, could cause us to incur significant legal expenses and loss of revenue from those joint ventures and divert our management's attention from the operation of our business.

We are dependent on our executive management team and the loss of the services of one or more of our executive management team could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our executive management team. In addition, we depend on the ability of our executive officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our executive management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our executive management team, we could experience a significant disruption in our operations and failure of the affected facilities to adhere to their respective business plans.

Difficulties with major expansion projects may involve delays and significant capital expenditures that could have an adverse impact on our operations and liquidity.

We may decide to construct major expansion projects to existing facilities or new facilities, including replacement facilities, in order to achieve our growth objectives. Our ability to complete new expansion projects on budget and on schedule would depend on a number of factors, including, but not limited to:

- our ability to control construction costs;
- adverse weather conditions;
- shortages of labor or materials;
- our ability to obtain necessary licensing and other required governmental authorizations; and
- other unforeseen problems and delays.

As a result of these and other factors, we cannot assure you that if we decide to pursue major expansion projects we will not experience greater construction or other expansion or replacement costs than originally planned in connection with such expansion or replacement projects. Additionally, we cannot assure you that such expansion or replacement projects will be completed in a timely manner. Any delays or other difficulties in our ability to complete new expansion or replacement projects on budget and on schedule could have a material adverse effect on our results of operations and liquidity.

Under the A&R Master Lease (defined below) that governs certain of our facilities, a default with respect to one facility could cause a default under all of the facilities subject to the A&R Master Lease, which would have a material adverse effect on our business, results of operations and financial condition.

If there is a default under that certain Amended and Restated Master Lease Agreement (the "***A&R Master Lease***") with MPT Camaro OpCo, LLC, a Delaware limited liability company and wholly-owned subsidiary of Medical Properties Trust, Inc. ("***MPT***"), a Maryland corporation operating as a real estate investment trust, even if such default relates to one facility, it may terminate the A&R Master Lease in its entirety with respect to all of the facilities governed by the A&R Master Lease.

Under the A&R Master Lease, we are subject to financial covenants based on certain fixed charges, and the failure to meet such covenants results in an event of default. Other events that could trigger a default under the A&R Master Lease if not cured within the time periods required by the A&R Master Lease include, without limitation, (i) failure to pay rent or other amounts due under the lease, (ii) failure to comply with the non-financial covenants under the lease, (iii) the bankruptcy of any facility lessee under the A&R Master Lease or guarantor under a Second Amended and Restated Guaranty, (iv) termination of any licenses necessary for operation of a facility or required for certification under Medicare or Medicaid, (v) a change of control (as defined in the A&R Master Lease) in violation of the A&R Master Lease and (vi) a default under any material documents between any lessee of the facilities and any lessor of any facility. The A&R Master Lease contains cross-default provisions so that a default with respect to one of our facilities may cause a default under the entire A&R Master Lease. Accordingly, a default under the A&R Master Lease that results in a termination of the A&R Master Lease would cause us to lose the ability to operate all of the facilities subject to the A&R Master Lease and to incur substantial costs in restoring the premises, which would have a material adverse effect on our business, results of operations and financial condition.

If the A&R Master Lease is terminated prior to its expiration because of a default and the applicable affiliate of MPT, as lessor, exercises its rights thereunder, in addition to losing the ability to operate our facilities, we may be liable for (i) damages and incur charges such as continued lease payments through the end of the lease term (or such shorter period as proscribed in the A&R Master Lease or by law) and (ii) maintenance costs for the leased property. Upon termination of the A&R Master Lease, we are obligated to restore the premises to its original condition and repair all damage caused by the installation or removal of our personal property, ordinary wear and tear excepted. We also have restoration obligations with respect to certain casualty and condemnation events. In addition, upon termination of the A&R Master Lease, the lessor has the option to purchase all of our personal property at fair market value.

Because the land used by many of the facilities we operate are subject to ground leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises.

The rights to use the land at many of our facilities are based upon long-term ground leases. Pursuant to the terms of these ground leases, we are required to pay all rent due and comply with all other lessee obligations. As of December 31, 2018, the remaining term of these ground leases (including renewal options) ranged from approximately 6 to 80 years. A pledge of our interest in some of these ground leases may also require the consent of the respective lessor and its lenders. As a result, we may not be able to sell, assign, transfer or convey our interest in certain facilities subject to such ground leases in the future absent consent of such third parties even if such transactions may be in our best interest. Most of the ground leases require that, upon the expiration or termination of the ground leases, we must surrender any improvements to the land to lessor. In addition, some of our ground leases include early termination provisions. We are typically responsible for all taxes, insurance, assessments and maintenance obligations under the ground leases. The ground leases also generally require the lessee to either reconstruct or restore the premises to its original condition following a casualty and to apply in a specified manner any proceeds received in connection therewith. In some leases the ground lessor has the option to purchase some or all of the assets owned by us and used in connection with the operation of the applicable facility. Accordingly, failure to comply with the terms of such leases, the invalidity of or default or termination under such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises, which could have a material adverse effect on our business, results of operations and financial condition.

If certain sale-leaseback transactions are not characterized as "operating leases" under GAAP, this could adversely affect our results of operations and our financial condition.

We have entered into sale-leaseback transactions in the past and may enter into similar sale-leaseback transactions for properties that we acquire in the future, including pursuant to that certain Strategic Agreement, dated as of March 21, 2016, with MPT Operating Partnership, L.P. ("***MPT Op***"), which grants MPT Op and its affiliates certain rights and options to provide future sale-leaseback funding or real estate loans for certain acquisitions of additional properties. Although we may intend, in some cases, for such leases to be accounted for as an "operating lease" pursuant to GAAP, depending on the terms of any specific transaction, our auditors might take the position that the leases should be accounted for as "financing obligations" under Accounting Standards Codification ("***ASC***") 840, "Leases" ("***ASC 840***"). In that event, this may materially affect assets and liabilities in our balance sheet and certain expenses in our income statement, which could have a material adverse effect on our results of operations and our financial condition.

Our debt agreements contain restrictions that will limit our flexibility in operating our business.

The ABL Agreement, the Term Loan Agreement and the Indentures contain, and any other existing or future indebtedness of ours would likely contain, a number of covenants that impose significant operating and financial restrictions on us, including restrictions on our and our subsidiaries ability to, among other things:

- incur additional debt, guarantee indebtedness or issue certain preferred shares;
- pay dividends on or make distributions in respect of, or repurchase or redeem, our capital stock or make other restricted payments;
- prepay, redeem or repurchase certain debt;
- make loans or certain investments;
- sell certain assets;
- create liens on certain assets;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates;
- alter the businesses we conduct;
- enter into agreements restricting our subsidiaries' ability to pay dividends; and
- designate our subsidiaries as unrestricted subsidiaries.

As a result of these covenants, we are limited in the manner in which we conduct our business, and we may be unable to engage in favorable business activities or finance future operations or capital needs.

In addition, the ABL Facility requires us to maintain a minimum fixed charge coverage ratio at any time when the average availability is less than the greater of $65.0 million and 10% of the lesser of the aggregate amount of revolving facility commitments and the borrowing base at such time. In that event, we must satisfy a minimum fixed charge ratio of 1.0 to 1.0. At December 31, 2018 we were in compliance with this financial maintenance covenant.

A failure to comply with the covenants under the ABL Facility, the Term Loan Facility, the Notes or any of our other future indebtedness could result in an event of default, which, if not cured or waived, could have a material adverse effect on our business, financial condition and results of operations. In the event of any such default, the lenders thereunder:

- will not be required to lend any additional amounts to us;
- could elect to declare all borrowings outstanding, together with accrued and unpaid interest and fees, to be due and payable and terminate all commitments to extend further credit;
- could require us to apply all of our available cash to repay these borrowings; or
- could effectively prevent us from making debt service payments on the Term Loan Facility and the Notes (due to a cash sweep feature under the ABL Facility).

Such actions by the lenders could cause cross defaults under our other indebtedness. If we were unable to repay those amounts, the lenders and holders under the ABL Facility, the Term Loan Facility and the Notes could proceed against the collateral granted to them to secure the ABL Facility, the Term Loan Facility or the Notes, respectively. If any of our outstanding indebtedness under the ABL Facility, the Term Loan Facility, the Notes or any of our other existing or future indebtedness were to be accelerated, there can be no assurance that our assets would be sufficient to repay such indebtedness in full.

Repayment of our debt is dependent on cash flow generated by our subsidiaries.

Repayment of our indebtedness, including the ABL Facility, the Term Loan Facility and the Notes, is dependent on the generation of cash flow by our subsidiaries and their ability to make such cash available to us, by dividend, debt repayment or otherwise. Unless they are guarantors of the indebtedness, our subsidiaries do not have any obligation to pay amounts due on such indebtedness or to make funds available for that purpose. Our subsidiaries may not be able to, or may not be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each subsidiary is a distinct legal entity and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries. While our debt agreements will limit the ability of our restricted subsidiaries to incur consensual restrictions on their ability to pay dividends or make other intercompany payments to us, these limitations are subject to certain qualifications and exceptions. In the event that we do not receive distributions from our subsidiaries, we may be unable to make required principal and interest payments on our indebtedness. In the event we require restructuring or refinancing, we cannot assure you that we will be able to restructure or refinance any of our debt on commercially reasonable terms or at all.

Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.

We and our subsidiaries may be able to incur substantial indebtedness in the future. Although the terms of the ABL Agreement, the Term Loan Agreement and the Indentures contain restrictions on our and our subsidiaries' ability to incur additional indebtedness, these restrictions are subject to a number of important qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. As of December 31, 2018, we would have had approximately $580.0 million available for additional borrowing under the ABL Facility (without giving effect to letters of credit), all of which would be secured. In addition to the Notes and our borrowings under the ABL Facility and the Term Loan Facility, the covenants under any other existing or future debt instruments could allow us to incur a significant amount of additional indebtedness and, subject to certain limitations, such additional indebtedness could be secured. The more leveraged we become, the more we, and in turn our security holders, will be exposed to certain risks described above under "—Our debt agreements contain restrictions that will limit our flexibility in operating our business."

Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. To manage this risk, we entered into an interest rate swap agreement on December 21, 2018 with Citibank, N.A. as counterparty (the "Interest Rate Swap"). The terms of the Interest Rate Swap require us to pay a fixed rate of 2.63% on a notional amount of $1,100.0 million and, in exchange, we receive one-month London Interbank Offered Rate ("***LIBOR***"). The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. We have not designated our Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging" ("***ASC 815***"). Therefore, all changes in the fair value of our Interest Rate Swap will be recognized through interest expense in our results of operations. Changes in the fair value of our Interest Rate Swap could result in a material effect on our consolidated results of operations and financial position; however, we do not anticipate that changes in the fair value of our Interest Rate Swap will have any impact on our cash flows.

Discontinuation, reform or replacement of LIBOR may adversely affect our results of operations.

The U.K. Financial Conduct Authority announced in 2017 that it intends to phase out LIBOR by the end of 2021. Changes to LIBOR or any other benchmark rate may impact credit markets. Borrowings under our Term Loan Facility and ABL Facility bear interest at rates based on LIBOR. The administrative agent for those facilities may approve a comparable or successor rate with respect to LIBOR or, if not feasible, another accommodation as reasonably determined by the agent. The replacement of LIBOR with a comparable or successor rate could cause the amount of interest payable on our Term Loan Facility and ABL Facility to be different than expected.

Additionally, the notional amount associated with our Interest Rate Swap is based on LIBOR. If LIBOR becomes unavailable, it is unclear how payments under our Interest Rate Swap would be calculated. Relevant industry groups are seeking to create a standard protocol addressing the expected discontinuation of LIBOR, but there can be no assurance that such a protocol will be developed or implemented with respect to our Interest Rate Swap.

Our ability to utilize our net operating loss carryforwards may be limited, and we may not be able to utilize our net operating loss carryforwards as a result of recent U.S. federal tax reform legislation.

As of December 31, 2018, we had net operating loss carryforwards ("***NOLs***") of approximately $342.4 million for federal income tax purposes, which expire at various dates between 2028 through 2037 for NOLs generated prior to 2018, and indefinite lives for NOLs generated in 2018 and future periods. Additionally, we had approximately $2.5 billion in state and local net operating loss carryforwards that expire at various dates between 2019 through 2038. To the extent available and not otherwise utilized, we intend to use any NOL carryforwards to reduce the applicable U.S. or state corporate income tax liability associated with our operations. However, our ability to utilize our NOL carryforwards is based on the extent to which we generate future taxable income and on prevailing corporate income tax rates, and we cannot provide any assurance as to when and to what extent we will generate sufficient future taxable income to realize our deferred tax assets, whether in whole or in part. Furthermore, the utilization of our NOL carryforwards may become subject to an annual limitation under Section 382 of the Code (and similar state provisions) in the event of certain cumulative changes in the ownership interest of significant shareholders in excess of 50 percent over a three-year period. This could limit the amount of NOL carryforwards that can be utilized annually to offset taxable income. The amount of the annual limitation is determined based on the value of a company immediately prior to the ownership change. Subsequent ownership changes may further affect the limitation in future years. For these reasons, our ability to utilize our NOLs may be limited.

Item 2. ***Properties.***

The table below presents certain information with respect to our hospital campuses as of December 31, 2018:

Facility Name	City	Licensed Beds	Ownership and Real Property Status
Alabama			
Andalusia Regional Hospital	Andalusia	88	Own
North Alabama Medical Center	Florence	358	Own
Shoals Hospital	Muscle Shoals	178	Own
Vaughan Regional Medical Center (a)	Selma	175	JV/Own
Arizona			
Canyon Vista Medical Center	Sierra Vista	100	Lease
Havasu Regional Medical Center (b)	Lake Havasu City	171	JV/Own
Valley View Medical Center	Fort Mohave	84	Own
Arkansas			
National Park Medical Center (c) (d)	Hot Springs	163	JV/Lease
Saline Memorial Hospital (a)	Benton	177	JV/Own
St. Mary's Regional Medical Center	Russellville	170	Own
Colorado			
Colorado Plains Medical Center	Fort Morgan	50	Lease
Georgia			
St. Francis Hospital	Columbus	376	Own
Idaho			
St. Joseph Regional Medical Center (e)	Lewiston	145	Lease
Indiana			
Clark Memorial Hospital (f)	Jeffersonville	236	JV/Own
Scott Memorial Hospital (f)	Scottsburg	25	JV/Own
Iowa			
Ottumwa Regional Health Center	Ottumwa	217	Own
Kansas			
Western Plains Medical Complex	Dodge City	99	Own
Kentucky			
Bluegrass Community Hospital	Versailles	25	Own
Bourbon Community Hospital	Paris	58	Own
Clark Regional Medical Center	Winchester	79	Own
Fleming County Hospital	Flemingsburg	52	Own
Georgetown Community Hospital	Georgetown	75	Own
Jackson Purchase Medical Center	Mayfield	107	Own
Lake Cumberland Regional Hospital	Somerset	295	Own
Logan Memorial Hospital	Russellville	75	Own
Meadowview Regional Medical Center	Maysville	100	Own
Spring View Hospital	Lebanon	75	Own
Louisiana			
Teche Regional Medical Center (g)	Morgan City	164	Lease
Michigan			
UP Health System - Bell	Ishpeming	25	Own
UP Health System - Marquette (h)	Marquette	307	JV/Own
UP Health System - Portage (a)	Hancock	96	JV/Own
Mississippi			
Bolivar Medical Center	Cleveland	199	Lease
Montana			
Community Medical Center	Missoula	151	Own
Nevada			
Northeastern Nevada Regional Hospital	Elko	75	Own
New Mexico			
Los Alamos Medical Center	Los Alamos	47	Own
Memorial Medical Center of Las Cruces	Las Cruces	199	Lease

Facility Name	City	Licensed Beds	Ownership and Real Property Status
North Carolina			
Central Carolina Hospital (h)	Sanford	137	JV/Own
Frye Regional Medical Center (h)	Hickory	355	JV/Lease
Harris Regional Hospital (h)	Sylva	86	JV/Own
Haywood Regional Medical Center (h)	Clyde	159	JV/Own
Maria Parham Medical Center (i)	Henderson	185	JV/Own
Person Memorial Hospital (h)	Roxboro	98	JV/Own
Rutherford Regional Medical Center (i)	Rutherfordton	143	JV/Own
Swain County Hospital (h)	Bryson City	48	JV/Own
Wilson Medical Center (i)	Wilson	384	JV/Own
Ohio			
Clinton Memorial Hospital	Wilmington	165	Own
Oklahoma			
Southwestern Medical Center	Lawton	107	Own
Southwestern Behavioral Health Center	Lawton	92	Own
Oregon			
Willamette Valley Medical Center (e)	McMinnville	60	Lease
Pennsylvania			
Conemaugh Memorial Medical Center (h)	Johnstown	537	JV/Own
Meyersdale Medical Center (h)	Meyersdale	20	JV/Own
Miners Medical Center (h)	Hastings	30	JV/Own
Nason Medical Center	Roaring Spring	45	Own
South Carolina			
Carolina Pines Regional Medical Center (c) (e)	Hartsville	116	JV/Lease
KershawHealth (e)	Camden	121	Lease
Providence Hospital - Downtown	Columbia	258	Own
Providence Hospital - Northeast	Columbia	74	Own
Tennessee			
Livingston Regional Hospital	Livingston	114	Own
Riverview Regional Medical Center	Carthage	35	Own
Southern Tennessee Regional Health System - Lawrenceburg	Lawrenceburg	99	Own
Southern Tennessee Regional Health System - Pulaski	Pulaski	95	Own
Southern Tennessee Regional Health System - Sewanee	Sewanee	41	Own
Southern Tennessee Regional Health System - Winchester	Winchester	157	Own
Starr Regional Medical Center - Athens	Athens	118	Own
Starr Regional Medical Center - Etowah	Etowah	160	Own
Sumner Regional Medical Center	Gallatin	155	Own
Trousdale Medical Center	Hartsville	25	Own
Texas			
Ennis Regional Medical Center	Ennis	60	Lease
Palestine Regional Medical Center	Palestine	156	Own
Paris Regional Medical Center	Paris	154	Own
Parkview Regional Hospital	Mexia	58	Lease
Utah			
Ashley Regional Medical Center	Vernal	39	Own
Castleview Hospital	Price	39	Own
Virginia			
Clinch Valley Medical Center	Richlands	175	Own
Fauquier Health	Warrenton	210	Own
Sovah Health - Danville	Danville	250	Own
Sovah Health - Martinsville	Martinsville	220	Own
Twin County Regional Hospital (i)	Galax	141	JV/Own
Wythe County Community Hospital	Wytheville	100	Lease

Facility Name	City	Licensed Beds	Ownership and Real Property Status
Washington			
Capital Medical Center (d) (j)	Olympia	107	JV/Lease
Lourdes Health - Medical Center (e)	Pasco	95	Lease
Lourdes Health - Counseling Center (e)	Pasco	32	Lease
Trios Health - Southridge Hospital (k) (l)	Kennewick	74	JV/Lease
Trios Health - Women's and Children's Hospital (k) (l)	Kennewick	37	JV/Lease
West Virginia			
Logan Regional Medical Center	Logan	140	Own
Raleigh General Hospital	Beckley	300	Own
Wisconsin			
Watertown Regional Medical Center (a)	Watertown	95	JV/Own
Wyoming			
SageWest Healthcare - Lander	Lander	89	Own
SageWest Healthcare - Riverton	Riverton	70	Own
		11,876	

(a) This facility is owned and operated by a joint venture between us and an unrelated third party. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(b) This facility is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest. The real property on which this facility is located is owned by the LifePoint member and leased to the joint venture.
(c) This facility is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest.
(d) This facility is subject to a sale-leaseback arrangement with MPT.
(e) This facility is subject to the A&R Master Lease.
(f) This facility is owned and operated by the Regional Health Network of Kentucky and Southern Indiana ("***RHN***"), a joint venture between us and Norton. A wholly-owned LifePoint affiliate owns a controlling interest in RHN.
(g) Refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report for information regarding ongoing negotiations to divest this facility.
(h) This facility is owned and operated by Duke LifePoint Healthcare. A wholly-owned LifePoint affiliate owns a controlling interest in Duke LifePoint Healthcare.
(i) This facility is owned and operated by a joint venture between a local not-for-profit entity and Duke LifePoint Healthcare.
(j) This facility is owned and operated by a joint venture among us, physicians and a joint venture between us and University of Washington. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(k) This facility is owned and operated by a joint venture between us and University of Washington. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(l) This facility is subject to a sale-leaseback arrangement with a third-party for a hospital building whose rent is contingent on the financial performance of the hospital and a sale-leaseback arrangement for a medical office building.

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

Item 3. ***Legal Proceedings.***

Healthcare facilities are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, medical malpractice, breach of contracts, wrongful restriction of or interference with physicians' staff privileges and employment related claims. In certain of these actions, plaintiffs request payment for damages, including punitive damages, that may not be covered by insurance. We are currently not a party to any pending proceedings, which, in management's opinion, would have a material adverse effect on our business, financial condition or results of operations.

For more information about legal proceedings and general liability claims, refer to Note 14 to our accompanying consolidated financial statements included elsewhere in this Report.

Item 4. ***Mine Safety Disclosures*****.**

Not applicable.

PART II

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

All of our equity securities are held by Holdings, whose indirect parent is DSB Parent. As of December 31, 2018, our Sponsor beneficially owned approximately 99.5% of the capital units of LifePoint with the remaining approximate 0.5% owned by current or former directors, members of management, employees and consultants of the Company. Because our equity securities are privately held, there is no established public trading market for our equity securities.

Equity Compensation Plan Information

Refer to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by DSB Parent to our employees and directors.

Recent Sales of Unregistered Securities

There have been no recent sales of unregistered equity securities of the Company within the period covered by this Report.

Item 6. ***Selected Financial Data.***

Set forth below is the selected historical consolidated financial data of the Company for the periods and as of the dates indicated.

On December 3, 2015, the Apollo/RegionalCare Acquisition was completed. For periods prior to the Apollo/RegionalCare Acquisition, our operations are referred to as the "***Predecessor***". For periods after the Apollo/RegionalCare Acquisition, our operations are referred to as the "***Successor***". Additionally, on April 29, 2016, the RegionalCare/Capella Merger was completed, which, for accounting purposes, became effective on May 1, 2016. Furthermore, on November 16, 2018, the LifePoint/RCCH Merger was completed, which, for accounting purposes became effective on November 17, 2018.

The Apollo/RegionalCare Acquisition, RegionalCare/Capella Merger and LifePoint/RCCH Merger were all significant transactions which affect the comparability of the selected financial data. The following information should be read in conjunction with "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations," as well as our accompanying consolidated financial statements included elsewhere in this Report.

	Successor				Predecessor	
$ in millions	Year Ended December 31, 2018	Year Ended December 31, 2017	Year Ended December 31, 2016	Period From 12/4/2015 through 12/31/2015	Period From 1/1/2015 through 12/3/2015	Year Ended December 31, 2014
Statements of Operations Data:						
Revenues	$ 2,778.1	$ 1,872.8	$ 1,502.7	$ 64.0	$ 770.1	$ 642.5
Net (loss) income attributable to LifePoint Health, Inc.	(293.7)	(45.4)	(44.0)	1.3	(59.3)	(81.8)
Balance Sheet Data (as of end of year):						
Cash and cash equivalents	$ 58.9	$ 16.9	$ 30.4	$ 8.0	$ -	$ 24.7
Working capital	570.3	121.2	199.9	72.5	-	56.2
Total assets	8,991.7	2,057.5	2,060.2	1,043.6	-	778.1
Total debt, excluding unamortized debt issuance costs	6,705.2	1,466.9	1,379.3	570.9	-	507.8
Total LifePoint Health, Inc. stockholders' equity	923.4	220.0	305.1	301.8	-	(259.4)
Statements of Cash Flows Data:						
Net cash (used in) provided by operating activities	$ (73.0)	$ 105.6	$ 54.8	$ (14.1)	$ 35.7	$ 39.1
Purchases of property and equipment	(319.7)	(145.1)	(67.5)	(3.6)	(31.2)	(24.5)
Net cash used in investing activities	(5,645.7)	(151.1)	(715.6)	(3.5)	(88.4)	(15.0)
Net cash provided by (used in) financing activities	5,760.7	32.0	683.2	6.4	47.3	(3.8)

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

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

The following discussion and analysis of our financial condition and results of operations covers periods prior to the consummation of the LifePoint/RCCH Merger, which was effective November 16, 2018, and for accounting purposes, became effective November 17, 2018, and the RegionalCare/Capella Merger, which was effective April 29, 2016, and for accounting purposes, became effective May 1, 2016. In this management's discussion and analysis, (i) the results of operations from January 1, 2018 to November 16, 2018 are those of RCCH only, (ii) the results of operations from November 17, 2018 to December 31, 2018 are those of Legacy LifePoint and RCCH on a combined basis, (iii) the results of operations for the year ended December 31, 2017 are those of RCCH only, (iv) the results of operations from January 1, 2016 to April 30, 2016 are those of RegionalCare only and (v) the results of operations for the period from May 1, 2016 to December 31, 2016 are those of RegionalCare and Capella on a combined basis. Additionally, in this management's discussion and analysis under "Supplemental Results of Operations for Legacy LifePoint and RCCH on a Combined Basis for the Years Ended December 31, 2018 and 2017," we are providing results of operations on a combined basis for the years ended December 31, 2018 and 2017 as if the LifePoint/RCCH Merger had occurred on January 1 for each of the years then ended. GAAP does not allow for such a combination of results of operations; however, we believe the combined results provide information that is useful in evaluating our financial performance.

Overview

We own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. As of December 31, 2018, we operated 89 hospital campuses in 30 states throughout the U.S., having a total of 11,876 licensed beds. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a network of hospitals and outpatient facilities. We generated $2,778.1 million, $1,872.8 million and $1,502.7 million in revenues during the years ended December 31, 2018, 2017 and 2016, respectively. In 2018, we derived approximately 50.7% of our revenues from the Medicare and Medicaid programs, collectively. Payments made to our facilities pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payers, together with certain limited services provided to Medicare recipients, to generate an operating profit. The healthcare industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payers. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our facilities.

Recent Developments

LifePoint/RCCH Merger

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. Our consolidated results of operations for the year ended December 31, 2018 include the results of Legacy LifePoint beginning on November 17, 2018. For more information about the LifePoint/RCCH Merger, refer to "Part 1, Item 1. Business—Our Background" and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Acquisitions & Divestitures

The following table summarizes our hospital acquisitions and divestitures completed during the years ended December 31, 2018, 2017 and 2016:

Facility	Location	Effective Date
Acquisitions:		
Lourdes Health ("***Lourdes***") (two hospital campuses)	Pasco, Washington	September 1, 2018
Trios Health ("***Trios***") (two hospital campuses) (JV)	Kennewick, Washington	August 4, 2018
St. Joseph Regional Medical Center ("***St. Joseph***")	Lewiston, Idaho	May 1, 2017
Saline Memorial Hospital ("***Saline***") (JV)	Benton, Arkansas	July 1, 2016
Divestitures:		
Sharon Hospital ("***Sharon***")	Sharon, Connecticut	August 1, 2017
EaStar Health System ("***EaStar***")	Muskogee, Oklahoma	April 1, 2017

Additionally, effective April 1, 2018, we acquired Pacific Medical Data Solutions ("***PMDS***"). PMDS is a healthcare technology and software services company that provides revenue cycle, billing automation and software solutions to multi-specialty physician groups, ambulatory surgery centers and urgent care clinics.

Lastly, in August 2018, Legacy LifePoint and certain of its subsidiaries entered into a proposed settlement agreement with The Hospital Service District No. 2 of the Parish of St. Mary ("***HSD***"), a political subdivision of the state of Louisiana, outlining the terms of a definitive settlement agreement to terminate our lease of Teche Regional Medical Center ("***Teche***") located in Morgan City, Louisiana. The proposed settlement agreement provides, among other things, that we will convey to HSD, or its designee, all assets of Teche in accordance with the existing lease agreement, and we will no longer operate Teche upon completion of the transaction. We anticipate this transaction to be completed during the second quarter of 2019, subject to the terms and conditions of a definitive settlement agreement.

For additional information regarding our recent acquisitions and divestitures, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Health Care Reform Efforts

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, creating the individual mandate to require most Americans to obtain health insurance, providing additional funding for Medicaid in states that choose to expand their programs, reducing IPPS, OPPS and Medicare and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria and instituting certain private health insurance reforms. The Affordable Care Act has, however, been subject to a number of legislative and regulatory changes and court challenges and its future is uncertain.

The net effect of the Affordable Care Act, as currently adopted, on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access and quality. Additional variables related to the Affordable Care Act impacting our business will be how, if at all, Congress repeals, replaces, or otherwise modifies the Affordable Care Act, whether the Affordable Care Act is found to be unconstitutional after the repeal of the penalties associated with the individual mandate, and how states, providers, insurance companies, employers and other market participants respond during this period of uncertainty. As a result, we are unable to predict the effect on our business, financial condition or results of operations, the availability of adequate insurance coverage for patients seeking healthcare at our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions potentially impacted by the repeal of the penalties associated with the individual mandate, the cessation of the cost sharing reduction payments, and the possible repeal, replacement or modification of the Affordable Care Act.

Refer to "Part I, Item 1. Business—Health Care Reform" included elsewhere in this Report for more information about the Affordable Care Act.

Competitive and Structural Environment

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

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

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

In addition to competitive concerns, many of our communities are experiencing slow growth, and in some cases, population losses. We believe this trend has occurred mainly as a result of recent challenging economic conditions because the economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves. In addition, other economic factors, including, potentially, self-rationing of healthcare services, have made it more difficult to increase the number of patients who seek care at many of our facilities.

Regulatory Environment

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

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

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

Revenue Sources

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

Medicare and Medicaid Reimbursement

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

In addition, Medicare payment methodologies have been, and are expected to continue to be, revised significantly based on cost containment and policy considerations.

For more information about Medicare and Medicaid reimbursement matters, refer to "Part I, Item 1. Business—Sources of Revenue" included elsewhere in this Report.

Physician Services

We employ an increasing number of physicians in our hospital markets. Medicare pays us for services provided by our employed physicians under the PFS system. Under the PFS, CMS has assigned a national RVU to most medical services and procedures that reflects the various resources required by a physician to provide the services relative to all other services. Historically, the conversion factor that is used to determine physician payments for each RVU had been updated by the SGR that is intended to account for inflation and targeted growth in Medicare expenditures. The SGR has generally resulted in significant reductions to payments made under the PFS, and Congress has passed multiple legislative acts delaying application of the SGR to the PFS. For more information, refer to "Part I, Item 1. Business—Sources of Revenue—Physician Services" included elsewhere in this Report.

HMOs, PPOs and Other Private Insurers

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

Self-pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities have experienced in recent years, including increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. Additionally, we cannot predict the impact of the cessation of cost sharing reduction payments, the repeal of the individual mandate or any other modifications to the Affordable Care Act that may be adopted.

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

Results of Operations

Certain Definitions

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

Adjusted EBITDA. EBITDA adjusted to exclude unusual items and other adjustments required or permitted in calculating debt covenant compliance under the Indentures governing the Notes and/or the Term Loan Facility and ABL Facility. We believe that this inclusion of supplementary adjustments to EBITDA applied in presenting Adjusted EBITDA are appropriate to provide additional information to investors about the impact of certain non-cash items, unusual items that we do not expect to continue at the same level in future and other items.

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

Combined. Combined information for the years ended December 31, 2018 and 2017 includes the results of Legacy LifePoint and RCCH as if the LifePoint/RCCH Merger had occurred on January 1 for each of the years then ended.

Consolidated. Consolidated information includes the results of all hospital operations and corporate overhead costs, including the results of our recent acquisitions and divestitures, and the results of Legacy LifePoint beginning on November 17, 2018.

EBITDA. Earnings before interest, taxes, depreciation and amortization.

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

Outpatient factor. The sum of gross inpatient revenue and gross outpatient revenue divided by gross inpatient revenue.

Same-hospital combined. Same-hospital combined information includes the results of the same 84 hospital campuses operated during the entire years ended December 31, 2018 and 2017 on a combined basis as if the LifePoint/RCCH Merger had occurred on January 1 for each of the years then ended. Same-hospital combined information excludes the results of our recent acquisitions and divestitures completed in 2018 and 2017.

Summary

The following table summarizes our results of operations for the years ended December 31, 2018, 2017 and 2016 (in millions):

	Years Ended December 31,					
	2018		2017		2016	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Revenues before provision for doubtful accounts	$ 3,136.0	112.9 %	$ 2,079.7	111.0 %	$ 1,667.9	111.0 %
Provision for doubtful accounts	357.9	12.9	206.9	11.0	165.2	11.0
Revenues	2,778.1	100.0	1,872.8	100.0	1,502.7	100.0
Salaries and benefits	1,329.4	47.9	874.3	46.7	694.4	46.2
Supplies	484.5	17.4	323.2	17.3	261.3	17.4
Other operating expenses, net	709.2	25.6	469.4	25.0	377.1	25.1
Depreciation and amortization	129.0	4.6	80.6	4.3	57.6	3.8
Interest expense, net	186.1	6.7	126.1	6.7	101.3	6.7
Merger and acquisition costs	141.5	5.1	7.8	0.4	25.1	1.7
Impairments of goodwill and long-lived assets	78.4	2.8	14.1	0.8	11.6	0.8
Other non-operating losses, net	7.8	0.3	16.7	0.9	11.6	0.8
	3,065.9	110.4	1,912.2	102.1	1,540.0	102.5
Loss before income taxes	(287.8)	(10.4)	(39.4)	(2.1)	(37.3)	(2.5)
Provision for (benefit from) income taxes	0.2	-	(1.3)	(0.1)	4.0	0.2
Net loss	(288.0)	(10.4)	(38.1)	(2.0)	(41.3)	(2.7)
Less: Net income attributable to noncontrolling and redeemable noncontrolling interests	(5.7)	(0.2)	(7.3)	(0.4)	(2.7)	(0.2)
Net loss attributable to LifePoint Health, Inc.	$ (293.7)	(10.6)%	$ (45.4)	(2.4)%	$ (44.0)	(2.9)%

For the Years Ended December 31, 2018 and 2017

Revenues

The following table summarizes our key revenue metrics on a consolidated basis for the years ended December 31, 2018 and 2017:

	Years Ended December 31,			
	2018	2017	Increase	% Increase
Consolidated:				
Number of hospital campuses at end of period	89	17	72	423.5 %
Revenues (in millions)	$ 2,778.1	$ 1,872.8	$ 905.3	48.3 %
Admissions	118,366	84,196	34,170	40.6 %
Equivalent admissions	287,619	199,563	88,056	44.1 %
Revenues per equivalent admission	$ 9,659	$ 9,385	$ 274	2.9 %
Inpatient surgeries	33,360	24,102	9,258	38.4 %
Outpatient surgeries	109,759	77,701	32,058	41.3 %
Total surgeries	143,119	101,803	41,316	40.6 %
Emergency department visits	616,150	445,257	170,893	38.4 %

For the year ended December 31, 2018, our consolidated revenues increased $905.3 million, or 48.3%, to $2,778.1 million compared to $1,872.8 million for the prior year. The increase in our revenues was primarily a result of the LifePoint/RCCH Merger and our 2018 and 2017 acquisitions, net of the impact of our 2017 divestitures. Refer to *"Supplemental Results of Operations for Legacy LifePoint and RCCH on a Combined Basis for the Years Ended December 31, 2018 and 2017"* included elsewhere in this Report for a more comparable analysis of our revenues on a combined basis as if the LifePoint/RCCH Merger had occurred on January 1 for each of the years ended December 31, 2018 and 2017.

During the year ended December 31, 2018, we recorded a decrease to revenues of $17.0 million as a result of a change in our accounting estimate of the collectability of accounts receivable. During the year ended December 31, 2018, we identified additional information which indicated that our current collection estimates might be different from our historical collection estimates. We utilized this new information to further refine our estimation procedures to more precisely estimate the collectability of accounts receivable. The change in our estimation procedures of the collectability of our accounts receivable is considered a change in accounting estimate in accordance with ASC 250, "Accounting Changes and Error Corrections" ("***ASC 250***").

The following table summarizes our revenues by payer as approximate percentages of our net patient revenues before the provision for doubtful accounts for the years ended December 31, 2018 and 2017:

	Years Ended December 31,	
	2018	**2017**
Medicare	37.6 %	40.4 %
Medicaid	13.1	12.2
HMOs, PPOs and other private insurers	41.3	40.7
Self-pay	8.0	6.7
	100.0 %	100.0 %

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

Salaries and Benefits

For the year ended December 31, 2018, our consolidated salaries and benefits expense was $1,329.4 million, or 47.9% of revenues, compared to $874.3 million, or 46.7% of revenues, for the prior year. The increase in our salaries and benefits expense was primarily a result of the LifePoint/RCCH Merger and our 2018 and 2017 acquisitions, net of the impact of our 2017 divestitures.

Supplies

For the year ended December 31, 2018, our consolidated supplies expense was $484.5 million, or 17.4% of revenues, compared to $323.2 million, or 17.3% of revenues, for the prior year. The increase in our supplies expense was primarily a result of the LifePoint/RCCH Merger and our 2018 and 2017 acquisitions, net of the impact of our 2017 divestitures.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the year ended December 31, 2018, our consolidated other operating expenses were $709.2 million, or 25.6% of revenues, compared to $469.4 million, or 25.0% of revenues, for the prior year. The increase in our other operating expenses was primarily a result of the LifePoint/RCCH Merger and our 2018 and 2017 acquisitions, net of the impact of our 2017 divestitures.

Depreciation and Amortization

For the year ended December 31, 2018, our consolidated depreciation and amortization expense was $129.0 million, or 4.6% of revenues, compared to $80.6 million, or 4.3% of revenues, for the prior year. The increase in our depreciation and amortization expense was primarily a result of the LifePoint/RCCH Merger and our 2018 and 2017 acquisitions, net of the impact of our 2017 divestitures.

Interest Expense, Net

For the year ended December 31, 2018, our consolidated interest expense was $186.1 million, or 6.7% of revenues, compared to $126.1 million, or 6.7% of revenues, for the prior year. The increase in our interest expense was primarily a result of the debt financing activities in connection with the LifePoint/RCCH Merger. For a further discussion of our debt and corresponding interest rates, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Merger and Acquisition Costs

For the year ended December 31, 2018, we recognized merger and acquisition costs of $141.5 million, primarily related to legal and transaction advisory services as well as employee severance and retention costs in connection with the LifePoint/RCCH Merger, in addition to our 2018 acquisitions. For the year ended December 31, 2017, we recognized acquisition costs of $7.8 million, primarily related to our acquisition of St. Joseph.

Impairment of Goodwill and Long-lived Assets

For the year ended December 31, 2018, we recognized impairment charges in the aggregate of $78.4 million, comprised of $53.9 million of goodwill impairments related to three of our facilities, and $24.5 million of long-lived asset impairments primarily related to the write-down of certain assets to their estimated fair values at one of our facilities. For the year ended December 31, 2017, we recognized a goodwill impairment charge of $14.1 million related to one of our facilities.

Other Non-Operating Losses, Net

For the year ended December 31, 2018, our net other non-operating losses were primarily related to the write-off of $8.2 million of previously capitalized debt issuance costs in connection with the termination of our Prior ABL Facility and Prior Term Facility, partially offset by other miscellaneous gains and losses. For the year ended December 31, 2017, our other non-operating losses were comprised of a $7.3 million loss on our divestitures of EaStar and Sharon, a $4.3 million loss on the refinancing of long-term debt, a $3.9 million loss on the conversion of a financing lease to an operating lease at the completion of a construction project to satisfy sale-leaseback accounting, and $1.2 million of contingent consideration expense.

Income Taxes

For the year ended December 31, 2018, we recorded a provision for income taxes of $0.2 million, primarily related to the non-deductibility of certain merger and acquisition costs and a $38.1 million increase in the valuation allowance against our deferred tax assets. For the year ended December 31, 2017, we recognized a benefit from income taxes of $1.3 million, primarily related to the reduction in the net deferred tax liability position as a result of the Tax Act that was signed into law on December 22, 2017. For a further discussion of our income taxes, refer to Note 6 to our accompanying consolidated financial statements included elsewhere in this Report.

For the Years Ended December 31, 2017 and 2016

Revenues

The following table summarizes our key revenue metrics on a consolidated basis for the years ended December 31, 2017 and 2016:

	Years Ended December 31,		Increase	% Increase
	2017	2016	(Decrease)	(Decrease)
Consolidated:				
Number of hospital campuses at end of period	17	18	(1)	(5.6)%
Revenues (in millions)	$ 1,872.8	$ 1,502.7	$ 370.1	24.6 %
Admissions	84,196	72,775	11,421	15.7 %
Equivalent admissions	199,563	168,907	30,656	18.1 %
Revenues per equivalent admission	$ 9,385	$ 8,897	$ 488	5.5 %
Inpatient surgeries	24,102	20,246	3,856	19.0 %
Outpatient surgeries	77,701	64,352	13,349	20.7 %
Total surgeries	101,803	84,598	17,205	20.3 %
Emergency department visits	445,257	366,674	78,583	21.4 %

For the year ended December 31, 2017, our consolidated revenues increased $370.1 million, or 24.6%, to $1,872.8 million compared to $1,502.7 million for the prior year. The increase in our revenues was primarily a result of the RegionalCare/Capella Merger and our 2017 and 2016 acquisitions, net of the impact of our 2017 divestitures.

The following table summarizes our revenues by payer as approximate percentages of our net patient revenues before the provision for doubtful accounts for the years ended December 31, 2017 and 2016:

	Years Ended December 31,	
	2017	2016
Medicare	40.4 %	36.4 %
Medicaid	12.2	12.8
HMOs, PPOs and other private insurers	40.7	42.5
Self-pay	6.7	8.3
	100.0 %	100.0 %

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

Salaries and Benefits

For the year ended December 31, 2017, our consolidated salaries and benefits expense was $874.3 million, or 46.7% of revenues, compared to $694.4 million, or 46.2% of revenues, for the prior year. The increase in our salaries and benefits expense was primarily a result of the RegionalCare/Capella Merger and our 2017 and 2016 acquisitions, net of the impact of our 2017 divestitures.

Supplies

For the year ended December 31, 2017, our consolidated supplies expense was $323.2 million, or 17.3% of revenues, compared to $261.3 million, or 17.4% of revenues, for the prior year. The increase in our supplies expense was primarily a result of the RegionalCare/Capella Merger and our 2017 and 2016 acquisitions, net of the impact of our 2017 divestitures.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the year ended December 31, 2017, our consolidated other operating expenses were $469.4 million, or 25.0% of revenues, compared to $377.1 million, or 25.1% of revenues, for the prior year. The increase in our other operating expenses expense was primarily a result of the RegionalCare/Capella Merger and our 2017 and 2016 acquisitions, net of the impact of our 2017 divestitures.

Depreciation and Amortization

For the year ended December 31, 2017, our consolidated depreciation and amortization expense was $80.6 million, or 4.3% of revenues, compared to $57.6 million, or 3.8% of revenues, for the prior year. The increase in our depreciation and amortization expense was primarily a result of the RegionalCare/Capella Merger and our 2017 and 2016 acquisitions, net of the impact of our 2017 divestitures.

Interest Expense, Net

For the year ended December 31, 2017, our consolidated interest expense was $126.1 million, or 6.7% of revenues, compared to $101.3 million, or 6.7% of revenues, for the prior year. The increase in our interest expense was primarily a result of the debt financing activities in connection with the RegionalCare/Capella Merger. For a further discussion of our debt and corresponding interest rates, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Merger and Acquisition Costs

For the year ended December 31, 2017, we recognized acquisition costs of $7.8 million, primarily related to our acquisition of St. Joseph. For the year ended December 31, 2016, we recognized merger and acquisition costs of $25.1 million, primarily related to legal and transaction advisory services in connection with the RegionalCare/Capella Merger and our acquisition of Saline.

Impairment of Goodwill and Long-lived Assets

For the year ended December 31, 2017, we recognized a goodwill impairment charge of $14.1 million related to one of our facilities. For the year ended December 31, 2016, we recognized long-lived asset impairments of $11.6 million primarily related to the write-down of certain assets to their estimated fair values at Sharon.

Other Non-Operating Losses, Net

For the year ended December 31, 2017, our other non-operating losses were comprised of a $7.3 million loss on our divestitures of EaStar and Sharon, a $4.3 million loss on the refinancing of long-term debt, a $3.9 million loss on the conversion of a financing lease to an operating lease at the completion of a construction project to satisfy sale-leaseback accounting, and $1.2 million of contingent consideration expense. For the year ended December 31, 2016, our net other non-operating losses were comprised of an $11.7 million loss on the refinancing of long-term debt, partially offset by $0.1 million of contingent consideration income.

Income Taxes

For the year ended December 31, 2017, we recognized a benefit from income taxes of $1.3 million, primarily related to the reduction in the net deferred tax liability position as a result of the Tax Act that was signed into law on December 22, 2017. For the year ended December 31, 2016, we recognized a provision for income taxes of $4.0 million. For a further discussion of our income taxes, refer to Note 6 to our accompanying consolidated financial statements included elsewhere in this Report.

Supplemental Results of Operations for Legacy LifePoint and RCCH on a Combined Basis for the Years Ended December 31, 2018 and 2017

As discussed above, the results of operations in this section for the years ended December 31, 2018 and 2017 are presented on a combined basis as if the LifePoint/RCCH Merger had occurred on January 1 for each of the years then ended. GAAP does not allow for such a combination of results of operations; however, we believe the combined results provide information that is useful in evaluating our financial performance.

Revenues

The following table summarizes our key revenue metrics on a combined and same-hospital combined basis for the years ended December 31, 2018 and 2017:

	Years Ended December 31,		Increase	% Increase
	2018	2017	(Decrease)	(Decrease)
Combined:				
Number of hospital campuses at end of period	89	88	1	1.1 %
Revenues (in millions)	$ 8,347.9	$ 8,164.2	$ 183.7	2.3 %
Admissions	344,172	351,310	(7,138)	(2.0)%
Equivalent admissions	891,161	906,777	(15,616)	(1.7)%
Revenues per equivalent admission	$ 9,367	$ 9,004	$ 363	4.0 %
Inpatient surgeries	93,713	95,890	(2,177)	(2.3)%
Outpatient surgeries	347,049	352,031	(4,982)	(1.4)%
Total surgeries	440,762	447,921	(7,159)	(1.6)%
Emergency department visits	1,958,555	2,094,886	(136,331)	(6.5)%
Same-hospital combined:				
Number of hospital campuses at end of period	84	84	-	- %
Revenues (in millions)	$ 8,003.3	$ 7,785.7	$ 217.6	2.8 %
Admissions	330,994	331,471	(477)	(0.1)%
Equivalent admissions	855,663	855,961	(298)	(0.0)%
Revenues per equivalent admission	$ 9,353	$ 9,096	$ 257	2.8 %
Inpatient surgeries	89,744	92,019	(2,275)	(2.5)%
Outpatient surgeries	336,928	337,487	(559)	(0.2)%
Total surgeries	426,672	429,506	(2,834)	(0.7)%
Emergency department visits	1,882,308	1,962,657	(80,349)	(4.1)%

For the year ended December 31, 2018, our combined revenues increased $183.7 million, or 2.3%, compared to the prior year. The increase in our combined revenues was primarily attributable to a 2.8% increase in our same-hospital combined revenues, partially offset by the impact of our divestitures completed in 2018 and 2017. The increase in our same-hospital combined revenues for the year ended December 31, 2018 was primarily driven by higher contracted rates from HMOs, PPOs and other private insurers as evidenced by a 2.8% increase in our same-hospital revenues per equivalent admission. Our same-hospital combined equivalent admissions for the year ended December 31, 2018 were consistent with the prior year.

Additionally, during the years ended December 31, 2018 and 2017, we recorded reductions to revenues of $17.0 million and $72.6 million, respectively, as a result of changes in our accounting estimates of the collectability of accounts receivable. The changes in our estimation procedures of the collectability of our accounts receivable is considered a change in accounting estimate in accordance with ASC 250. When adjusted to exclude the impact of the changes in accounting estimates recorded during each of the years ended December 31, 2018 and 2017, our same-hospital combined revenues increased 2.1% for the year ended December 31, 2018 compared to the prior year and our same-hospital combined revenues per equivalent admission increased 2.1% for the year ended December 31, 2018 compared to the prior year.

Non-GAAP Measures

Adjusted EBITDA

The following table presents EBITDA and Adjusted EBITDA on a combined basis for the years ended December 31, 2018 and 2017 (in millions):

		2018		2017
Net (loss) income		$ (424.0)	$	74.8
Interest expense, net		315.9		274.9
Income taxes		0.3		45.6
Depreciation and amortization		413.5		431.2
EBITDA		305.7		826.5
(a)	Stock-based compensation	91.8		26.1
(b)	Change in accounting estimate of collectability of accounts receivable	17.0		72.6
(c)	Merger and acquisition costs	321.0		20.0
(d)	Impairments of goodwill and long-lived assets	204.2		70.0
(e)	Facility lease expense	(28.2)		(38.7)
(f)	Discontinued operations	5.2		10.9
(g)	Non-cash and other items	39.3		(5.7)
(h)	One-time costs and non-recurring items	18.2		(19.6)
(i)	Run rate EBITDA from in-market investments and acquisitions	60.3		22.9
(j)	Pro forma cost savings	67.5		60.0
Adjusted EBITDA		$ 1,102.0	$	1,045.0

(a) Represents the exclusion of stock-based compensation expense.

(b) Represents the exclusion of one-time, non-cash charges recognized by Legacy LifePoint in the fourth quarter of 2017 and RCCH in the fourth quarter of 2018 related to changes in our accounting estimates of the collectability of accounts receivable.

(c) Represents costs associated with the LifePoint/RCCH Merger and other acquisitions that occurred during the years ended December 31, 2018 and 2017, including legal, financing and transaction advisory services, employee severance and retention costs and other integration costs associated with such transactions.

(d) Represents the exclusion of non-cash impairment charges related to goodwill and long-lived assets. For the year ended December 31, 2018, such items consist of (i) losses of approximately $107 million related to the divestiture of certain Legacy LifePoint facilities; (ii) goodwill impairment losses of approximately $54 million related to three of our facilities; and (iii) other long-lived asset impairment losses of approximately $43 million related to certain buildings and equipment. For the year ended December 31, 2017, such items consist of (i) losses of approximately $13 million related to the divestiture of one Legacy LifePoint facility; (ii) other Legacy LifePoint long-lived asset impairment losses of approximately $43 million related to certain buildings and equipment; and (iii) a goodwill impairment loss of approximately $14 million related to one of our facilities.

(e) Represents incremental cash rent expense in connection with certain leases that are recorded as capital and financing leases within our accompanying consolidated financial statements included elsewhere in this Report. Pursuant to the terms of our financial covenants contained in our debt agreements, we are required to consider cash rent expense and capital payments on facility capital leases within the definition of Adjusted EBITDA. Additionally, differences between cash payments and reported rent expense for facility operating leases are reflected within this adjustment, in accordance with our debt agreements.

(f) Represents the elimination of EBITDA associated with facilities that have either been divested or are currently contracted to be divested.

(g) Represents the exclusion of certain non-cash and other items. For the year ended December 31, 2018, such items consist of (i) losses of approximately $26 million related to the write-off of previously capitalized debt issuance costs; and (ii) other miscellaneous non-cash charges. For the year ended December 31, 2017, such items consist of (i) a non-cash gain of approximately $18 million recognized by Legacy LifePoint upon the release of a legal liability reserve; (ii) losses of approximately $11 million recognized by RCCH upon the sale of certain locations and facilities; and (iii) other miscellaneous non-cash charges.

(h) Represents the exclusion of certain one-time costs and non-recurring items. For the year ended December 31, 2018, such items consist of (i) costs of approximately $12 million related to the installation of certain clinical IT systems; and (ii) other miscellaneous one-time charges. For the year ended December 31, 2017, such items consist of (i) a non-cash gain of approximately $29 million recognized by Legacy LifePoint in connection with the transfer of home health agencies and hospices to a non-consolidated joint venture; (ii) costs of approximately $5 million related to the installation of certain clinical IT systems; and (iii) other miscellaneous one-time charges.

(i) Represents the EBITDA of acquired facilities for periods prior to the acquisition date, inclusive of certain run rate cost savings for implemented headcount reductions. Additionally, the net pro forma EBITDA from new or expanded service lines and newly constructed facilities are included within this adjustment.

(j) Represents the estimated unrealized annual cost savings related to certain corporate integration, operational improvements and synergies anticipated from the LifePoint/RCCH Merger. There can be no assurances that these estimated cost savings will be achieved.

Leverage

The following table illustrates our indebtedness and certain leverage ratios prepared in accordance with the calculations set forth in the 9.75% Unsecured Notes Indenture and the ABL Agreement and the Term Loan Agreement as of and for the year ended December 31, 2018 on a combined basis (dollars in millions):

Cash and cash equivalents (a)	$	58.1
ABL Facility	$	20.0
Term Loan Facility		3,550.0
8.25% Secured Notes		800.0
Total Secured Debt (b)	$	4,370.0
Net Secured Debt (b)	$	4,311.9
9.75% Unsecured Notes	$	1,425.0
11.5% Unsecured Notes		350.0
Total Debt (b)	$	6,145.0
Net Debt (b)	$	6,086.9
Adjusted EBITDA	$	1,102.0
Total Secured Debt (b) / Adjusted EBITDA		3.97x
Net Secured Debt (b) / Adjusted EBITDA		3.91x
Total Debt (b) / Adjusted EBITDA		5.58x
Net Debt (b) / Adjusted EBITDA		5.52x

(a) Excludes cash held by unrestricted subsidiaries which is not included as cash for purposes of calculating the ratios set forth in the Indentures governing the Notes, the ABL Agreement and the Term Loan Agreement.

(b) Excludes financing and capital leases, which are not considered indebtedness for purposes of calculating the ratios set forth in the 9.75% Unsecured Notes Indenture, the ABL Agreement and the Term Loan Agreement, as well as unamortized debt issuance costs. Under the 8.25% Secured Notes Indenture and the 11.5% Unsecured Notes Indenture, calculation of leverage ratios only exclude financing and capital leases relating to hospitals and related or ancillary facilities.

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash generated by operations and borrowings under the ABL Facility. Our primary uses of cash are working capital requirements, debt service requirements and capital expenditures. Based on our current level of operations and available cash, we believe our cash flows from operations, combined with availability under the ABL Facility, will provide sufficient liquidity to fund our current obligations, projected working capital requirements, debt service requirements and capital spending requirements over the next twelve months. We cannot assure you, however, that our business will generate sufficient cash flows from operations or that future borrowings will be available to us under the ABL Facility, which is subject to a borrowing base, in an amount sufficient to enable us to pay principal and interest on the ABL Facility, the Term Loan Facility and the Notes, or to fund other liquidity needs. Our ability to do so depends on prevailing economic conditions, many of which are beyond our control. In addition, upon the occurrence of certain events, such as a change of control, we could be required to repay or refinance our indebtedness. We cannot assure you that we will be able to refinance any of our indebtedness on commercially reasonable terms or at all. Any future acquisitions, joint ventures or other similar transactions will likely require additional capital, and there can be no assurance that any such capital will be available to us on acceptable terms or at all.

The following table presents summarized cash flow information for the years ended December 31, 2018, 2017 and 2016 (in millions):

	2018	2017	2016
Net cash (used in) provided by operating activities	$ (73.0)	$ 105.6	$ 54.8
Net cash used in investing activities	(5,645.7)	(151.1)	(715.6)
Net cash provided by financing activities	5,760.7	32.0	683.2
Net change in cash and cash equivalents	$ 42.0	$ (13.5)	$ 22.4

Operating Activities

For the year ended December 31, 2018, our cash flows from operating activities decreased by $178.6 million compared to the prior year, primarily as a result of merger-related expenses including legal and transaction advisory services as well as employee severance and retention costs in connection with the LifePoint/RCCH Merger. For the year ended December 31, 2017, our net cash provided by operating activities increased by $50.8 million compared to the prior year. Our operating performance, adjusted for non-cash items, accounted for $30.0 million of the increase, while the remainder of the increase was primarily related to a decrease in net working capital as a result of improved collections on accounts receivable and the timing of payments on accounts payable and prepaid expenses.

Investing Activities

For the years ended December 31, 2018, 2017 and 2016, we invested $5,345.9 million, $112.9 million and $673.8 million, respectively, in mergers and acquisitions. For the year ended December 31, 2018, our acquisition spend consisted primarily of the LifePoint/RCCH Merger in addition to our acquisitions of Lourdes, Trios and PMDS. For the year ended December 31, 2017, our acquisition spend consisted primarily of our acquisition of St. Joseph. For the year ended December 31, 2016, our acquisition spend consisted primarily of the RegionalCare/Capella Merger and our acquisition of Saline.

For the years ended December 31, 2018, 2017 and 2016, we invested $319.7 million, $145.1 million and $67.5 million, respectively, in purchases of property and equipment. Refer to “Capital Expenditures” for further information.

Financing Activities

For the year ended December 31, 2018, net cash provided by financing activities related primarily to the net increase in borrowings and equity to effectuate the LifePoint/RCCH Merger. Refer to “Capital Resources” for further information regarding our recent debt transactions. For the year ended December 31, 2017, net cash provided by financing activities related primarily to net MPT financing activity to finance our acquisition of St. Joseph and construction projects at two facilities, partially offset by the repayment of the financing lease related to EaStar upon completion of its sale. For the year ended December 31, 2016, net cash provided by financing activities related primarily to the net increase in borrowings and equity to effectuate the RegionalCare/Capella Merger.

Capital Expenditures

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

The following table summarizes our capital expenditures as a percentage of revenues and as a percentage of depreciation expense for the years ended December 31, 2018, 2017 and 2016 (dollars in millions):

	2018		2017		2016	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Capital expenditures	$ 319.7	11.5 %	$ 145.1	7.7 %	$ 67.5	4.5 %
Depreciation expense	128.5		80.1		56.9	
Ratio of capital expenditures to depreciation expense	248.8 %		181.1 %		118.6 %	

On a combined basis, our capital expenditures were elevated in 2018 and 2017 primarily as a result of certain significant capital projects, including the construction of two replacement hospital campuses and the installation of a new clinical system at certain of our facilities.

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

Capital Resources

ABL Facility

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we entered into the ABL Facility in an aggregate principal amount of up to $800.0 million with a maturity of five years and we terminated our Prior ABL Facility. For further information regarding the ABL Facility, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Term Loan Facility

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we entered into the Term Loan Facility in an aggregate principal amount of $3,550.0 million with a maturity of seven years and we repaid in full our Prior Term Facility. For further information regarding the Term Loan Facility, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

9.75% Unsecured Notes

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we issued the 9.75% Unsecured Notes in an aggregate principal amount of $1,425.0 million with a maturity of eight years. For further information regarding the 9.75% Unsecured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

8.25% Secured Notes

Effective April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, we issued the 8.25% Secured Notes in an aggregate principal amount of $800.0 million with a maturity of seven years. For further information regarding the 8.25% Secured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

11.5% Unsecured Notes

Effective April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, we issued the 11.5% Unsecured Notes in a private offering in an aggregate principal amount of $350.0 million with a maturity of eight years. For further information regarding the 11.5% Unsecured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

A roll-forward of our long-term debt, including current portions, during 2018 is as follows (in millions):

	December 31, 2017	Proceeds from Borrowings	Payments of Borrowings	Payments of Debt Financing Costs	Amortization of Debt Issuance Costs	New Financing and Capital Leases	Other	December 31, 2018
Senior borrowings:								
ABL Facility	$ -	$ 20.0	$ -	$ -	$ -	$ -	$ -	$ 20.0
Prior ABL Facility	10.0	-	(10.0)	-	-	-	-	-
Term Loan Facility	-	3,550.0	-	-	-	-	-	3,550.0
Prior Term Facility	-	150.0	(150.0)	-	-	-	-	-
9.75% Unsecured Notes	-	1,425.0	-	-	-	-	-	1,425.0
8.25% Secured Notes	800.0	-	-	-	-	-	-	800.0
11.5% Unsecured Notes	350.0	-	-	-	-	-	-	350.0
Unamortized debt issuance costs	(32.9)	-	-	(206.5)	7.2	-	4.8	(227.4)
Financing and capital leases	265.0	-	(10.0)	-	-	302.2	-	557.2
Secured loan from affiliate	37.6	-	(37.6)	-	-	-	-	-
Subordinated borrowings, net	4.3	-	(1.7)	-	-	-	0.4	3.0
	$ 1,434.0	$ 5,145.0	$ (209.3)	$ (206.5)	$ 7.2	$ 302.2	$ 5.2	$ 6,477.8

Liquidity and Capital Resources Outlook

We expect total capital expenditures to continue to be elevated, primarily as a result of ongoing capital commitments in connection with several of our acquired facilities. At December 31, 2018, we estimated our total remaining capital expenditure commitments to be approximately $1,436.3 million, which generally have remaining terms of three to seven years. Of this amount, approximately one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the ABL Facility.

Our business strategy contemplates the selective acquisition of additional hospitals and other healthcare service providers, and we regularly review potential acquisitions. These acquisitions may, however, require additional financing. Our primary sources of liquidity are cash flows provided by our operations and our borrowings available under the ABL Facility. We believe that our internally generated cash flows and borrowing availability under the ABL Facility will be adequate to service existing debt, finance internal growth and fund capital expenditures and small to mid-size hospital acquisitions over the next twelve months and into the foreseeable future prior to maturity dates of our outstanding debt. Certain larger hospital acquisitions may, however, require additional financing.

Inflation

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

Contractual Obligations, Commitments and Off-Balance Sheet Arrangements

Contractual Obligations and Commitments

Our contractual obligations and commitments as of December 31, 2018 are materially consistent with disclosure set forth in in the offering memorandum dated November 14, 2018 for the 9.75% Unsecured Notes (the "***November 2018 OM***"), except as otherwise disclosed in this Report, including the financial statements and notes thereto.

Off-Balance Sheet Arrangements

We had letters of credit outstanding of approximately $32.0 million as of December 31, 2018, primarily related to the self-insured retention level of our general and professional liability insurance and workers' compensation programs as security for payment of claims.

Recently Issued Accounting Pronouncements

Refer to Note 1 to our consolidated financial statements included elsewhere in this Report for a discussion of accounting standards not yet adopted.

Critical Accounting Estimates

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

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

Our critical accounting estimates include the following areas:

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

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

Revenue Recognition and Accounts Receivable

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

Approximately 92.0%, 93.3% and 91.7% of our patient revenues recognized during the years ended December 31, 2018, 2017 and 2016, respectively, related to discounted charges, which were comprised of the following sources (as a percentage of our net patient revenues before the provision for doubtful accounts):

	2018	2017	2016
Medicare	37.6 %	40.4 %	36.4 %
Medicaid	13.1	12.2	12.8
HMOs, PPOs and other private insurers	41.3	40.7	42.5

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

We monitor our processes for calculating contractual allowances through:

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

Medicare and Medicaid

The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e. gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under the Medicaid program's prospective reimbursement systems, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates.

Discounts for retrospectively cost-based revenues are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under these programs are subject to adjustment based on administrative review and audit by third party intermediaries, which can take several years to resolve completely.

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

HMOs, PPOs and Other Private Insurers

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

The process of determining the allowance requires us to estimate the amount expected to be received based on payer contract provisions, historical collection data as well as other factors and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts for managed care plans would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Provision and Allowance for Doubtful Accounts

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts. Our allowance for doubtful accounts, included in our consolidated balance sheets as of December 31, 2018 and 2017 was $403.4 million and $251.9 million, respectively. Our provision for doubtful accounts, included in our consolidated results of operations for the years ended December 31, 2018, 2017 and 2016, was $357.9 million, $206.9 million and $165.2 million, respectively. During the year ended December 31, 2018, we recorded a decrease to revenues of $17.0 million as a result of a change in our accounting estimate of the collectability of accounts receivable. During the year ended December 31, 2018, we identified additional information which indicated that our current collection estimates might be different from our historical collection estimates. We utilized this new information to further refine our estimation procedures to more precisely estimate the collectability of accounts receivable. The change in our estimation procedures of the collectability of our accounts receivable is considered a change in accounting estimate in accordance with ASC 250.

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

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

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

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

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

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

The process of determining our allowance for doubtful accounts requires us to estimate uncollectible self-pay accounts. Our estimate of uncollectible self-pay accounts is primarily based on our collection history, adjusted for anticipated changes in collection trends, if significant. Our estimate may be impacted by changes in regional economic conditions, business office operations, payer mix and trends in federal or state governmental healthcare coverage or other third party payers.

Goodwill Impairment Analysis

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired businesses. Our goodwill included in our consolidated balance sheet as of December 31, 2018 was $2,567.6 million. Refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report for a detailed rollforward of our goodwill.

In accordance with ASC 350, "Intangibles — Goodwill and Other" ("***ASC 350***") goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. The impairment evaluation is performed at the individual hospital level as each hospital represents a reporting unit as defined in ASC 350. For the annual impairment evaluation, we may perform an initial qualitative assessment to determine whether it is more likely than not that the fair value of the reporting unit is less than its carrying value. This assessment is used as a basis for determining whether it is necessary to perform the goodwill impairment test. For those reporting units on which we perform the impairment test, we determine fair value using a discounted cash flow ("***DCF***") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing our assumptions. The cash flows employed in the DCF analysis are based on our most recent financial budgets and business plans and, when applicable, various growth rates for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the respective reporting units.

If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. Refer to Note 5 to our consolidated financial statements included elsewhere in this Report for further discussion of the results of our annual goodwill impairment evaluation procedures.

Accounting for Income Taxes

Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or increase this allowance, we must include an expense as part of the income tax provision in our results of operations. Our deferred tax asset balances in our consolidated balance sheets were $456.4 million and $163.9 million as of December 31, 2018 and 2017, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $274.4 million and $134.1 million as of December 31, 2018 and 2017, respectively.

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

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

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

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

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

Our deferred tax assets exceeded our deferred tax labilities by $270.4 million as of December 31, 2018, excluding the impact of valuation allowances. Historically, we have not produced federal taxable income, and in connection with the LifePoint/RCCH Merger, the Company became highly leveraged. As such, we believe it is likely that the deferred tax assets will not be realized and thus have established a valuation allowance against the deferred tax assets as of December 31, 2018. In addition, we do have subsidiaries with a history of tax losses in certain state jurisdictions and, based upon those historical tax losses, we assumed that the subsidiaries would not be profitable in the future for those states’ tax purposes. If our assertion regarding the future profitability of those subsidiaries was incorrect, then our deferred tax assets would be understated by the amount of the state valuation allowance of $274.4 million at December 31, 2018.

Additionally, on December 22, 2017, the Tax Act was signed into law. The Tax Act significantly revises the U.S. corporate income tax by, among other things, lowering the statutory corporate tax rate from 35% to 21% and eliminating certain deductions. Due to the timing of the enactment and the complexity involved in applying the provisions of the Tax Act, we have made reasonable estimates of the effects of the Tax Act on our existing deferred tax assets and liabilities and recognized a provisional benefit for income taxes of $57.7 million during the year ended December 31, 2017. We completed our analysis during the year ended December 31, 2018 and determined that no additional adjustment was needed to the $57.7 million provisional expense that we recorded for the year ended December 31, 2017.

Reserves for Self-Insurance Claims

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding SIR and deductible levels. At December 31, 2018, our SIR for professional liability claims is $5.0 million per claim, with a $5.0 million inner aggregate, at the majority of our facilities, and $2.0 million per claim at certain of our facilities. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2018, our deductibles for workers' compensation claims range from $0.5 million to $1.0 million per claim in all states in which we operate except for Montana, Oklahoma, Ohio, Washington and Wyoming. We participate in state-specific programs for our workers' compensation claims arising in these states. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

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

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

Our reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. Our reserves for employee workers' compensation claims are based upon semi-annual actuarial calculations. Our reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. We have discounted our reserves for self-insured claims to their present value using a discount rate of 1.8% at December 31, 2018 and in a range of 1.4% to 2.4% at December 31, 2017 and 0.9% to 2.3% at December 31, 2016. We select a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

The following table provides information regarding our reserves for self-insured claims at December 31, 2018 and 2017 (in millions):

	2018	2017
Undiscounted	$ 279.0	$ 70.7
Discounted (as reported)	$ 264.7	$ 65.0

As of December 31, 2018 and 2017, less than 1% of our reserves for self-insured claims represents reserves for settled and unpaid claims. Our average lag time between the settlement and payment of a self-insured claim ranges from 1 to 2 weeks.

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

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

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

Ultimately, from an actuarial standpoint, the sensitivity in the estimates of reserves for self-insured claims is reflected in the various actuarial confidence levels. Our best estimate of our reserves for self-insured claims utilizes a statistical confidence level that is 50%. Higher statistical confidence levels, while not representative of our best estimate, reflect reasonably likely outcomes upon the ultimate resolution of related claims. Using a higher statistical confidence level would increase the estimated reserves for self-insured claims. A 25% increase in our utilized statistical confidence level would increase our estimated reserve by $30.7 million. Changes in our estimates of reserves for self-insured claims are non-cash charges and accordingly, do not impact our liquidity or capital resources.

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of our quarterly and semi-annual actuarial calculations resulted in changes to our reserves for self-insured claims for prior years. As a result, for the years ended December 31, 2018, 2017 and 2016, our related self-insured claims expense decreased by $3.9 million, $12.1 million and $4.5 million, respectively.

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

Market Risk

Market risk is defined as the risk of loss resulting from changes in market prices as a result of changes in interest rates, credit and liquidity or general economic conditions. Our principal market risks in the ordinary course of business are credit risk, liquidity risk and interest rate risk. We currently do not have direct exposure to either market risk from trading activities or foreign currency exchange rate risk.

Credit Risk

We define credit risk as the risk that amounts payable by uninsured patients and remaining patient responsibility amounts (deductibles and co-payments) for patient accounts where the primary insurance carrier has paid the amounts covered by the applicable agreements will not be paid. The provision for doubtful accounts relates primarily to amounts due directly from patients. While we have experienced a reduction in uninsured patients, the risk of collection from insured patients and the amounts due, may increase as more individuals are enrolled in insurance plans with larger deductibles and/or co-payments, including those purchased on insurance exchanges.

The provision for doubtful accounts is based on our assessments of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage and other collection indicators. To date, the Affordable Care Act has decreased the number of uninsured individuals by incentivizing states to expand their Medicaid eligibility requirements, incentivizing employers to offer health insurance, and requiring individuals to carry health insurance or be subject to penalties. However, it is difficult to predict the future impact of the Affordable Care Act on the uninsured population and the collectability of patient receivables because of ongoing state determinations on whether to expand Medicaid, the availability of federal premium subsidies, as well as our inability to foresee how individuals, businesses, private payers and states will respond to the choices afforded them by the Affordable Care Act. If the recent decrease in the uninsured population does not continue, the proportion of accounts receivable being comprised of uninsured accounts and deterioration in the collectability of these accounts could adversely affect our collections of accounts receivable, results of operations and revenues.

The counterparty to our Interest Rate Swap exposes us to credit risk in the event of nonperformance. However, we do not anticipate nonperformance by our counterparty. We do not hold or issue derivative financial instruments for trading purposes.

Liquidity Risk

We define liquidity risk as the risk that we will not meet our payment obligations in a timely manner or the risk that market conditions or institution-specific events may reduce our ability to raise funds from market counterparties. An adverse institution-specific event such as a major loss that causes a perceived or actual deterioration in our financial condition or an adverse systemic event could affect our funding liquidity.

Interest Rate Risk

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. To manage this risk, we entered into an Interest Rate Swap. The terms of the Interest Rate Swap require us to pay a fixed rate of 2.63% on a notional amount of $1,100.0 million and, in exchange, we receive one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. We have not designated our Interest Rate Swap as a cash flow hedge in accordance with ASC 815. Therefore, all changes in the fair value of our Interest Rate Swap will be recognized through interest expense in our results of operations. Changes in the fair value of our Interest Rate Swap could result in a material effect on our consolidated results of operations and financial position; however, we do not anticipate that changes in the fair value of our Interest Rate Swap will have any impact on our cash flows.

As of December 31, 2018, we had total outstanding debt of approximately $6,148.0 million, excluding capital and financing leases and unamortized debt issuance costs, of which $2,470.0 million, or 40.2%, was subject to variable rates of interest after giving effect to our Interest Rate Swap. If the interest rate on our variable rate long-term debt outstanding as of December 31, 2018, not subject to our Interest Rate Swap, were to increase by 100 basis points during any annual period, our cash flows would be negatively impacted by approximately $24.7 million.

Item 8. ***Financial Statements and Supplementary Data.***

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

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

None.

Item 9A. ***Controls and Procedures.***

The information that would be required to be disclosed under Part II, Item 9A of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a**)** of each of the Indentures.

Item 9B. ***Other Information.***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance*.**

The following table provides information regarding our executive officers and the members of our Board of Directors (ages as of March 28, 2019):

Name	Age	Position(s)
David M. Dill	50	President and Chief Executive Officer
Michael S. Coggin	49	Executive Vice President and Chief Financial Officer
John P. Bumpus	58	Executive Vice President, Administration
Victor E. Giovanetti	55	Executive Vice President, Hospital Operations
Robert F. Jay	51	Executive Vice President, Integrated Operations
Jennifer C. Peters	47	Executive Vice President, General Counsel and Corporate Secretary
J. Michael Grooms	41	Senior Vice President and Chief Accounting Officer
Matthew H. Nord	39	Director and Chairman
William F. Carpenter III	64	Director and Chairman Emeritus
Norman Brownstein	75	Director
Christopher J. Christie	56	Director
Maxwell David	28	Director
Michael P. Haley	68	Director
Steve Levin	53	Director
Holly McMullan	42	Director
Daniel Morissette	53	Director
Eric L. Press	53	Director
Martin S. Rash	64	Director
Olivia Wassenaar	39	Director
G. Rodney Wolford	72	Director

David M. Dill became our Chief Executive Officer upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Dill served in various roles at Legacy LifePoint as President since January 2011 and as Chief Operating Officer since April 2009. Mr. Dill served as Executive Vice President from February 2008 to January 2011. Mr. Dill joined Legacy LifePoint in July 2007 as Chief Financial Officer and continued to serve in that role until April 2009. From March 2006 until Mr. Dill joined Legacy LifePoint, he served as executive vice president of Fresenius Medical Care North America and as chief executive officer of one of two United States divisions of Fresenius Medical Care Services, a wholly owned subsidiary of Fresenius Medical Care AG & Co. KGaA. Mr. Dill previously served as executive vice president, chief financial officer and treasurer of Renal Care Group, Inc., a publicly-traded dialysis services company, from November 2003 until Renal Care Group was acquired by Fresenius Medical Care in March 2006. From 1996 to November 2003, Mr. Dill served in various finance and accounting roles with Renal Care Group, Inc. Mr. Dill served as a member of the board of directors of Psychiatric Solutions, Inc., a behavioral health services company, from 2005 until 2010.

Michael S. Coggin became our Executive Vice President and Chief Financial Officer upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Coggin served in various roles at Legacy LifePoint as Executive Vice President, Chief Financial Officer and Chief Accounting Officer, since September 2016. From December 2008 until September 2016, Mr. Coggin served as Senior Vice President and Chief Accounting Officer of Legacy LifePoint. From September 2007 until December 2008, Mr. Coggin served as chief financial officer of Specialty Care Services Group, a multi-service line healthcare provider primarily focused on providing perfusion and auto-transfusion services to hospitals. Mr. Coggin was a senior vice president in the finance, accounting and internal audit groups of Renal Care Group, Inc. from April 2004 until its acquisition by Fresenius Medical Care AG & Co. KGaA in March 2006. Following the acquisition, Mr. Coggin provided finance and accounting oversight for business units within the East Division of Fresenius. Prior to that time, Mr. Coggin was an audit manager at KPMG Peat Marwick in Nashville, Tennessee.

John P. Bumpus became our Executive Vice President, Administration upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Bumpus served as Executive Vice President and Chief Administrative Officer of Legacy LifePoint since 2008. In this role, Mr. Bumpus was responsible for overseeing human resources and talent development; employee and labor relations; compensation and benefits; capital and construction management; communications; administration; and aviation. He previously served as Senior Vice President, Human Resources and Administration of Legacy LifePoint. Prior to joining Legacy LifePoint, Mr. Bumpus served as vice president, human resources for Province Healthcare Company. He also held various leadership positions during his tenure with The Kroger Company, including strategic planning and implementation specialist; manager, human resources; and various positions in operations for the Nashville marketing area.

Victor E. Giovanetti became our Executive Vice President, Hospital Operations upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Giovanetti served as President of Legacy LifePoint's Eastern Group since January 2017. From July 2015 to January 2017, Mr. Giovanetti served as President of Legacy LifePoint's Western Group. Mr. Giovanetti joined Legacy LifePoint in July 2013 as Chief Operating Officer of Legacy LifePoint's Eastern Group. Mr. Giovanetti has more than 25 years of management experience in operations, financial, clinical and strategic aspects of healthcare administration. Prior to joining the Company, his positions included president of HCA Lewis-Gale Regional Health System in Roanoke, Virginia, chief executive officer and chief operating officer of Southern Hills Medical Center in Nashville, Tennessee, and various management roles with HCA, Symbion and other healthcare organizations in Georgia.

Robert F. Jay became our Executive Vice President, Integrated Operations upon consummation of the LifePoint/RCCH Merger. Mr. Jay previously served as RCCH's Executive Vice President and Chief Operating Officer, a position he held from January 2018. Mr. Jay has served in various roles with RCCH, including Executive Vice President Operations Support from May 2016 to September 2016 and Division President from September 2016 to January 2018. Prior to that he served as Chief Operating Officer for RCCH from January 2014 until May 2016. Prior to joining RCCH, he spent seven years at Vanguard Health Systems in a variety of operations and development positions. He joined Vanguard Health Systems as its Corporate Director Operations and Financial Analysis where he was responsible for managing and reporting operational, clinical, and financial results. In 2008, Mr. Jay was promoted to Vice President, Supply Chain Management of Vanguard where he oversaw the overall strategic direction and tactical execution of supply chain operations. In 2009 he transitioned to Vice President, Development of Vanguard where he led acquisition teams that closed on hospital transactions with combined net revenues of over $2.2 billion. Prior to joining Vanguard Health Systems, Mr. Jay worked as the Corporate Controller for Health Management Associates, Inc. in Naples, Florida. He has also served as a Controller in a not-for-profit hospital and also spent time at KPMG as an auditor.

Jennifer C. Peters became our Executive Vice President and General Counsel upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Ms. Peters served as Legacy LifePoint's General Counsel since April 2017 and Corporate Secretary since June 2017. Prior to that, Ms. Peters served as senior vice president and chief operations counsel of Legacy LifePoint, where she was responsible for overseeing the Company's operations lawyers and contract management team to ensure consistent legal guidance across all operational units. Prior to joining Legacy LifePoint in November 2013, Ms. Peters served as general counsel, secretary and chief compliance officer for Simplex Healthcare from October 2010 through November 2013. Ms. Peters has also served as vice president and associate general counsel at Community Health Systems. In addition, Ms. Peters has experience as a hospital administrator.

J. Michael Grooms became our Senior Vice President and Chief Accounting Officer upon consummation of the LifePoint/RCCH Merger. Mr. Grooms previously served as Chief Accounting Officer of Legacy Lifepoint from June 2018 and as Vice President of Accounting and Financial Reporting from March 2012. Additionally, Mr. Grooms served in various other accounting financial reporting roles since joining Legacy Lifepoint in September 2006. Prior to that time, he served as controller with Delek US from 2005 to 2006, and as an auditor with KPMG from 2001 to 2005.

Matthew H. Nord has been our Director since consummation of the Apollo/RegionalCare Acquisition in December 2015 and became Chairman of the Board in December 2018. Mr. Nord is a Senior Partner of Apollo Global Management, LLC, where he has been employed since 2003. From 2001 to 2003, Mr. Nord was a member of the Investment Banking division of Salomon Smith Barney Inc. Mr. Nord serves on several boards of directors, including West Corporation, Presidio, Inc., ADT, and Exela Technologies, Inc. Mr. Nord also serves on the Board of Trustees of Montefiore Health System and on the Board of Overseers of the University of Pennsylvania's School of Design. During the past five years, Mr. Nord has also served as a director of Affinion Group Holdings, Inc. (from October 2006 to November 2015), Constellium N.V. (from May 2010 to November 2015), EVERTEC, Inc. (from September 2010 to December 2013), Hughes Telematics, Inc. (from December 2006 to July 2012), MidCap Financial Holdings, LLC (from December 2013 to January 2015), Noranda Aluminum Holding Corporation (from March 2007 to December 2015) and SourceHOV Holdings, Inc. (from January 2006 to April 2013). Mr. Nord graduated summa cum laude with a B.S. in Economics from the Wharton School of the University of Pennsylvania. Between his work at Apollo and his prior experience in investment banking, Mr. Nord has approximately 15 years of experience analyzing, financing and investing in public and private companies.

William F. Carpenter III became our Director and Chairman Emeritus upon consummation of the LifePoint/RCCH Merger. Mr. Carpenter was a founding member of Legacy LifePoint, having served in various roles as Executive Vice President, Senior Vice President, General Counsel, Secretary and Corporate Governance Officer. In 2006, Mr. Carpenter was appointed Chief Executive Officer and elected to the Board of Directors of Legacy LifePoint and, in 2010, was appointed Chairman of the Board. Mr. Carpenter serves on the board of directors of the American Hospital Association, and formerly served as Chairman and a member of the board of the Federation of American Hospitals, the national public policy organization for investor-owned hospitals. Mr. Carpenter is also a member and past chairman of the Nashville Health Care Council Board of Directors, and serves on the boards of directors of the Nashville Area Chamber of Commerce, NashvilleHealth, the Center for Medical Interoperability, United Way of Nashville, and Nashville Public Radio. A recognized leader in the healthcare industry, he has appeared on *Modern Healthcare* magazine's annual "100 Most Influential People in Healthcare" list numerous times.

Norman Brownstein became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Brownstein is the founding member and chairman of the board of the law firm of Brownstein Hyatt Farber Schreck, LLP. Mr. Brownstein is nationally recognized for his extensive experience in real estate law, commercial transactions and public policy advocacy, which spans the economic spectrum, extending to telecommunications, financial services, agriculture, tax and health care interests. Mr. Brownstein serves on the board of directors of National Jewish Health, and during the past five years has also served as a director of Ardent Healthcare Services. Mr. Brownstein received a B.S. from the University of Colorado and a J.D. from the University of Colorado Law School.

Christopher J. Christie became our Director in December 2018. Mr. Christie served two terms as Governor of New Jersey from 2010 to 2018. Prior to that, Mr. Christie served as U.S. Attorney for the District of New Jersey from 2002 to 2008. During his governorship, Mr. Christie chaired the President's Commission on Combating Drug Addiction and the Opioid Crisis in 2017. He currently serves as a legal and political commentator for ABC News. Mr. Christie is a graduate of the University of Delaware and Seton Hall University School of Law.

Maxwell David became our Director in December 2018. Mr. David is a principal in Apollo Global Management's Private Equity business, having joined in 2014. Prior to that time, Mr. David was a member of the Investment Banking division of Bank of America Merrill Lynch. Mr. David serves on the board of directors of CareerBuilder. Mr. David graduated cum laude from Dartmouth College with a B.A. in Economics.

Michael P. Haley became our Director in December 2018. Prior to that time, Mr. Haley served as a director of Legacy LifePoint since 2005 and as chair of its Audit Committee since 2016. Mr. Haley is also a member of the board of directors of American National Bankshares, Inc., a bank holding company. From 2005 until April 2018, Mr. Haley served as a director of Ply Gem Holdings, Inc., a producer of window, door and siding products for the residential construction industry. Mr. Haley served as an advisor to Fenway Partners, LLC, a private equity investment firm, from April 2006 to June 2015, and was a managing director of its affiliate, Fenway Resources, from 2008 to June 2015. Mr. Haley's previous executive leadership experience includes service as executive chairman of Coach America, a transportation services operator, and as chairman, president and chief executive officer of MW Manufacturers, Inc., a subsidiary of Ply Gem Industries, Inc. In addition, Mr. Haley previously served on the board of the Martinsville-Henry County United Way and as chairman of the board of trustees of Memorial Hospital of Martinsville and of the Martinsville-Henry County Economic Development Corporation.

Steven Levin became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Levin is the chief strategy officer of Waystar, a healthcare revenue cycle technology platform. In 2018, Waystar acquired Connance, an analytics company that delivers workflow optimization technology for healthcare providers, which Mr. Levin founded in collaboration with Tenet Healthcare, FICO and Northbridge Venture Partners following a nearly two decade management consulting career at Monitor Company working with hospitals, HCIT companies and health insurers. Mr. Levin holds a B.A. from Dartmouth College and an M.B.A. from Harvard Business School.

Holly McMullan became our Director in December 2018. Ms. McMullan is a Partner in Apollo Global Management's Marketing and Business Development group, where she is responsible for fundraising efforts, having jointed in 2008. Prior to that time, Ms. McMullan was a Senior Vice President at Pequot Capital and was previously a member of Guggenheim Advisors, Bear Stearns, and Robertson Opp. Capital.

Daniel Morissette became our Director upon consummation of the Transaction in April 2016. Mr. Morissette has served as Senior Executive Vice President/Chief Financial Officer for Dignity Health since February 2016. Previously, Mr. Morissette served as the Chief Financial Officer for Stanford Health Care. Mr. Morissette has over 25 years of experience in health care, consulting and international business development. During the past five years, Mr. Morissette served as a director for Optum360 and University Healthcare Alliance. Mr. Morissette received a B.S. from DePaul University and an M.B.A. from The University of Chicago, Booth School of Business.

Eric L. Press has been our Director since consummation of the Apollo/RegionalCare Acquisition in December 2015. Mr. Press is a senior partner of Apollo Global Management, LLC, where he has been employed since 1998 and has served as an officer of certain affiliates of Apollo. From 1992 to 1998, Mr. Press was associated with the law firm of Wachtell, Lipton, Rosen & Katz specializing in mergers, acquisitions, restructurings and related financing transactions. From 1987 to 1989, Mr. Press was a consultant with The Boston Consulting Group. Mr. Press serves on several boards of directors, including Apollo Commercial Real Estate Finance, Inc., PlayAGS, Inc., Princimar Chemical Holdings, LLC, ADT Inc. and Constellis Holdings, LLC. During the past five years, Mr. Press also served as a director of Affinion Group Holdings, Inc. (from October 2005 to September 2015), Athene Holding Ltd. (from July 2009 to February 2014), Metals USA Holdings Corp. (from May 2005 to April 2013), Noranda Aluminum Holding Corporation (from March 2007 to December 2015), Prestige Cruise Holdings, Inc. (from April 2007 to November 2014), Verso Corporation (from January 2009 to July 2016) and Caesars Entertainment Corporation (from January 2008 to October 2017). Mr. Press graduated magna cum laude from Harvard University with a A.B. in economics and received his JD from Yale Law School. Mr. Press has significant experience making and managing private equity investments on behalf of Apollo. Between his work at Apollo and his prior experience as an attorney and a management consultant, Mr. Press has approximately 28 years of experience in the process of financing, analyzing, and investing in public and private companies and serving on their board of directors.

Martin S. Rash has been our director since October 2015 following the Apollo/RegionalCare Acquisition and served as Executive Chairman following the consummation of the RegionalCare/Capella Merger in April 2016 until the consummation of the LifePoint/RCCH Merger. Additionally, Mr. Rash served as Chief Executive Officer of RegionalCare from October 2015 until the consummation of the LifePoint/RCCH Merger. Mr. Rash served as the Executive Chairman at RegionalCare Hospital Partners, Inc. from March 2013 to October 2015 and served as its Chief Executive Officer from 2009 until March 2013. From December 1996 to 2005, Mr. Rash was Chairman and Chief Executive Officer of Province Healthcare, a $1 billion NYSE company that owned 21 hospitals and managed more than 50 facilities. Prior to his tenure at Province Healthcare, Mr. Rash served as Executive Vice President and Chief Operating Officer for Community Health Systems where he led the growth of the company from 10 to 41 hospitals in 17 states. Earlier in his 39-year healthcare career, he worked at numerous community hospitals in various administrative and financial roles. Mr. Rash's experience and leadership includes Board of Directorships in the past at Healthspring, a NYSE company, and Odyssey Healthcare, a NASDAQ company. He is a past Chairman of the Federation of American Hospitals and currently serves on the board of the Nashville Health Care Council. He holds both a B.A. and M.B.A. from Middle Tennessee State University. He currently serves as Chairman of American Pathology Partners.

Olivia Wassenaar became our Director in December 2018. Ms. Wassenaar is a partner in Apollo Global Management's Natural Resources business, having joined in 2018. Prior to that time, Ms. Wassenaar was a Managing Director at Riverstone Holdings and was previously a member of the Investment Banking division of Goldman Sachs. Ms. Wassenaar also serves on the boards of directors of Talos Energy and Pegasus.

G. Rodney Wolford became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Wolford has over 40 years of wide-ranging experience in the health care industry, having served in leadership roles with health care providers, suppliers, consulting firms, associations and insurers. Redirecting his professional time from active executive leadership, he now focuses his professional time on multiple boards of directors and rural community economic development. Among his many executive positions, Mr. Wolford served as chief executive officer of Alliant Healthcare (now Norton Healthcare), the leading hospital system in Louisville, KY, Sterling Diagnostic, a worldwide manufacturer of x-ray film, Forhealth Technologies, the inventor of the first robot dedicated to hospital IV production, and a senior executive of Blue Cross Tennessee. Mr. Wolford currently serves on the boards of Atlanta based D4C Brands, a pediatric dentistry company, and Liberate Medical, which develops electronic stimulation for ventilator patients, and as a fund manager of Bluegrass Angel Fund III. During the past five years, Mr. Wolford has also served as a director of Haven Behavioral, Laboratory Supply Company, VetCor and Essent Healthcare.

Code of Ethics

Our Board expects its members, as well as our officers and employees, to act ethically at all times and to acknowledge in writing their adherence to the policies comprising our Code of Conduct, which is known as "Common Ground," and, as applicable, our Code of Ethics for Senior Financial Officers and Chief Executive Officer.

Board Structure

The Board consists of 13 directors. The Board has the following standing committees: audit; compensation; nominating and governance; compliance; quality; and executive. In addition, the board of directors of our parent company, DSB Parent, also has a compensation committee that administers equity-based compensation plans in which our managers, officers, employees, consultants and directors participate. As a result of the LifePoint/RCCH Merger and the RegionalCare/Capella Merger, Apollo has the power to control us and our affairs and policies, including the designation of a majority of the members of our Board and the appointment of management.

Committees of our Board of Directors

The Board has adopted written charters for each of the following standing committees:

Audit Committee

The current members of our audit committee are Messrs. Morissette, Haley and Wolford. Mr. Morissette is the chairman of our audit committee. The principal duties and responsibilities of our audit committee are to assist the Board in overseeing:

- the integrity of our financial statements;
- the independent auditor's qualifications, independence and performance;
- the performance of our internal audit function; and
- our compliance with certain legal, ethical and regulatory requirements.

The audit committee has the authority to conduct or authorize investigations into or studies of matters within its scope of responsibilities. It also has the authority to retain and determine funding for independent legal, accounting or other advisors (without seeking Board approval) as it determines necessary or appropriate to carry out its duties and responsibilities.

Our Board has determined that each of Messrs. Morissette and Wolford is an "audit committee financial expert" within the meaning of applicable SEC regulations.

Compensation Committee

The current members of our compensation committee are Messrs. Nord and Press. Mr. Press is the chairman of our compensation committee. The principal duties and responsibilities of our compensation committee are as follows:

- approving the non-equity-based compensation of our officers, directors and employees;
- administering our non-equity-based compensation plans; and
- making recommendations to DSB Parent for the equity-based compensation of DSB Parent and its subsidiaries' officers, directors and employees.

Nominating and Governance Committee

The current members of our nominating and governance committee are Messrs. Christie, Press and Rash. Mr. Press is the chairman of our nominating and governance committee. The principal duties and responsibilities of our nominating and governance committee are as follows:

- to assist the Board in identifying individuals qualified to serve as members of the Board and/or its committees; and
- other duties and responsibilities that our Board may delegate to the nominating and governance committee.

Compliance Committee

The current members of our compliance committee are Messrs. Levin, Morissette, Wolford and Rash. Mr. Wolford is the chairman of our compliance committee. The compliance committee is responsible for overseeing our legal and regulatory compliance program, including certain healthcare and regulatory compliance matters that affect us and our business operations.

Quality Committee

The current members of our compliance committee are Messrs. Brownstein, Carpenter, David, Haley and Ms. McMullan. Mr. Carpenter is the chairman of our quality committee. The quality committee is responsible for monitoring and evaluating the adequacy and effectiveness of our quality of care and patient safety programs and initiatives.

Executive Committee

The current members of our executive committee are Messrs. David, Nord and Press. Mr. Nord is the chairman of our executive committee. The principal duties and responsibilities of our executive committee are as follows:

- to advise and counsel the Chief Executive Officer regarding company matters; and
- to take such actions as are necessary due to their urgent or highly confidential nature, or where convening the Board is impracticable, subject to certain limitations.

Item 11. ***Executive Compensation.***

The information that would be required to be disclosed under Part III, Item 11 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

The information that would be required to be disclosed under Part III, Item 12 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

The following discussion reflects certain relationships and related party transactions entered into in connection with the LifePoint/RCCH Merger. For a further discussion of our relationships and related party transactions, refer to the notes to our accompanying consolidated financial statements included elsewhere in this Report and disclosure regarding our relationships and related party transactions contained in the November 2018 OM.

New Employment Agreements

In connection with the consummation of the LifePoint/RCCH Merger, we entered into an employment agreement with each of Messrs. Dill, Bumpus, Coggin and Giovanetti and Ms. Peters. Additionally, we entered an amended and restated employment agreement with Mr. Jay.

Each applicable executive's employment agreement contains an indefinite term of employment. Each employment agreement established the applicable executive's annual base salary (the annual base salary in the employment agreements for each of Messrs. Dill, Bumpus, Coggin, Giovanetti and Jay and Ms. Peters was set at $1,100,000, $550,000, $650,000, $650,000, $650,000 and $550,000, respectively) and his or her eligibility to receive an annual bonus with the target bonus for each fiscal year determined annually by our board of directors or our compensation committee. Pursuant to his or her respective employment agreement, Mr. Dill's target bonus is at least 150% of base salary, and each of Messrs. Bumpus', Coggin's, Giovanetti's and Jay's and Ms. Peters' target bonus is at least 100% of base salary with a maximum of 200% of base salary. The actual bonus payable to each applicable executive will be based upon the level of achievement of annual Company and individual performance objectives, as determined by the board of directors or our compensation committee.

As disclosed in the November 2018 OM, we implemented a transaction severance plan (the "***RCCH Severance Plan***") under which certain employees are eligible to receive severance payments and benefits in connection with their "qualifying termination" (as defined in the November 2018 OM) of employment under the plan within 18 months after the consummation of the LifePoint/RCCH Merger. Under the RCCH Severance Plan and the applicable employment agreement, in the event of his or her qualifying termination under the plan within such 18-month period and execution of a release of claims, each of the executives other than Mr. Bumpus will be entitled to receive the severance payments and benefits provided to "category one" employees as described in the November 2018 OM. Following the expiration of the 18-month period and execution of a release of claims, each of the executives other than Mr. Bumpus will be entitled to receive the severance payments and benefits as described in the applicable employment agreement in the event of his or her termination without cause (other than due to death or disability) or resignation due to good reason. Under his employment agreement, in the event of his termination for any reason other than for cause (including due to retirement) and his execution of a release of claims, Mr. Bumpus will be entitled to receive the same severance payments and benefits payable to "category one" employees under the RCCH Severance Plan and certain additional severance benefits.

Additionally, as disclosed in the November 2018 OM, on November 8, 2018, we entered into an amended and restated employment agreement with Mr. Rash. Mr. Rash's amended and restated employment agreement contains an indefinite term of employment and provides for an annual base salary and payment of an annual fee in connection with his service on our board of directors and severance payments and benefits in the event of his termination of employment without cause (other than due to death or disability) or resignation for good reason and execution of a release of claims. Mr. Rash is not entitled to receive any severance payments or benefits under the RCCH Severance Plan.

Each applicable executive is subject to a (i) 12-month post-termination non-competition covenant relating to competitors of the Company, (ii) 12-month post-termination non-solicitation covenant in respect of our employees, consultants, clients, customers and similar business relationships of the Company and (iii) perpetual confidentiality and non-disparagement covenants.

Retention Bonuses and Severance Payments

As contemplated in the November 2018 OM, in connection with the consummation of the LifePoint/RCCH Merger, we have paid or are paying retention bonuses and severance payments to certain former Legacy LifePoint or RCCH executives and other employees. The aggregate amount for such payments made through the end of December 31, 2018 is included within merger and acquisition costs on our consolidated statement of operations for the year ended December 31, 2018 and are discussed in Note 2 to our accompanying consolidated financial statements included elsewhere in this Report. Certain retention bonuses and severance payments in connection with the LifePoint/RCCH merger are anticipated to continue to be made during 2019 and 2020 and will be reflected within merger and acquisition costs on our consolidated statement of operations for subsequent periods.

DSB Parent L.P. Capital Units and Profits Units

Certain of our executives, employees, consultants and directors, including our new executive officers following the LifePoint/RCCH Merger, have been granted profits units and certain of our executives, employees and directors have purchased capital units in DSB Parent (the "***capital units***"). Further information about such capital unit acquisitions and certain of the profits unit grants is provided below.

The profits units provide the recipients with the opportunity to share in our future appreciation, subject to vesting. In general, 40% of the profits units vest in substantially equal installments on the last day of each of the first twenty (20) calendar quarters commencing on or after the applicable grant date or, in the case of certain grants, November 16, 2018 (the "***time-vested profits units***") and the remaining 60% of the profits units vest based on the achievement of certain investment returns to our Sponsor. The profits units granted to directors (the "***directors profits units***") generally vest on a time basis, either in substantially equal installments on each of the first three anniversaries of the date of grant or on the date that is six months and one day from November 16, 2018. In addition, the time-vested profits units and the director profits units will vest in full on a sale of the Company. Refer to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by DSB Parent to our executives, employees, consultants and directors.

The capital units and profits units are generally subject to the terms and condition set forth in the applicable award agreements or subscription agreements, as the case may be, and in the partnership agreement of DSB Parent, including, but not limited to, customary transfer restrictions, redemption rights and obligations, drag-along rights, tag-along rights, and preemptive rights.

Equity Repurchases

As contemplated in the November 2018 OM, in connection with the LifePoint/RCCH Merger, DSB Parent has repurchased or is in process of repurchasing capital units and vested profits units from certain of our former or departing employees, including certain former executive officers. Although none of these repurchases were completed prior to the end of 2018, the aggregate amount of such repurchases is included under the caption "Other current liabilities" in our accompanying consolidated balance sheet as of December 31, 2018 included elsewhere in this Report. Repurchases are ongoing and are anticipated to continue to occur during 2019.

Director Arrangements

Certain members of our Board of Directors are entitled to receive annual retainers and fees in accordance with our director compensation policy in connection with their service on our Board.

In addition, as contemplated in November 2018 OM, we entered into a letter agreement with Mr. Carpenter, dated November 16, 2018, regarding the terms of his stepping down as the chief executive officer and chairman of the board of directors of Legacy LifePoint and the terms of his continued service with us on our board of directors.

Item 14. *Principal Accounting Fees and Services*.

The Audit Committee has appointed Ernst & Young LLP as our independent registered public accounting firm. Services provided to us by Ernst & Young LLP in fiscal 2018 are described below.

Audit Fees. The aggregate audit fees billed by Ernst & Young LLP for professional services rendered for the audit of our annual consolidated financial statements and services that are normally provided by the independent registered public accounting firm in connection with statutory and regulatory filings totaled approximately $6.0 million for 2018 and approximately $1.2 million for 2017.

Audit-Related Fees. The aggregate fees billed by Ernst & Young LLP for assurance and related services other than those described under “Audit Fees” were approximately $0.2 million for 2018.

Tax Fees. The aggregate fees billed by Ernst & Young LLP for professional services rendered for tax compliance, tax advice and tax planning were approximately $0.3 million for 2018 and approximately $0.1 million for 2017.

All Other Fees. There were no fees billed by Ernst & Young LLP for products or services other than those described above in 2018 or 2017.

PART IV

Item 15. ***Exhibits, Financial Statement Schedules*.**

(a) The following documents are filed as part of this Report:

1. *Consolidated Financial Statements*:

2. *Financial Statement Schedule*: All schedules for which provision is made in the applicable accounting regulations of the SEC are omitted because they either are not required under the related instructions, are inapplicable, or the required information is shown in the consolidated financial statements or notes thereto.

3. *Exhibits*: The exhibits required by Item 601 of Regulation S-K that would be disclosed under Part IV, Item 15 of an annual report on Form 10-K filed with the SEC have been omitted as permitted pursuant to Section 4.02(a) of the Indentures.

Ernst & Young LLP
222 2nd Avenue South
Suite 2100
Nashville, TN 37201

Tel: (615) 252 2000
Fax: (615) 242-9128
ey.com

Report of Independent Auditors

Board of Directors and Shareholders of
LifePoint Health, Inc.

We have audited the accompanying consolidated financial statements of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.), which comprise the consolidated balance sheets as of December 31, 2018 and 2017, and the related consolidated statements of operations, comprehensive loss, equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.) at December 31, 2018 and 2017, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2018 in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

March 28, 2019

LifePoint Health, Inc.

Consolidated Statements of Operations
For the Years Ended December 31, 2018, 2017 and 2016
(In millions)

	2018	2017	2016
Revenues before provision for doubtful accounts	$ 3,136.0	$ 2,079.7	$ 1,667.9
Provision for doubtful accounts	357.9	206.9	165.2
Revenues	2,778.1	1,872.8	1,502.7
Salaries and benefits	1,329.4	874.3	694.4
Supplies	484.5	323.2	261.3
Other operating expenses, net	709.2	469.4	377.1
Depreciation and amortization	129.0	80.6	57.6
Interest expense, net	186.1	126.1	101.3
Merger and acquisition costs	141.5	7.8	25.1
Impairments of goodwill and long-lived assets	78.4	14.1	11.6
Other non-operating losses, net	7.8	16.7	11.6
	3,065.9	1,912.2	1,540.0
Loss before income taxes	(287.8)	(39.4)	(37.3)
Provision for (benefit from) income taxes	0.2	(1.3)	4.0
Net loss	(288.0)	(38.1)	(41.3)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(5.7)	(7.3)	(2.7)
Net loss attributable to LifePoint Health, Inc.	$ (293.7)	$ (45.4)	$ (44.0)

LifePoint Health, Inc.

Consolidated Statements of Comprehensive Loss
For the Years Ended December 31, 2018, 2017 and 2016
(In millions)

	2018	2017	2016
Net loss	$ (288.0)	$ (38.1)	$ (41.3)
Other comprehensive (loss) income , net of income taxes:			
Unrealized loss on changes in funded status of pension benefit obligations	(3.1)	-	-
Other	-	0.3	(0.4)
Other comprehensive (loss) income	(3.1)	0.3	(0.4)
Comprehensive loss	(291.1)	(37.8)	(41.7)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(5.7)	(7.3)	(2.7)
Comprehensive loss attributable to LifePoint Health, Inc.	$ (296.8)	$ (45.1)	$ (44.4)

LifePoint Health, Inc.

Consolidated Balance Sheets
As of December 31, 2018 and 2017
(In millions, except for share and per share amounts)

	2018	2017
ASSETS		
Current assets:		
Cash and cash equivalents	$ 58.9	$ 16.9
Accounts receivable, less allowances for doubtful accounts of $403.4 and $251.9 at December 31, 2018 and 2017, respectively	1,108.9	256.8
Inventories	224.4	55.5
Prepaid expenses	92.7	18.9
Other current assets	227.8	35.5
	1,712.7	383.6
Property and equipment:		
Land	265.7	55.6
Buildings and improvements	2,784.5	617.1
Equipment	1,079.2	250.9
Construction in progress	436.5	161.8
	4,565.9	1,085.4
Accumulated depreciation	(248.8)	(133.9)
	4,317.1	951.5
Intangible assets, net	74.5	7.3
Other long-term assets	319.8	63.6
Goodwill	2,567.6	651.5
Total assets	$ 8,991.7	$ 2,057.5
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 318.3	$ 115.8
Accrued salaries	343.5	77.7
Other current liabilities	422.2	59.1
Current maturities of long-term debt	58.4	9.8
	1,142.4	262.4
Long-term debt, net	6,419.4	1,424.2
Long-term portion of reserves for self-insurance claims	194.0	50.9
Other long-term liabilities	146.5	39.3
Total liabilities	7,902.3	1,776.8
Redeemable noncontrolling interests	136.1	60.7
Equity:		
LifePoint Health, Inc. stockholders' equity:		
Common stock, $0.01 par value; 30,000 shares authorized; 100 shares issued and outstanding at December 31, 2018 and 2017	-	-
Capital in excess of par value	1,308.3	308.1
Accumulated other comprehensive loss	(3.1)	-
Accumulated deficit	(381.8)	(88.1)
Total LifePoint Health, Inc. equity	923.4	220.0
Noncontrolling interests	29.9	-
Total equity	953.3	220.0
Total liabilities and equity	$ 8,991.7	$ 2,057.5

LifePoint Health, Inc.

Consolidated Statements of Cash Flows
For the Years Ended December 31, 2018, 2017 and 2016
(In millions)

	2018	2017	2016
Cash flows from operating activities:			
Net loss	$ (288.0)	$ (38.1)	$ (41.3)
Adjustments to reconcile net loss to net cash (used in) provided by operating activities:			
Depreciation and amortization	129.0	80.6	57.6
Other non-cash amortization	9.9	5.8	4.0
Stock-based compensation	7.0	0.7	0.6
Impairments of goodwill and long-lived assets	78.4	14.1	11.6
Other non-operating losses, net	7.8	16.7	11.6
Deferred income taxes	(0.6)	(1.7)	4.0
Reserve for self-insurance claims, net of payments	2.3	(3.2)	2.3
Changes in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:			
Accounts receivable	(48.1)	17.8	(8.5)
Inventories, prepaid expenses and other current assets	(0.2)	(15.5)	11.1
Accounts payable, accrued salaries and other current liabilities	(8.9)	37.7	2.1
Income taxes payable/receivable	53.0	(2.9)	2.0
Other	(14.6)	(6.4)	(2.3)
Net cash (used in) provided by operating activities	(73.0)	105.6	54.8
Cash flows from investing activities:			
Acquisitions, net of cash acquired	(5,345.9)	(112.9)	(673.8)
Purchases of property and equipment	(319.7)	(145.1)	(67.5)
Proceeds from sales of hospitals	-	93.5	-
Proceeds from restricted cash for use in construction of replacement hospital	20.3	10.4	-
Proceeds from sales of investments, net of purchases	(0.4)	3.0	25.7
Net cash used in investing activities	(5,645.7)	(151.1)	(715.6)
Cash flows from financing activities:			
Proceeds from borrowings	5,125.0	37.6	1,150.0
Payments of borrowings	(189.3)	(1.7)	(554.9)
Net change in ABL Facility and Prior ABL Facility	10.0	10.0	-
Proceeds from lease financing	38.0	100.5	109.7
Repayment of MPT lease obligation in connection with hospital sale	-	(64.3)	-
Payments of debt financing costs	(207.0)	(0.9)	(54.9)
Cash contributed by (distributed to) parent	1,000.0	(37.6)	46.7
Distributions to noncontrolling interests and redeemable noncontrolling interests, net of proceeds	(6.0)	(3.9)	(8.6)
Financing and capital lease payments and other	(10.0)	(7.7)	(4.8)
Net cash provided by financing activities	5,760.7	32.0	683.2
Change in cash and cash equivalents	42.0	(13.5)	22.4
Cash and cash equivalents at beginning of period	16.9	30.4	8.0
Cash and cash equivalents at end of period	$ 58.9	$ 16.9	$ 30.4
Supplemental disclosure of cash flow information:			
Interest payments	$ 138.1	$ 127.3	$ 81.9
Capitalized interest	$ 17.4	$ 6.1	$ 1.7
Income tax (refunds) payments, net	$ (53.7)	$ 0.8	$ 0.4

LifePoint Health, Inc.

Consolidated Statements of Equity
For the Years Ended December 31, 2018, 2017 and 2016
(Dollars in millions)

	Common Stock		Capital in Excess of	Accumulated Other Comprehensive	Accumulated Earnings	Noncontrolling	
	Shares	Amount	Par Value	Income (Loss)	(Deficit)	Interests	Total
Balance at January 1, 2016	100	$ -	$ 300.4	$ 0.1	$ 1.3	$ -	$ 301.8
Net loss	-	-	-	-	(44.0)	-	(44.0)
Other comprehensive loss	-	-	-	(0.4)	-	-	(0.4)
Stock-based compensation	-	-	0.6	-	-	-	0.6
Capital contribution from parent	-	-	46.7	-	-	-	46.7
Capital contributions from management	-	-	3.3	-	-	-	3.3
Repurchase of parent units	-	-	(2.9)	-	-	-	(2.9)
Balance at December 31, 2016	100	-	348.1	(0.3)	(42.7)	-	305.1
Net loss	-	-	-	-	(45.4)	-	(45.4)
Other comprehensive income	-	-	-	0.3	-	-	0.3
Stock-based compensation	-	-	0.7	-	-	-	0.7
Capital distribution to parent	-	-	(37.6)	-	-	-	(37.6)
Fair value adjustments related to redeemable noncontrolling interests	-	-	(3.1)	-	-	-	(3.1)
Balance at December 31, 2017	100	-	308.1	-	(88.1)	-	220.0
Net loss (income)	-	-	-	-	(293.7)	0.2	(293.5)
Other comprehensive loss	-	-	-	(3.1)	-	-	(3.1)
Stock-based compensation	-	-	7.0	-	-	-	7.0
Reclassification of vested stock-based compensation units to a liability	-	-	(6.8)	-	-	-	(6.8)
Capital contribution from parent	-	-	1,000.0	-	-	-	1,000.0
Noncontrolling interests assumed in LifePoint/RCCH Merger	-	-	-	-	-	29.9	29.9
Distributions to noncontrolling interests	-	-	-	-	-	(0.2)	(0.2)
Balance at December 31, 2018	100	$ -	$ 1,308.3	$ (3.1)	$ (381.8)	$ 29.9	$ 953.3

Note 1. Organization and Summary of Significant Accounting Policies

Organization

LifePoint Health, Inc., a Delaware corporation, acting through its subsidiaries, owns or leases and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. At December 31, 2018, on a consolidated basis, LifePoint Health, Inc. operated 89 hospital campuses in 30 states throughout the United States ("U.S.").

Unless otherwise indicated or the context otherwise requires, references throughout these notes to the consolidated financial statements to the "Company" or "LifePoint" refer to LifePoint Health, Inc., and each of its consolidated subsidiaries after giving effect to the LifePoint/RCCH Merger (defined below) and (ii) "RCCH" refer to RegionalCare Hospital Partners Holdings, Inc. and each of its consolidated subsidiaries before giving effect to the LifePoint/RCCH Merger. References in this Report to the "Sponsor" refer to certain funds that are affiliates of the Company (the "Apollo Funds") that are ultimately controlled and/or managed by Apollo Management VIII, L.P. ("Apollo Management" and, when acting on behalf of the Apollo Funds, "Apollo"), which is an affiliate of Apollo Global Management LLC.

Additionally, references throughout these notes to the consolidated financial statements to the "LifePoint/RCCH Merger" refer to the merger, which was effective on November 16, 2018, of Legend Merger Sub, Inc., a Delaware corporation and wholly owned subsidiary of RCCH ("Legend Merger Sub"), with and into LifePoint Health, Inc., a Delaware corporation ("Legacy LifePoint"), with Legacy LifePoint surviving the LifePoint/RCCH Merger as a subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners, Inc." to "LifePoint Health, Inc."

Furthermore, references throughout these notes to the consolidated financial statements to the "RegionalCare/Capella Merger" refer to the merger of Crimson Merger Sub, LLC ("Crimson Merger Sub"), a Delaware limited liability company and wholly-owned subsidiary of RegionalCare Hospital Partners Inc. ("RegionalCare"), with and into Capella Health Holdings, LLC ("Capella"), with Capella surviving the RegionalCare/Capella Merger as a wholly-owned subsidiary of RegionalCare, which began to do business as RCCH Healthcare Partners. The RegionalCare/Capella Merger was consummated on April 29, 2016; however, for accounting purposes, the RegionalCare/Capella Merger became effective on May 1, 2016.

References throughout these notes to the consolidated financial statements to the "Apollo/RegionalCare Acquisition" refer to the merger, which was effective on December 3, 2015, of DSB Merger Sub Inc., a Delaware corporation and wholly-owned subsidiary of DSB Acquisition LLC, a Delaware limited liability company ("Holdings"), with and into RegionalCare with RegionalCare surviving such merger as a direct wholly-owned subsidiary of Holdings, which is indirectly controlled by our Sponsor.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through majority voting control, and variable interest entities which the Company controls. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation. Noncontrolling interests in non-wholly-owned consolidated subsidiaries of the Company are presented as noncontrolling interests and redeemable noncontrolling interests and distinguish between the interests of the Company and the interests of the noncontrolling owners. Net income attributable to noncontrolling interests and redeemable noncontrolling interests represents the amounts attributable to the noncontrolling interests for each of the applicable periods presented. Investments in entities the Company does not control but does have a substantial ownership interest and can exercise significant influence are accounted for using the equity method.

The Company's financial statements have been presented on the basis of push down accounting in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") No. 805-50-S99. Under the push down basis of accounting, certain transactions incurred by the parent company which would otherwise be accounted for in the accounts of the parent are "pushed down" and recorded on the financial statements of the subsidiary. Accordingly, certain items resulting from the acquisition by Apollo have been recorded on the financial statements of the Company.

Use of Estimates

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

Revenue Recognition and Accounts Receivable

Overview

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

Change in Accounting Estimate

During the year ended December 31, 2018, the Company recorded a decrease to revenues of $17.0 million as a result of a change in its accounting estimate of the collectability of accounts receivable. During the year ended December 31, 2018, the Company identified additional information which indicated that its current collection estimates might be different from its historical collection estimates. Management utilized this new information to further refine its estimation procedures to more precisely estimate the collectability of accounts receivable. The Company's change in its estimation procedures of the collectability of its accounts receivable is considered a change in accounting estimate in accordance with ASC 250, "Accounting Changes and Error Corrections."

Payer Mix

The following table summarizes the Company's revenues by payer as approximate percentages of net patient revenues before the provision for doubtful accounts for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
Medicare	37.6 %	40.4 %	36.4 %
Medicaid	13.1	12.2	12.8
HMOs, PPOs and other private insurers	41.3	40.7	42.5
Self-pay	8.0	6.7	8.3
	100.0 %	100.0 %	100.0 %

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

Contractual Discounts and Cost Report Settlements

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

Cost report settlements under reimbursement agreements with Medicare and Medicaid are estimated and recorded in the period the related services are rendered and will be adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. For the year ended December 31, 2018, the net adjustments to estimated cost report settlements resulted in a decrease to revenues of approximately $4.0 million, and for the years ended December 31, 2017 and 2016, the net adjustments to estimated cost report settlements resulted in increases to revenues of approximately $3.6 million and $3.7 million, respectively. The net estimated cost report settlements due to Medicare and Medicaid were approximately $0.5 million and $0.3 million as of December 31, 2018 and 2017, respectively. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these agreements.

The Company believes that it is in compliance with all applicable laws and regulations with regard to its Medicare and Medicaid programs and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Company's consolidated financial statements. Compliance with such laws and regulations can be subject to future governmental review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

Charity Care

Self-pay revenues are derived primarily from patients who do not have any form of healthcare coverage. The revenues associated with self-pay patients are generally reported at the Company's gross charges. The Company evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the local hospital's policy for charity care. The Company provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the years ended December 31, 2018, 2017 and 2016, the Company estimates that its costs of care provided under its charity care programs approximated $16.8 million, $11.7 million and $5.7 million, respectively. The Company does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Company's policy not to pursue collection of amounts related to these patients.

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

Provision and Allowance for Doubtful Accounts

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

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

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

	Balances at Beginning of Year	Additions Recognized as a Reduction to Revenues	Accounts Written Off, Net of Recoveries	Balances at End of Year
Year ended December 31, 2018	$ 251.9	$ 357.9	$ (206.4)	$ 403.4
Year ended December 31, 2017	$ 127.7	$ 206.9	$ (82.7)	$ 251.9
Year ended December 31, 2016	$ 7.9	$ 165.2	$ (45.4)	$ 127.7

The allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts were 26.7% and 49.5% as of December 31, 2018 and 2017, respectively. The decrease in the Company's allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts, is primarily a result of the accounts receivable acquired in connection with the LifePoint/RCCH Merger, which was recognized in the Company's balance sheet net of allowances for doubtful accounts at the effective time of the LifePoint/RCCH Merger. Additionally, as of December 31, 2018 and 2017, the allowances for doubtful accounts plus certain contractual allowances and discounts related to self-pay patients as a percentage of self-pay receivables were 95.3% and 94.1%, respectively.

Concentration of Revenues

During the years ended December 31, 2018, 2017 and 2016, approximately 50.7%, 52.6% and 49.2%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs, collectively. The Company's management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies. Any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs could have an adverse effect on the Company's revenues or results of operations. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payer or geographic area that would subject the Company to any significant credit risks in the collection of its accounts receivable.

Other Revenue

Other revenue primarily consists of hospital ancillary sales and services as well as rental income. The Company leases certain real estate assets it owns to unrelated third parties, primarily medical office buildings to non-employed physicians. The Company recognizes rental income for these operating lease arrangements in which the Company is the lessor on a straight-line basis over the lease term in accordance with ASC 840, "Leases" ("ASC 840").

General and Administrative Costs

The majority of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as "general and administrative" by the Company would include its corporate overhead costs, excluding depreciation and amortization and merger and acquisition costs, which were $72.4 million, $42.8 million and $29.7 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Other Income

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

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

The Company recognized EHR incentive income under the Medicare and Medicaid HITECH Act programs, collectively, of $9.8 million during the year ended December 31, 2016, which is included under the caption "Other operating expenses, net" in the Company's accompanying consolidated statements of operations. The Company's incentive payments under these programs substantially concluded in 2017.

Cash and Cash Equivalents

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

Inventories

Inventories of supplies are stated at the lower of cost (first-in, first-out) or market and consist of purchased items. Inventories acquired in connection with business combinations are recorded at fair value which approximates replacement cost. Inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

Investments

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, under the equity method of accounting in accordance with ASC 323, "Investments – Equity Method and Joint Ventures" ("ASC 323"). The Company does not consolidate its equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period. Refer to Note 9 for further discussion of the Company's equity method investments.

Property and Equipment

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

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

	Years		
Buildings and improvements (including those under capital leases and financing obligations)	3	-	49
Equipment	2	-	12
Equipment under capital leases	3	-	5

Depreciation expense (including lease amortization) totaled $128.5 million, $80.1 million and $56.9 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

For the year ended December 31, 2018, the Company recognized an impairment charge of $24.5 million to reduce the carrying amounts of certain long-lived assets at one of its facilities to their estimated fair values, which is included under the caption "Impairments of goodwill and long-lived assets" in the accompanying consolidated statements of operations for the year ended December 31, 2018. There were no long-lived asset impairments recorded for the years ended December 31, 2017 and 2016.

Goodwill and Intangible Assets

The Company accounts for its acquisitions in accordance with ASC 805 using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350, Intangibles – Goodwill and Other ("ASC 350"), goodwill and intangible assets with indefinite lives are reviewed by the Company annually for impairment on October 1. The impairment evaluation is performed at the individual hospital level as each hospital represents a reporting unit as defined in ASC 350. For the annual impairment evaluation, the Company may perform an initial qualitative assessment to determine whether it is more likely than not that the fair value of the reporting unit is less than its carrying value. This assessment is used as a basis for determining whether it is necessary to perform the goodwill impairment test. For those reporting units on which the Company performs the impairment test, the Company determines fair value using a discounted cash flow ("DCF") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing the Company's assumptions. The cash flows employed in the DCF analysis are based on the Company's most recent financial budgets and business plans and, when applicable, various growth rates for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the respective reporting units.

The Company's intangible assets relate to contract-based physician minimum revenue guarantees; non-competition agreements; certificates of need and certificates of need exemptions; and licenses, provider numbers, accreditations and other. Contract-based physician minimum revenue guarantees and non-competition agreements are amortized over the terms of the agreements. The certificates of need, certificates of need exemptions, licenses, provider numbers, accreditations and other have been determined to have indefinite lives and, accordingly, are not amortized. Refer to Note 5 for further discussion of the Company's goodwill and intangible assets.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the income tax provision in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is not likely, a valuation allowance is established. The establishment or increase in a valuation allowance is included as an expense within the provision for income taxes in the consolidated statements of operations. The Company classifies interest and penalties related to its tax positions as a component of income tax expense. Refer to Note 6 for further discussion of the Company's accounting for income taxes.

Reserves for Self-Insurance Claims

Given the nature of the Company's operating environment, it is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("SIR") and deductible levels. At December 31, 2018, the Company's SIR for professional liability claims is $5.0 million per claim, with a $5.0 million inner aggregate, at the majority of its facilities, and $2.0 million per claim at certain of its facilities. Additionally, the Company participates in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2018, the Company's deductibles for workers' compensation claims range from $0.5 million to $1.0 million per claim in all states in which it operates except for Montana, Oklahoma, Ohio, Washington and Wyoming. The Company participates in state-specific programs for its workers' compensation claims arising in these states. The Company's SIR and deductible levels are evaluated annually as a part of its insurance program's renewal process.

The Company's reserves for self-insurance and deductible claims reflect the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The Company's expense for self-insurance and deductible claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's self-insured retention and deductible levels; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance and deductible claims was approximately $20.7 million, $7.7 million and $12.5 million for the years ended December 31, 2018, 2017 and 2016, respectively.

The Company's reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. The Company's reserves for employee workers' compensation claims are based upon semi-annual actuarial calculations. These reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. The Company's reserves for self-insured claims have been discounted to their present value using a discount rate of 1.8% at December 31, 2018 and in a range of 1.4% to 2.4% at December 31, 2017 and 0.9% to 2.3% at December 31, 2016. The Company's management selects a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

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

The following table provides information regarding the classification of the Company's reserves for self-insured claims at December 31, 2018 and 2017 (in millions):

	2018	2017
Current portion	$ 70.7	$ 14.1
Long-term portion	194.0	50.9
	$ 264.7	$ 65.0

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2018 and 2017 (in millions):

	2018	2017
Reserve at the beginning of the period	$ 65.0	$ 64.5
Liabilities assumed in LifePoint/RCCH Merger	194.7	-
Increase for the provision of current year claims	23.0	19.8
Decrease for the provision of prior year claims	(3.9)	(12.1)
Payments related to current year claims	(1.0)	(0.8)
Payments related to prior year claims	(14.8)	(10.0)
Provision for the change in discount rate	1.6	-
Noncash change in reserve for claims in excess of self-insured retention levels	0.1	3.6
Reserve at the end of the period	$ 264.7	$ 65.0

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of the Company's quarterly and semi-annual actuarial calculations resulted in changes to its reserves for self-insured claims for prior years. As a result, for the years ended December 31, 2018, 2017 and 2016, the Company's related self-insured claims expense decreased by $3.9 million, $12.1 million and $4.5 million, respectively.

Point of Life Indemnity, Ltd.

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

Self-Insured Medical Benefits

The Company is self-insured for substantially all of the medical expenses and benefits of its employees. The reserve for medical benefits primarily reflects the current estimate of incurred but not reported losses based upon an annual actuarial calculation as of the balance sheet date. The undiscounted reserve for self-insured medical benefits was $46.1 million and $7.1 million at December 31, 2018 and 2017, respectively, and is included in the Company's accompanying consolidated balance sheets under the caption "Other current liabilities".

Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to the Company. The Company's accompanying consolidated financial statements include all assets, liabilities, revenues, and expenses at their consolidated amounts, which include the amounts attributable to the Company and the noncontrolling interest. The Company recognizes as a separate component of earnings that portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company. Refer to Note 10 for further discussion of the Company's noncontrolling interests and redeemable noncontrolling interests.

Variable Interest Entities

The Company's consolidated financial statements at December 31, 2018 include eight facilities that qualify as a variable interest entity in which the Company is the primary beneficiary under the provisions of ASC 810, "Consolidation," and in which the Company owns a controlling economic interest.

Stock-Based Compensation

The Company's indirect parent, DSB Parent L.P., a Delaware limited partnership ("DSB Parent"), has issued profits units (the "Units") to certain employees, directors and consultants under the terms and conditions of the Amended and Restated Limited Partnership Agreement of DSB Parent dated of December 3, 2015 (the "DSB Parent Partnership Agreement") and forms of award agreements. The Company accounted for these stock-based awards in accordance with the provisions of ASC 718, "Compensation – Stock Compensation" ("ASC 718"). In accordance with ASC 718, the Company recognized compensation expense based on the estimated grant date fair value of each stock-based award. The Company recognizes forfeitures of Units as they occur. Refer to Note 14 for further discussion of the Company's accounting for Units.

Defined Benefit Pension Plans

In connection with the LifePoint/RCCH Merger, the Company acquired certain assets and assumed certain liabilities associated with two separate defined benefit pension plans covering certain employees at two of Legacy LifePoint's facilities. The Company accounts for its defined benefit pension plans in accordance with ASC 715, "Compensation – Defined Benefit Plans", ("ASC 715"). In accordance with ASC 715, the Company recognizes the unfunded liability of its defined benefit pension plans in the Company's consolidated balance sheets and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the defined benefit pension plans' assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligation is measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality. Refer to Note 12 for further discussion of the Company's defined benefit pension plans.

Defined Contribution Plans

The Company maintains three separate defined contribution retirement plans covering a majority of the Company's employees, including Legacy LifePoint employees, RCCH employees and employees at Community Medical Center. These defined contribution retirement plans contain discretionary matching policies based on the Company's financial performance and definite contribution formulas for employees at certain facilities. Refer to Note 12 for further discussion of the Company's defined contribution plans.

Reclassifications

Certain reclassifications have been made to the prior years to conform to current year presentation. These reclassifications had no effect on net loss or cash flows as previously reported.

Accounting Standards Not Yet Adopted

Accounting Standards Update ("ASU") 2014-9, "Revenue from Contracts with Customers"

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

Step 1: Identify the contract(s) with a customer.
Step 2: Identify the performance obligations in the contract.
Step 3: Determine the transaction price.
Step 4: Allocate the transaction price to the performance obligations in the contract.
Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

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

The provisions of the New Revenue Standard are effective for annual reporting periods beginning after December 15, 2018 by applying either the full retrospective method or the cumulative catch-up transition method. The full retrospective method requires application of the provisions of the New Revenue Standard for all periods presented while the cumulative catch-up transition method requires the application of the provisions of the New Revenue Standard as of the date of adoption with the cumulative effect of the retrospective application of the provisions as an adjustment through retained earnings. Currently, the Company anticipates adopting the provisions of the New Revenue Standard using the full retrospective method.

The Company does not anticipate that the provisions of the New Revenue Standard will have an impact on its current or historical financial position, results of operations or cash flows. Additionally, the Company does not anticipate that the provisions of the New Revenue Standard will have an impact on the amount or timing of when it recognizes revenues prospectively. However, upon adoption of the New Revenue Standard, the Company will recognize the majority of its previously reported provision for doubtful accounts, primarily related to its self-pay patient population, as a direct reduction to revenues as an implicit pricing concession, instead of separately as a discrete deduction to arrive at revenues, and the related presentation of the allowance for doubtful accounts will be eliminated for all periods presented.

ASU 2016-2, "Leases"

In February 2016, the FASB issued ASU 2016-2 "Leases" ("ASU 2016-2"). ASU 2016-2 requires the rights and obligations arising from lease contracts, including existing and new arrangements, to be recognized as assets and liabilities on the balance sheet. ASU 2016-2 is effective for annual reporting periods beginning after December 15, 2019. The Company anticipates that the adoption of ASU 2016-2 will result in an increase in both total assets and total liabilities reflected on the Company's balance sheets. The Company is still evaluating the impact that the adoption of this standard will have on its policies, procedures, financial disclosures, and control framework.

Note 2. Mergers

LifePoint/RCCH Merger

Summary

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

Equity Contribution

In connection with the LifePoint/RCCH Merger, the Apollo Funds, together with certain other co-investors investing through a co-investment vehicle controlled by our Sponsor or its affiliates, indirectly contributed $1,000.0 million of newly invested capital to DSB Parent, which is our indirect parent and is owned by the Apollo Funds, such co-investment vehicle and certain current or former directors, members of management, employees and consultants of the Company, and the $1,000.0 million of newly invested capital was further contributed to the Company to be used to partially fund the LifePoint/RCCH Merger.

Financing Transactions

Concurrently with the closing of the LifePoint/RCCH Merger, the Company (1) issued $1,425.0 million principal amount of 9.750% Senior Notes due 2026 (the "9.75% Unsecured Notes"), (2) entered into a new senior secured asset-based revolving credit facility (the "ABL Facility") in an aggregate principal amount of $800.0 million with a maturity of five years, (3) terminated its existing senior secured asset-based revolving credit facility, entered into on April 29, 2016 (the "Prior ABL Facility"), (4) entered into a senior secured term loan credit facility (the "Term Loan Facility") in an aggregate principal amount of $3,550.0 million with a maturity of seven years, and (4) repaid in full its $150.0 million term loan facility, entered into on April 25, 2018 (the "Prior Term Facility").

The Company has accounted for the LifePoint/RCCH Merger in accordance with ASC 805 under the acquisition method of accounting. The following table summarizes the fair values of assets acquired and liabilities assumed on a preliminary basis in connection with the LifePoint/RCCH Merger (in millions):

Cash	$	139.8
Accounts receivable		778.8
Other current assets		479.2
Property and equipment		3,117.3
Goodwill		1,950.1
Intangible assets		60.3
Other long-term assets		240.0
Accounts payable		(185.3)
Accrued salaries		(407.8)
Other current liabilities		(266.0)
Capital and financing leases		(136.1)
Other long-term liabilities		(235.1)
Noncontrolling interests and redeemable noncontrolling interests		(105.6)
Net assets acquired	$	5,429.6

The fair values assigned to certain assets acquired and liabilities assumed in relation to the LifePoint/RCCH Merger have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of property and equipment, goodwill, intangible assets, equity method investments, noncontrolling interests and redeemable noncontrolling interests, as well as deferred income taxes. The Company expects to finalize its analysis during 2019.

The results of operations of Legacy LifePoint are included in the Company's results of operations beginning on November 17, 2018. Revenues from the operations acquired in the LifePoint/RCCH Merger included in the Company's consolidated statements of operations were $754.9 million for the year ended December 31, 2018. Income before income taxes from the operations acquired in the LifePoint/RCCH Merger was $50.9 million for the year ended December 31, 2018.

For the year ended December 31, 2018, the Company recognized merger-related costs of $134.7 million primarily related to legal and transaction advisory services as well as employee severance and retention costs in connection with the LifePoint/RCCH Merger. Included in this amount is a $55.0 million transaction fee paid by the Company to an affiliate of its Sponsor upon the closing of the LifePoint/RCCH Merger.

RegionalCare/Capella Merger

On March 21, 2016, RegionalCare and Capella entered into an agreement and plan of merger, pursuant to which, effective on April 29, 2016, Crimson Merger Sub merged with and into Capella, with Capella continuing as the surviving company in the merger as a wholly-owned subsidiary of RegionalCare. After the RegionalCare/Capella Merger was consummated we began to do business as RCCH HealthCare Partners. Concurrently with the closing of the RegionalCare/Capella Merger, the Company (i) issued the 8.25% Secured Notes due 2023 in an aggregate principal amount of $800.0 million (the "8.25% Secured Notes") and the 11.5% Unsecured Notes due 2024 an aggregate principal amount of $350.0 million (the "11.5% Unsecured Notes") (ii) entered into the Prior ABL Facility and (iii) refinanced certain indebtedness of DSB Holdings Inc., a Delaware corporation and wholly-owned subsidiary of DSB Parent ("DSB Holdings"), RegionalCare and Capella.

The Company accounted for the RegionalCare/Capella Merger in accordance with ASC 805 under the acquisition method of accounting. The following table summarizes the fair values of assets acquired and liabilities assumed in connection with the RegionalCare/Capella Merger (in millions):

Cash	$	16.5
Accounts receivable		116.4
Other current assets		75.6
Property and equipment		397.3
Goodwill		367.0
Other long-term assets		17.1
Accounts payable		(32.6)
Accrued salaries		(27.4)
Other current liabilities		(27.1)
Financing leases		(177.6)
Other long-term liabilities		(32.2)
Redeemable noncontrolling interests		(21.1)
Net assets acquired		671.9
Cash contributed to parent by Capella management		(3.4)
Total merger consideration	$	668.5

The results of operations of Capella are included in the Company's results of operations beginning on May 1, 2016. Revenues from the operations acquired in the RegionalCare/Capella Merger included in the Company's consolidated statements of operations were $578.1 million for the year ended December 31, 2016. Income before income taxes from the operations acquired in the RegionalCare/Capella Merger was $42.8 million for the year ended December 31, 2016.

For the year ended December 31, 2016, the Company recognized merger-related costs of $21.7 million primarily related to legal and transaction advisory services and employee severance costs in connection with the RegionalCare/Capella Merger.

Note 3. Acquisitions & Divestitures

Acquisitions

Lourdes Health ("Lourdes")

At the close of business on August 31, 2018, the Company acquired Lourdes for $21.3 million, of which $17.5 million was financed from a sale-leaseback transaction with an affiliate of Medical Properties Trust ("MPT"), a Maryland corporation operating as a real estate investment trust. Lourdes is comprised of a 95 bed medical center and a 32 bed counseling center each located in Pasco, Washington. The results of operations of Lourdes are included in the Company's results of operations beginning on September 1, 2018.

Trios Health ("Trios")

At the close of business on August 3, 2018, the Company acquired Trios for $18.0 million. Trios is comprised of two hospital campuses with a total of 111 beds each located in Kennewick, Washington. In connection with the Trios acquisition, the Company entered into a sale-leaseback arrangement for a hospital building whose rent is contingent on the financial performance of the hospital and a sale-leaseback arrangement for a medical office building. The results of operations of Trios are included in the Company's results of operations beginning on August 4, 2018. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of Trios have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired as well as obligations assumed. The Company expects to finalize its analysis during 2019.

Pacific Medical Data Solutions ("PMDS")

Effective April 1, 2018, the Company acquired PMDS for $10.7 million. PMDS is a healthcare technology and software services company that provides revenue cycle, billing automation and software solutions to multi-specialty physician groups, ambulatory surgery centers and urgent care clinics.

St. Joseph Regional Medical Center ("St. Joseph")

At the close of business on April 30, 2017, the Company acquired St. Joseph, a 145 bed hospital in Lewiston, Idaho, for $112.2 million of which $87.5 million was financed from a sale-leaseback transaction with MPT. The results of operations of St. Joseph are included in the Company's results of operations beginning on May 1, 2017.

Saline Memorial Hospital ("Saline")

Effective June 30, 2016, the Company acquired a controlling interest in Saline County Medical Center Joint Venture, LLC, ("Saline") which owns and operates a 177 bed hospital in Benton, Arkansas for $16.6 million. The results of operations of Saline are included in the Company's results of operations beginning on July 1, 2016.

Divestitures

Teche Regional Medical Center ("Teche")

In August 2018, Legacy LifePoint and certain of its subsidiaries entered into a proposed settlement agreement with The Hospital Service District No. 2 of the Parish of St. Mary ("HSD"), a political subdivision of the state of Louisiana, outlining the terms of a definitive settlement agreement to terminate the Legacy LifePoint's lease of Teche, located in Morgan City, Louisiana. The proposed settlement agreement provides, among other things, that the Company will convey to HSD, or its designee, all assets of Teche in accordance with the existing lease agreement, and the Company will no longer operate Teche upon completion of the transaction. The Company anticipates this transaction to be completed during the second quarter of 2019 subject to the terms and conditions of a definitive settlement agreement. Included in the Company's consolidated results of operations for the year ended December 31, 2018 is a net operating loss before income taxes attributable to Teche of $0.6 million.

Sharon Hospital ("Sharon")

The Company sold Sharon Hospital, located in Sharon, Connecticut on August 1, 2017 for $3.6 million. The Company recorded an estimated impairment of long-lived assets of $11.6 million during the year ended December 31, 2016, in order to reduce the carrying value of Sharon's property and equipment to its estimated fair value. The Company subsequently recorded a loss on sale of $2.8 million during the year ended December 31, 2017 as the divestiture was finalized. Included in the Company's consolidated results of operations for the year ended December 31, 2017 and 2016 are net operating losses before income taxes attributable to Sharon of $2.1 million and $1.6 million, respectively.

EaStar Health System ("EaStar")

On March 31, 2017, the Company sold EaStar Health System, located in Muskogee, Oklahoma. The total sales price was $89.3 million, plus certain working capital items and sales taxes. Of the proceeds, $68.5 million were paid to MPT to pay off the financing lease obligation and the related prepayment penalty. The remainder of the proceeds of $20.8 million were paid directly to the Company's parent. Included in the Company's consolidated results of operations for the year ended December 31, 2017 and 2016 are net operating losses before income taxes attributable to EaStar of $8.9 million and $1.4 million, respectively.

Note 4. Long-Term Debt

The Company's long-term debt, including current portions and financing and capital leases, consists of the following at December 31, 2018 and 2017 (in millions):

	2018	2017
Senior borrowings:		
ABL Facility	$ 20.0	$ -
Prior ABL Facility	-	10.0
Term Loan Facility	3,550.0	-
9.75% Unsecured Notes	1,425.0	-
8.25% Secured Notes	800.0	800.0
11.5% Unsecured Notes	350.0	350.0
Financing and capital leases	557.2	265.0
Secured loan from affiliate	-	37.6
Unamortized debt issuance costs	(227.4)	(32.9)
	6,474.8	1,429.7
Subordinated borrowings, net	3.0	4.3
Total debt	$ 6,477.8	$ 1,434.0

Maturities of the Company's long-term debt outstanding at December 31, 2018, including financing and capital leases, but excluding unamortized debt issuance costs and other obligations that do not require eventual settlement in cash, are as follows for the years indicated (in millions):

2019	$ 58.4
2020	48.2
2021	50.4
2022	116.7
2023	847.5
Thereafter	5,533.1
	$ 6,654.3

ABL Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Co-Borrowers entered into the ABL Facility in an aggregate principal amount of $800.0 million and terminated its Prior ABL Facility. The ABL Facility has a maturity of five years; provided that if more than $200.0 million aggregate principal amount of the 8.25% Secured Notes remain outstanding 91 days before the stated maturity thereof (the "ABL Springing Maturity Date"), then the ABL Facility will mature and the commitments ABL Facility will terminate on the ABL Springing Maturity Date. At the Effective Time, Legacy LifePoint assumed all of the rights and obligations of Legend Merger Sub under the ABL Facility. The ABL Facility also includes both a letter of credit sub-facility and a swingline loan sub-facility (including in its capacity as co-borrower under the Term Loan Facility). In addition, the Company may request one or more incremental revolving commitments in an aggregate principal amount up to the greater of (x) the greater of (i) $255.0 million and (ii) 0.23 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, and (y) the amount by which the borrowing base exceeds the aggregate commitments under the ABL Facility, subject to certain conditions and receipt of commitments by existing or additional lenders.

As of December 31, 2018, the Company had $20.0 million in borrowings outstanding under the ABL Facility and approximately $32.0 in letters of credit outstanding primarily related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims. Amounts available for borrowing under the ABL Facility were approximately $548.0 million as of December 31, 2018.

Collateral and Guarantors

All obligations under the ABL Facility are unconditionally guaranteed by Holdings on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Co-Borrowers, subject to certain exceptions.

The obligations under the ABL Facility are secured by a pledge of the capital stock of the Co-Borrowers and substantially all of their assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy LifePoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the ABL Priority Collateral and a second-priority lien with respect to the Non-ABL Priority Collateral. Additionally, certain of the Company's restricted subsidiaries that are not guarantors will pledge certain of their assets (the "Credit Support Party Collateral") on a first-priority basis, as further security of the obligations under the ABL Facility. The Credit Support Party Collateral will secure only the obligations under the ABL Facility.

All borrowings under the ABL Facility are subject to the satisfaction of customary conditions, including the absence of a default and the accuracy of representations and warranties.

Interest Rates and Fees

Borrowings under the ABL Facility will bear interest at a rate equal to, at the Company's option, either (a) a LIBOR rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an initial applicable margin of 1.75% for LIBOR loans and 0.75% for base rate loans. The applicable margin for borrowings will be subject to step-downs based on average availability thresholds.

In addition to paying interest on outstanding principal under the ABL Facility, the Co-Borrowers will be required to pay a commitment fee under the ABL Facility in respect of the unutilized commitments under the ABL Facility at an initial rate equal to 0.375% per annum. The commitment fee may be subject to one step-down based on the average daily utilization under the ABL Facility. The Co-Borrowers will also be required to pay customary agency fees as well as letter of credit participation fees.

Restrictive Covenants and Other Matters

The ABL Facility contains certain customary affirmative covenants and events of default. The negative covenants in the ABL Facility include, among other things, limitations (none of which are absolute) on the Co-Borrowers and their subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates, enter into sale-leaseback transactions, change their lines of business, restrict dividends from their subsidiaries or restrict liens, change their fiscal year; and modify the terms of certain debt.

The ABL Facility requires that the Co-Borrowers and its restricted subsidiaries maintain a minimum fixed charge coverage ratio at any time when availability is less than an agreed amount.

The ABL Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the ABL Facility are entitled to take various actions, including the acceleration of amounts due under the ABL Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the ABL Facility.

Term Loan Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Company and Legend Merger Sub (together, prior to the Effective Time, the "Co-Borrowers") entered into the Term Loan Facility in an aggregate principal amount of $3,550.0 million and repaid in full its Prior Term Facility. The Term Loan Facility has a maturity of seven years; provided that if more than $150.0 million aggregate principal amount of the 11.5% Unsecured Notes remain outstanding 91 days before the stated maturity thereof (the "Term Springing Maturity Date"), then the Term Loan Facility will mature and the commitments under the Term Loan Facility will terminate on the Term Springing Maturity Date. At the Effective Time, Legacy LifePoint assumed all of the rights and obligations of Merger Sub under the Term Loan Facility (including in its capacity as a Co-Borrower under the Term Loan Facility). In addition, the Company may request one or more incremental commitments in an aggregate principal amount up to the sum of (x) the greater of (i) $800.0 million and (ii) 0.75 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, plus additional amounts subject to certain agreed leverage requirements, certain other conditions and receipt of commitments by existing or additional lenders.

The Term Loan Facility requires scheduled quarterly amortization payments on the term loans in an annual amount equal to 1.0% of the original principal amount of the term loans, with the balance to be paid at maturity.

Collateral and Guarantors

All obligations under the Term Loan Facility are unconditionally guaranteed by Holdings on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Co-Borrowers, subject to certain exceptions.

The obligations under the Term Loan Facility are secured by a pledge of the capital stock of the Company and substantially all of its assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy LifePoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the "Non-ABL Priority Collateral" (which generally includes most inventory and fixed assets, equity interests and intellectual property of the Co-Borrowers and the subsidiary guarantors) and a second-priority lien with respect to the "ABL Priority Collateral" (which generally includes most accounts receivable and certain related assets of the Co-Borrowers and the subsidiary guarantors).

Interest Rates

Borrowings under the Term Loan Facility will bear interest at a rate equal to, at the Company's option, either (a) a LIBOR rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an applicable margin of 4.50% for LIBOR loans and 3.50% for base rate loans.

Restrictive Covenants and Other Matters

The Term Loan Facility contains certain customary affirmative covenants and events of default. The negative covenants in the Term Loan Facility include, among other things, limitations (none of which are absolute) on the Co-Borrowers and their subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates enter into sale-leaseback transactions, change their lines of business, restrict dividends from subsidiaries or restrict liens, change their fiscal year and modify the terms of certain debt or organizational agreements.

The Term Loan Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the Term Loan Facility are entitled to take various actions, including the acceleration of amounts due under the Term Loan Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the Term Loan Facility.

9.75% Unsecured Notes

On November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Company issued $1,425.0 million aggregate principal amount of the 9.75% Unsecured Notes. The 9.75% Unsecured Notes will mature on December 1, 2026. Interest on the 9.75% Unsecured Notes will accrue at 9.750% per annum and will be paid semi-annually, in arrears, on June 1 and December 1 of each year, beginning June 1, 2019.

Prior to December 1, 2021, the Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 9.75% Unsecured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. Additionally, prior to December 1, 2021, the Company may redeem in the aggregate up to 40% of the aggregate principal amount of the 9.75% Unsecured Notes in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 109.750%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 9.75% Unsecured Notes must remain outstanding after each such redemption. On or after December 1, 2021, the Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in indenture governing the 9.75% Unsecured Notes (the "9.75% Unsecured Notes Indenture").

The Company's obligations under the 9.75% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 9.75% Unsecured Notes and the related guarantees are unsecured obligations of the Issuers and the subsidiary guarantors.

The 9.75% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 9.75% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 9.75% Unsecured Notes Indenture also provides for customary events of default.

8.25% Secured Notes

On April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, the Company issued $800.0 million aggregate principal amount of 8.25% Secured Notes. The 8.25% Secured Notes are senior obligations of the Company which mature on May 1, 2023 and bear interest at a rate of 8.25% per annum, payable semiannually on May 1 and November 1 of each year.

Prior to May 1, 2019, the Company may redeem the Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the notes redeemed plus an applicable "make-whole" premium and accrued and unpaid interest, if any. Additionally, prior to May 1, 2019, the Company may redeem up to 40% of the aggregate principal amount of the 8.25% Secured Notes in an amount equal to the net proceeds of one or more equity offerings at a price equal to 108.25% of the principal amount thereof, plus accrued and unpaid interest, so long as at least 50% of the 8.25% Secured Notes remain outstanding. On or after May 1, 2019, the Company may redeem the 8.25% Secured Notes at its option, in whole at any time or in part from time to time, at redemption prices set forth in the indenture governing the 8.25% Secured Notes.

The Company's obligations under the 8.25% Secured Notes are fully and unconditionally guaranteed, jointly and severally, by the Company's present and future direct and indirect wholly-owned material domestic subsidiaries that guarantee the Term Loan Facility. The 8.25% Secured Notes are secured by first priority security interests in the Non-ABL Priority Collateral and a second priority security interests in the ABL Priority Collateral.

The indenture governing the 8.25% Secured Notes contains restrictive covenants that are substantially the same as those in the 9.75% Unsecured Notes Indenture.

11.5% Senior Unsecured Notes

Effective April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, the Company issued $350.0 million aggregate principal amount of 11.5% Unsecured Notes in a private offering. The 11.5% Unsecured Notes mature on May 1, 2024 and bear interest at a rate of 11.5% per annum, payable semi-annually on May 1 and November 1 of each year.

Prior to May 1, 2019, the Company may redeem some or all of the 11.5% Unsecured Notes at a redemption price equal to 100% of the principal amount of the 11.5% Unsecured Notes, plus accrued and unpaid interest, and the applicable "make-whole" premium and accrued and unpaid interest, if any. Additionally, prior to May 1, 2019, the Company may redeem up to 40% of the aggregate principal amount of the 11.5% Unsecured Notes in an amount equal to the net proceeds of one or more equity offerings at a price equal to 111.5% of the principal amount thereof, plus accrued and unpaid interest, so long as at least 50% of the 11.5% Unsecured Notes remain outstanding. On or after May 1, 2019, the Company may redeem the 11.5% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the indenture governing the 11.5% Unsecured Notes.

The Company's obligations under the 11.5% Unsecured Notes are fully and unconditionally guaranteed, jointly and severally, by the Company's present and future direct and indirect wholly-owned material domestic subsidiaries that guarantee the Term Loan Facility.

The indenture governing the 11.5% Unsecured Notes contains restrictive covenants that are substantially the same as those in the 9.75% Unsecured Notes Indenture.

Financing and Capital Leases

Refer to Note 8 for further discussion of the Company's financing and capital leases.

Secured loan from Affiliate

On October 31, 2017, the Company received $37.6 million from an affiliate in connection with an agreement for the sale and assignment of the accounts receivable of St. Joseph. The transaction did not qualify as a true sale of accounts receivable pursuant to ASC 860, "Transfers and Servicing of Financials Assets." Accordingly, the transaction was accounted for as a secured borrowing. On June 18, 2018, the loan was repaid in full.

Interest Rate Swap Agreement

On December 21, 2018, the Company entered into an interest rate swap agreement with Citibank, N.A. as counterparty (the "Interest Rate Swap") whereby the Company pays a fixed rate of 2.63% on a notional amount of $1,100.0 million and receives one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. Refer to Note 11 for additional information regarding the Company's accounting for its Interest Rate Swap.

Debt Transaction Costs

In connection with the issuance of the Term Loan Facility, the ABL Facility and the 9.75% Unsecured Notes, the Company capitalized $201.7 million of new debt issuance costs associated with these new debt instruments, which are included as a reduction to "Long-term debt, net" on the Company's accompanying consolidated balance sheet. Additionally, during the year ended December 31, 2018, the Company wrote off $8.2 million of previously capitalized debt issuance costs in connection with the extinguishment of the Prior ABL Facility and Prior Term Facility, which is included under the caption "Other non-operating losses, net" in the accompanying consolidated statements of operations for the year ended December 31, 2018. For the years ended December 31, 2017 and 2016, the Company recorded losses on various debt refinancing activities of $4.3 million and $11.7 million, respectively, which are included under the caption "Other non-operating losses, net" in the accompanying consolidated statements of operations for the years ended December 31, 2017 and 2016.

Note 5. Goodwill and Intangible Assets

Goodwill

The following table presents the changes in the carrying amount of goodwill for the year ended December 31, 2018 (in millions):

Balance at December 31, 2017	$	651.5
LifePoint/RCCH Merger		1,950.1
Acquisitions		19.9
Impairments		(53.9)
Balance at December 31, 2018	$	2,567.6

The Company performed its annual goodwill impairment testing as of October 1, 2018. Based on the Company's updated financial projections for each reporting unit developed during the fourth quarter of 2018, the Company concluded that the carrying values of three of its facilities exceeded their estimated fair values. Accordingly, for the year ended December 31, 2018, the Company recorded non-cash impairment charges in the aggregate of $53.9 million. The results of the annual goodwill impairment testing for the year ended December 31, 2018 for the Company's other reporting units indicated varying degrees of excess estimated fair value over carrying value, ranging from approximately 1% to 102% of the respective carrying values, with an average of approximately 36%.

For the year ended December 31, 2017, the Company recorded a non-cash impairment charge of $14.1 million equal to the excess carrying value of one of its facilities as compared to its fair value. There were no impairments of goodwill for the year ended December 31, 2016.

Intangible Assets

The following table provides information regarding the Company's intangible assets, included in the accompanying consolidated balance sheets as of December 31, 2018 and 2017 (in millions):

	2018	2017
Amortizable intangible assets:		
Contract-based physician minimum revenue guarantees		
Gross carrying amount	$ 34.0	$ 14.7
Accumulated amortization	(7.1)	(7.4)
Net total	26.9	7.3
Non-competition agreements and other		
Gross carrying amount	4.5	-
Accumulated amortization	(0.5)	-
Net total	4.0	-
Total amortizable intangible assets		
Gross carrying amount	38.5	14.7
Accumulated amortization	(7.6)	(7.4)
Net total	30.9	7.3
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	31.0	-
Licenses, provider numbers, accreditations and other	12.6	-
Net total	43.6	-
Total intangible assets:		
Gross carrying amount	82.1	14.7
Accumulated amortization	(7.6)	(7.4)
Net total	$ 74.5	$ 7.3

Contract-Based Physician Minimum Revenue Guarantees

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or "physician minimum revenue guarantees," with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460, "Guarantees" ("ASC 460"). In accordance with ASC 460, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized as a component of other operating expenses, in the accompanying consolidated statements of income, over the period of the physician contract, which typically ranges from four to five years. As of December 31, 2018 and 2017, the Company's liability for contract-based physician minimum revenue guarantees was $12.6 million and $2.3 million, respectively. These amounts are included as a current liability under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheets.

Non-Competition Agreements

The Company has entered into non-competition agreements with certain physicians and other individuals which are amortized on a straight-line basis over the term of the agreements.

Certificates of Need and Certificates of Need Exemptions

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and certain equipment at the Company's facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. The Company has acquired facilities in certain states that have adopted certificate of need laws. The Company has determined that these intangible assets have an indefinite useful life.

Licenses, Provider Numbers, Accreditations and Other

To operate hospitals, the Company must obtain certain licenses, provider numbers and accreditations from federal, state and other accrediting agencies. The Company has acquired facilities in certain jurisdictions that require licenses, provider numbers and accreditations. The Company has determined that these intangible assets have an indefinite useful life.

Amortization Expense

Amortization expense for the Company's intangible assets, including physician minimum revenue guarantee expense in accordance with ASC 460, during the years ended December 31, 2018, 2017 and 2016 was $4.7 million, $3.6 million and $3.5 million, respectively.

Total estimated amortization expense for the Company's intangible assets during the next five years are as follows (in millions):

2019	$	12.5
2020		9.1
2021		5.9
2022		2.7
2023		0.6
Thereafter		0.1
	$	30.9

Note 6. Income Taxes

The provision for (benefit from) income taxes for the years ended December 31, 2018, 2017 and 2016 consisted of the following (in millions):

	2018	2017	2016
Current:			
Federal	$ -	$ -	$ -
State	1.3	0.4	0.3
	1.3	0.4	0.3
Deferred:			
Federal	(27.1)	37.7	17.7
State	(10.0)	(4.4)	3.6
	(37.1)	33.3	21.3
Change in valuation allowance	36.0	(35.0)	(17.6)
Total	$ 0.2	$ (1.3)	$ 4.0

The Tax Cuts and Jobs Act (the "Tax Act") was signed into law on December 22, 2017. The Tax Act significantly revised the U.S. corporate income tax laws. The Company is most notably impacted by the reduction of the U.S. corporate tax rate from 35% to 21% for tax years after December 31, 2017 and limiting certain deductions such as interest expense and net operating loss carryforwards. The Tax Act also enhanced and extended through 2026 the option to claim accelerated depreciation deductions on qualified property. Due to the timing of the enactment and the complexity involved with applying the provisions of the Tax Act, the Company had not completed its determination of the accounting implications of the Tax Act on its income tax accruals for the year ended December 31, 2017. However, the Company reasonably estimated the effects of the Tax Act on its existing deferred tax assets and liabilities and recognized a provisional expense for income taxes of $57.7 million for the year ended December 31, 2017. The Company completed its analysis during the year ended December 31, 2018 and determined that no additional adjustment was needed to the $57.7 million provisional expense recorded for the year ended December 31, 2017.

The following table reconciles the differences between the statutory federal income tax rate to the Company's effective tax rate on net loss from continuing operations before income taxes and including net income attributable to noncontrolling interests and redeemable noncontrolling interests for the years ended December 31, 2018, 2017 and 2016 (in millions):

	2018	2017	2016
Federal statutory rate	21.0 %	35.0 %	35.0 %
State income taxes, net of federal income tax benefits	2.2	23.2	(1.6)
Change in valuation allowance	(12.5)	99.6	(38.1)
Provisional expense resulting from the Tax Act	-	(146.6)	-
Tax effect of impairment on goodwill	(2.3)	(12.5)	-
Noncontrolling interests and redeemable noncontrolling interests	0.4	6.4	2.6
Nondeductible acquisition costs	(6.6)	-	(6.3)
Nondeductible merger compensation costs	(1.6)	-	-
Other items	(0.7)	(1.9)	(2.3)
Effective income tax rate	(0.1) %	3.2 %	(10.7) %

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects were as follows as of December 31, 2018 and 2017 (in millions):

	2018	2017
Deferred income tax liabilities:		
Depreciation and amortization	$ (137.7)	$ (21.7)
Deferred loan costs	(0.4)	(0.8)
Tax deductible goodwill	(11.2)	(11.4)
Debt discount	(0.1)	(0.2)
Equity investments	(32.6)	-
Other	(4.0)	(0.4)
Total deferred income tax liabilities	(186.0)	(34.5)
Deferred income tax assets:		
Provision for doubtful accounts	72.4	10.5
Employee compensation	50.5	5.8
Acquisition and start-up costs	10.2	4.1
Net operating loss carryforwards	195.8	113.9
Insurance reserves	64.4	11.4
Prepaid rent	18.5	2.1
Section 163(j) interest expense carryforward	31.7	-
Investment in Partnerships	-	9.6
Other	12.9	6.5
Total deferred income tax assets	456.4	163.9
Valuation allowance	(274.4)	(134.1)
Net deferred income tax assets	182.0	29.8
Deferred income taxes	$ (4.0)	$ (4.7)

Noncurrent deferred income tax liabilities totaled $4.0 million and $4.7 million at December 31, 2018 and 2017, respectively. As of December 31, 2018, the Company had federal net operating loss carryforwards of $342.4 million and state and local net operating loss carryforwards of approximately $2.5 billion. The federal net operating loss carryforwards generated prior to 2018 expire between 2028 and 2037. The federal net operating loss carryforwards generated in 2018 and forward have an indefinite carryforward period. The state net operating loss carryforwards will expire between 2019 and 2038. As of December 31, 2017, the Company had federal net operating loss carryforwards of $390.2 million and state and local net operating loss carryforwards of $779.0 million. The Company has established a valuation allowance for deferred tax assets at December 31, 2018 and 2017, due to the uncertainty of realizing these assets in the future. The valuation allowance increased $140.3 million during 2018, of which $103.2 million of the increase was a result of the LifePoint/RCCH Merger. The valuation allowance decreased $9.0 million during 2017.

No federal income tax payments were made during the years ended December 31, 2018, 2017 or 2016. State and local income tax payments in the amount of $2.4 million, $0.8 million, and $0.4 million were made during the years ended December 31, 2018, 2017 and 2016, respectively.

The Company’s policy is to accrue interest and penalties related to potential underpayment of income taxes within the provision for income taxes. Interest is computed on the difference between the Company’s uncertain tax benefit positions and the amount deducted or expected to be deducted in our income tax returns. As there were no unrecognized tax benefits at December 31, 2018 and 2017, the Company did not have any amounts accrued for interest and penalties.

The Company files a consolidated U.S. federal income tax return, as well as income tax returns in various state jurisdictions. All of the Company’s tax years are subject to examination by the Internal Revenue Service and various state taxing authorities.

Note 7. Other Current Liabilities

The following table provides information regarding the Company's other current liabilities, which are included in the accompanying consolidated balance sheets at December 31, 2018 and 2017 (in millions):

	2018	2017
Accrued interest	$ 68.9	$ 19.5
Current portion of self-insurance reserves	70.7	14.1
Self-insured medical benefits liabilities	46.1	7.1
Accrued property taxes	19.1	7.7
Accrued expenses and other	217.4	10.7
	$ 422.2	$ 59.1

Note 8. Leases

The Company leases real estate property and equipment under cancelable and non-cancelable leases. The leases expire at various times and have various renewal options. Certain leases that meet the lease capitalization criteria in accordance with ASC 840 have been recorded as an asset and liability at the lower of the net present value of the minimum lease payments at the inception of the lease or the fair value of the asset at the inception date. Interest rates used in computing the net present value of the lease payments are based on the Company's incremental borrowing rate at the inception of the lease. All of the lease agreements generally require the Company to pay maintenance, repairs, taxes and insurance costs. Rental expense of operating leases totaled $57.3 million, $44.0 million and $31.0 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Future minimum lease payments at December 31, 2018, for those leases having an initial or remaining noncancelable lease term in excess of one year, but excluding obligations that do not require eventual settlement in cash, are as follows for the years indicated (in millions):

	Operating Leases	Financing and Capital Leases	Total
2019	$ 55.9	$ 52.9	$ 108.8
2020	43.9	54.2	98.1
2021	34.7	57.6	92.3
2022	26.3	119.2	145.5
2023	21.2	48.5	69.7
Thereafter	92.4	833.8	926.2
	$ 274.4	$ 1,166.2	$ 1,440.6
Less: interest portion		(660.3)	
		$ 505.9	

Sale-Leaseback Transactions

The real estate associated with certain of the Company's facilities and its health support center are leased from various third party entities in connection with sale-leaseback transactions. Certain of these leasing arrangements contain various forms of continuing involvement and resultantly fail sale-leaseback accounting criteria in accordance with ASC 840-40, "Leases – Sale-Leaseback Transactions." Those leases with continuing involvement are accounted for as financing transactions. Additionally, for certain properties which satisfied the sale-leaseback accounting criteria, the sales proceeds received were in excess of the fair value of the properties leased. Accordingly, financing obligations have been recorded for such excess. At December 31, 2018, the Company has recorded $434.7 million of total financing obligations, including current portions, associated with sale-leaseback transactions in its accompanying consolidated balance sheet.

Properties failed sale-leaseback criteria due to several reasons, including fully prepaid arrangements with government authorities, the ability to share in the appreciation rights of the property, involvement in an ongoing build to suit construction project financed by a third party and more than minor subleasing arrangements. One property was previously accounted for as a financing lease due to an ongoing build to suit construction project which was completed during 2017, and the lease is now accounted for as an operating lease. At completion of the construction project, the Company reduced land and buildings by $62.4 million and reduced financing and capital leases by $59.3 million and recognized a loss of $3.9 million, which is included under the caption "Other non-operating losses, net" in the accompanying consolidated statements of operations for the year ended December 31, 2017.

Note 9. Investments

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, under the equity method of accounting in accordance with ASC 323. The Company does not consolidate its equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period. In connection with the LifePoint/RCCH Merger, the Company acquired equity method investments with an estimated fair value of $208.9 million. The Company's equity method investments totaled $231.9 million and $13.8 million at December 31, 2018 and 2017, respectively, and are included under the caption "Other long-term assets" in the accompanying consolidated balance sheets.

Note 10. Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling Interests

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

The following table presents the changes in the Company's noncontrolling interests during the year ended December 31, 2018 (in millions):

Balance at December 31, 2017	$	-
Noncontrolling interests assumed in the LifePoint/RCCH Merger		29.9
Net income attributable to noncontrolling interests		0.2
Distributions		(0.2)
Balance at December 31, 2018	$	29.9

Redeemable Noncontrolling Interests

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

The following table presents the changes in the Company's redeemable noncontrolling interests during the year ended December 31, 2018 (in millions):

Balance at January 1, 2017	$	54.2
Net income attributable to redeemable noncontrolling interests		7.3
Fair value adjustments		3.1
Distributions		(3.9)
Balance at December 31, 2017		60.7
Redeemable noncontrolling interests assumed in LifePoint/RCCH Merger		75.7
Net income attributable to redeemable noncontrolling interests		5.5
Distributions, net of proceeds		(5.8)
Balance at December 31, 2018	$	136.1

Note 11. Fair Value of Financial Instruments

Fair Value Hierarchy

Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the fair value hierarchy pursuant to ASC 820, "Fair Value Measurements and Disclosures" ("ASC 820") that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

Level 1: Quoted market prices in active markets for identical assets or liabilities.

Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.

Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability.

Cash and Cash Equivalents, Accounts Receivable, Accounts Payable and Other Current Liabilities

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

Long-Term Debt

The carrying amounts and fair values of the Company's ABL Facility, Prior ABL Facility, Term Loan Facility, 9.75% Unsecured Notes, 8.25% Secured Notes and 11.5% Unsecured Notes, excluding unamortized debt issuance costs, as of December 31, 2018 and December 31, 2017 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2018	December 31, 2017	December 31, 2018	December 31, 2017
ABL Facility	$ 20.0	$ -	$ 20.0	$ -
Prior ABL Facility	$ -	$ 10.0	$ -	$ 10.0
Term Loan Facility	$ 3,550.0	$ -	$ 3,487.9	$ -
9.75% Unsecured Notes	$ 1,425.0	$ -	$ 1,353.8	$ -
8.25% Secured Notes	$ 800.0	$ 800.0	$ 808.0	$ 843.0
11.5% Unsecured Notes	$ 350.0	$ 350.0	$ 359.6	$ 350.0

The fair values of the Company's long-term debt instruments were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820.

Interest Rate Swap

The Company measures its Interest Rate Swap at fair value on a recurring basis. The fair value of the Company's Interest Rate Swap is based on quotes from its counterparty. The Company considers those inputs to be Level 2 in the fair value hierarchy. At December 31, 2018, the fair value of the Company's Interest Rate Swap was a total liability of $5.8 million, of which $0.7 million is included under the caption "Other current liabilities" and $5.1 million is included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheet.

The Company has not designated its Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging." Accordingly, all changes in the fair value of the Company's Interest Rate Swap are recognized through interest expense in its results of operations. For the year ended December 31, 2018, the Company recognized additional interest expense of $5.8 million related to changes in the fair value of its Interest Rate Swap.

Changes in the fair value of the Company's Interest Rate Swap could result in a material effect on its consolidated results of operations and financial position; however, the Company does not anticipate that changes in the fair value of its Interest Rate Swap will have any impact on its cash flows. The counterparty to the Interest Rate Swap exposes the Company to credit risk in the event of nonperformance. However, the Company does not anticipate nonperformance by its counterparty. The Company does not hold or issue derivative financial instruments for trading purposes.

Financial Liabilities

The Company has a contingent consideration liability payable to the former owners of Canyon Vista that represents the Level 3 estimated fair value of the contingent consideration using unobservable inputs and assumptions available to the Company. The liability for Canyon Vista is recorded at an estimated fair value of approximately $13.6 million and $13.2 million at December 31, 2018 and 2017, respectively. The key assumptions used in estimating the fair value of the Canyon Vista liability are the range of probabilities that the payments will be earned by the seller and a discount rate adjusted for the Company's credit risk.

Note 12. Employee Benefit Plans

Defined Benefit Pension Plans

In connection with the LifePoint/RCCH Merger, the Company acquired certain assets and assumed certain liabilities associated with two separate defined benefit pension plans (i) associated with certain employees of Marquette General Hospital covered by a collective bargaining agreement (the "Marquette Pension Plan") and (ii) associated with certain non-union employees of Bell Hospital (the "Bell Pension Plan" and, collectively with the Marquette Pension Plan, the "Pension Plans"). Both Pension Plans are closed to new participants. Participants in the Marquette Pension Plan are required to make annual contributions totaling 6% of annual compensation to the Marquette Pension Plan to continue accruing benefits. Participants in the Bell Pension Plan no longer accrue benefits. The Company makes contributions to the Pension Plans sufficient to meet its minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended.

Status and Expense

The following table presents the changes in the benefit obligations and plan assets of the Pension Plans during the year ended December 31, 2018 and the unfunded liability of the Pension Plans at December 31, 2018 (in millions):

Change in benefit obligation:	
Benefit obligation at beginning of year	$ -
Benefit obligations assumed in LifePoint/RCCH Merger	56.5
Service costs	0.1
Interest costs	0.3
Participant contributions	0.1
Actuarial loss	1.8
Benefits paid	(0.2)
Benefit obligation at end of year	58.6
Change in plan assets:	
Fair value of plan assets at beginning of year	-
Plan assets acquired in LifePoint/RCCH Merger	39.6
Actual return on plan assets	(1.0)
Participant contributions	0.1
Benefits and expenses paid	(0.2)
Fair value of plan assets at end of year	38.5
Unfunded liability included in other long-term liabilities in the Company's accompanying consolidated balance sheet	$ 20.1

The Company recognizes changes in the funded status of the Pension Plans as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). For the year ended December 31, 2018, the Company recognized a comprehensive loss of $3.1 million as a decrease in stockholders' equity through accumulated other comprehensive loss. This adjustment was primarily related to changes in the Company's unfunded pension liability due to changes in the discount rates and mortality assumptions used to measure the projected benefit obligation.

The following table summarizes the projected benefit obligation, accumulated benefit obligation and fair value of plan assets related to the Pension Plans as of December 31, 2018 (in millions):

Projected benefit obligation	$ 58.6
Accumulated benefit obligation	$ 54.9
Fair value of plan assets	$ 38.5

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligation as of December 31, 2018 (in millions):

Discount rate	4.1 %
Rate of compensation increases, when applicable	3.0 %

The following table summarizes the components of net periodic costs for the year ended December 31, 2018 (in millions):

Service cost	$ 0.1
Interest cost	0.3
Expected return on plan assets	(0.3)
Amortization of net actuarial loss	-
Total net periodic benefit cost	$ 0.1

The following table summarizes the weighted-average assumptions used by the Company to determine its net periodic benefit costs during the year ended December 31, 2018 (in millions):

Discount rate	4.2 %
Rate of compensation increases, when applicable	3.0 %
Expected long-term return on plan assets	5.8 %

Plan Assets

The investment policy for the Pension Plans has been formulated to achieve a risk adjusted return that balances the need for asset growth against the risk of significant fluctuations in asset prices and the need for significant contributions from the Company. On a quarterly basis, or more frequently as necessary, the current risk levels, asset performance and expected return on assets are reviewed and evaluated against goals and targets by a committee appointed to oversee investment of the Pension Plans' assets (the "Investment Committee"). The Investment Committee strives to maintain a balance between risk and return through the use of modern portfolio theory methods, in conjunction with Monte Carlo modeling to evaluate the behavior of the portfolio under different scenarios. At December 31, 2018, the Pension Plans' investments include a balance of mutual funds and money market funds in order to achieve an overall rate of return that minimizes the need for additional employer contributions. The Company measures the fair value of its Pension Plans' assets in accordance with ASC 820.

The Pension Plans' investments in mutual funds are valued at the net asset value ("NAV") of shares reported in the active market in which the funds are traded. Because quoted prices are available for mutual funds and the markets in which they are traded are generally considered active, the Company has classified each of them as a Level 1 investment. The Pension Plans' investments in money market funds are valued at quoted prices in markets that are not active by a combination of inputs, including but not limited to dealer quotes who are market makers in the underlying funds and other directly and indirectly observable inputs. Because the inputs used to value money market funds are either directly or indirectly observable, but are not quoted prices in active markets, the Company has classified these assets as Level 2 investments.

The following table summarizes the assets of the Pension Plans, measured at fair value as of December 31, 2018, by major asset category and aggregated by level within the fair value hierarchy (in millions):

	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds	$ 34.6	$ 34.6	$ -	$ -
Money market funds	3.9	-	3.9	-
Total	$ 38.5	$ 34.6	$ 3.9	$ -

The Company expects to contribute approximately $2.1 million to the Pension Plans during the year ended December 31, 2019. Additionally, the Company expects to make future benefit payments from the Pension Plans as follows for the years indicated (in millions):

2019	2.1
2020	2.3
2021	2.5
2022	2.6
2023	2.9
Five years thereafter	16.7
	$ 29.1

Multiemployer Pension Plan

In connection with the LifePoint/RCCH Merger, the Company assumed the obligation to contribute to a multiemployer pension plan on behalf of certain employees covered by collective bargaining agreements, in accordance with the terms of such collective bargaining agreements. The Company's contributions to the multiemployer pension plan are determined based on the terms of the applicable collective bargaining agreements. Multiemployer plans are different from single-employer plans because assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers. Also, if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers. If the Company stops participating in the multiemployer plan, the Company may be required to pay a withdrawal liability based on its portion of the unfunded status of the plan. Currently, the Company does not anticipate ending its participation in this plan.

Defined Contribution Plans

The Company maintains three separate defined contribution retirement plans covering a majority of the Company's employees, including Legacy LifePoint employees, RCCH employees and employees at Community Medical Center. These defined contribution plans contain discretionary matching policies based on the Company's financial performance and definite contribution formulas for employees at certain facilities. The Company's expense related to its defined contribution plans was $5.6 million, $3.1 million and $4.3 million for the years ended December 31, 2018, 2017 and 2016, respectively.

The Company maintains a supplemental deferred compensation plan ("the RCCH Deferred Compensation Plan"). As of December 31, 2018 and 2017, the deferred compensation liability was $10.8 million and $7.3 million, respectively. The Company did not make any matching contributions in 2018, 2017 and 2016.

In connection with the LifePoint/RCCH Merger, the Company assumed liabilities under the LifePoint Health Deferred Compensation Plan (the "LifePoint Deferred Compensation Plan") and acquired a rabbi trust holding assets equal to the present value of all liabilities under the LifePoint Deferred Compensation Plan as of the effective time of the LifePoint/RCCH Merger. The assets in the rabbi trust are subject to the claims of the Company's creditors in the event of the Company's insolvency but are otherwise only available to pay liabilities under the LifePoint Deferred Compensation Plan. As of December 31, 2018, the assets and liabilities associated with the LifePoint Deferred Compensation Plan were $23.7 million and $23.3 million, and are included under the captions "Other long-term assets" and "Other long-term liabilities", respectively, on the accompanying consolidated balance sheet at December 31, 2018.

Note 13. Stock-Based Compensation

DSB Parent is authorized to issue Units to employees, executives, consultants and directors of the Company, under the DSB Parent Partnership Agreement. The Company has determined that the Units are a substantive class of members' equity for accounting purposes because the Units are legal equity of DSB Parent, they have participation features, including distribution and liquidation rights which allow them to participate in the residual returns of the DSB Parent and vested interests are retained upon termination. As a result, these awards are accounted for under ASC 718.

There are 35,270,000 aggregate number of Units authorized for issuance. Service Units and Performance Units have been issued under the DSB Parent Partnership Agreement and forms of award agreements.

Service Units

Service Units have been granted to certain members of the board of directors and Tranche A Units to certain employees, executives and consultants. Units that have been granted to members of the board of directors vest on a time-basis only, either in three equal installments on each of the first three anniversaries of the grant date or on the date that is the earliest of (i) six months and one day following November 16, 2018 or (ii) the date of the applicable director's termination of service due to death, disability or as a result of the director's removal from the board of directors other than for cause. Tranche A Units granted to certain employees, executives and consultants vest in equal installments on the last day of each of the first twenty calendar quarters that commence on or after the grant date or, in some cases, November 16, 2018. Service Units will automatically vest upon the sale of the Company. In the event of an ("IPO"), all unvested Service Units will remain outstanding and continue to vest based on the stated vesting pattern. Unvested Service Units are forfeited upon a holder's termination of service.

Service Units are accounted for as equity awards and related compensation expense is recognized ratably over the vesting period. On November 16, 2018, Service Units originally issued to approximately 40 employees and executives were modified in connection with the LifePoint/RCCH Merger. For employees and executives granted Service Units prior to November 16, 2018 who are severed during the 18-month period following the LifePoint/RCCH Merger under certain circumstances, Tranche A Units vest in full upon the eligible employee's termination date. The Company calculated the fair value of the service units before and after the modification and recorded expense of $2.7 million related to the modification and acceleration of service units. Total stock compensation expense, including modification expense, for Service Units was $3.4 million and $0.7 million for 2018 and 2017, respectively. As of December 31, 2018, Service Units had unrecognized compensation expense of $1.4 million. The expense is expected to be recognized over a weighted-average period of 2.5 years from December 31, 2018.

Performance Units

Performance Units, which have been granted as Tranche B Units and Tranche C Units, will vest based upon equity holders of DSB Parent realizing certain targeted multiples of invested capital ("MOIC thresholds"). Performance Units are accounted for as equity awards with expense recognition occurring upon the realization of the stated MOIC thresholds due to a liquidity event. On November 16, 2018, Tranche B Units previously issued to approximately 40 employees and executives were modified in connection with the LifePoint/RCCH Merger. For employees and executives granted Performance Units prior to November 16, 2018 who were severed in connection with the LifePoint/RCCH Merger, Tranche B units vest in full upon the eligible employee's termination date and Tranche C units are forfeited in accordance with the original terms and conditions of the applicable Profits Units award agreement. The Company calculated the fair value of the Tranche B Units before and after the modification and recorded expense of $3.6 million related to the modification and acceleration of Tranche B Units. For Performance Units not modified in connection with the LifePoint/RCCH Merger, the Company determined that a liquidity event was not probable, therefore no compensation expense has been recognized related to the unmodified Performance Units. Performance Units had unrecognized compensation expense of $1.9 million as of December 31, 2018. Unvested Units that do not vest on termination are forfeited upon such termination, subject to certain conditions.

Valuation Assumptions

The fair value of all Units was determined using a Monte Carlo simulation framework. The following table shows the weighted average assumptions the Company used to develop the fair value estimates and the resulting estimates of weighted-average fair value per Unit granted during the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
Common equity value of the Company	$ 624.1	$ 513.8	$ 297.2
Expected volatility	24.0 %	27.5 %	34.0 %
Risk-free interest rate	1.60 %	1.10 %	1.60 %
Expected dividends	-	-	-
Average expected term (years)	3.2	4.1	4.9

Units Activity

The following represents the activity of the Units for the years ended December 31, 2018, 2017 and 2016:

	Service Units		Performance Units			
	Tranche A and Units to the Board	Weighted Average Grant Date Fair Value per Unit	Tranche B	Weighted Average Grant Date Fair Value per Unit	Tranche C	Weighted Average Grant Date Fair Value per Unit
Unvested at January 1, 2016	2,088,792	$ 0.66	2,088,792	$ 0.40	1,044,395	$ 0.30
Granted	4,768,578	0.69	4,480,578	0.41	2,240,289	0.30
Vested	(741,956)	0.67	-	-	-	-
Forfeited	(1,593,281)	0.66	(1,675,801)	0.40	(837,899)	0.30
Unvested at December 31, 2016	4,522,133	$ 0.69	4,893,569	$ 0.41	2,446,785	$ 0.30
Granted	548,200	0.93	548,200	0.47	274,100	0.28
Vested	(1,104,234)	0.64	-	-	-	-
Forfeited	(165,070)	0.84	(179,600)	0.44	(89,800)	0.28
Unvested at December 31, 2017	3,801,029	$ 0.71	5,262,169	$ 0.41	2,631,085	$ 0.30
Granted	1,229,200	1.43	1,229,200	0.68	614,600	0.37
Vested	(2,054,331)	0.82	(1,636,959)	0.46	-	-
Forfeited	(266,140)	0.70	(379,400)	0.41	(1,008,180)	0.31
Unvested at December 31, 2018	2,709,758	$ 0.97	4,475,010	$ 0.47	2,237,505	0.31

During the year ended December 31, 2018, there were no convertible or expired Units.

Note 14. Commitments and Contingencies

Capital Expenditure Commitments

The Company is reconfiguring some of its facilities to more effectively accommodate patient services and to provide for a greater variety of services. The Company has incurred approximately $436.5 million in costs related to uncompleted projects as of December 31, 2018, which is included under the caption "Construction in progress" in the Company's accompanying consolidated balance sheet. At December 31, 2018, these uncompleted projects had an estimated cost to complete of approximately $226.7 million. The estimated timeframe for completion of these projects generally ranges from less than one year up to two years. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities. At December 31, 2018, the Company estimated its total remaining capital expenditure commitments to be approximately $1,436.3 million, which generally have remaining terms of three to seven years. Of this amount, approximately one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time.

Legal Proceedings and General Liability Claims

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

In addition, the Company is subject to the regulation and oversight of various state and federal governmental agencies. Further, under the False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against healthcare facilities that submit false claims for payments to, or improperly retain identified overpayments from, governmental payers. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without the Company's knowledge. If a provider is found to be liable under the False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus substantial civil monetary penalties that are subject to annual adjustment for inflation for each separate false claim.

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

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

The Company accrues an estimate for a contingent liability when losses are both probable and reasonably estimable. The Company reviews its accruals each quarter and adjusts them to reflect the impact of developments, advice of legal counsel and other information pertaining to a particular matter.

Note 15. Subsequent Events

In accordance with the provisions of ASC 855, "Subsequent Events," the Company evaluated all material events subsequent to the balance sheet date through March 28, 2019, the date of issuance, for events requiring disclosure or recognition in the Company's consolidated financial statements. There were no subsequent events requiring disclosure or recognition in the Company's consolidated financial statements other than those noted below.

During 2019, the Company borrowed additional amounts under its ABL Facility for general corporate purposes. As of March 28, 2019, the Company had $90.0 million in borrowings outstanding under its ABL Facility.

SIGNATURES

LifePoint Health, Inc. has caused this Report to be signed on its behalf by the undersigned thereunto duly authorized.

LIFEPOINT HEALTH, INC.

Date: March 28, 2019

By: /s/ Michael S. Coggin
Michael S. Coggin
Executive Vice President and Chief Financial Officer

ANNUAL REPORT

OF

LIFEPOINT HEALTH, INC.

FOR THE

FISCAL YEAR ENDED DECEMBER 31, 2019

PREPARED IN ACCORDANCE WITH

ANNUAL REPORT ON FORM 10-K
(AS MODIFIED UNDER DEBT AGREEMENTS)

LifePoint Health, Inc.
(Exact Name of Company as Specified in Its Charter)

Delaware	**27-0500485**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**

330 Seven Springs Way **Brentwood, Tennessee**	**37027**
(Address of Principal Executive Offices)	**(Zip Code)**

(615) 920-7000
(Company's Telephone Number, Including Area Code)

At March 12, 2020, there were 100 outstanding shares of common stock of LifePoint Health, Inc.

LifePoint Health, Inc.

Annual Report

For the Fiscal Year Ended December 31, 2019

TABLE OF CONTENTS

DISCLOSURE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report for the fiscal year ended December 31, 2019 (this "***Report***") contains forward-looking statements that involve risks and uncertainties. Forward-looking statements include any statements that address future results or occurrences. In some cases you can identify forward-looking statements by terminology such as "may," "might," "will," "would," "should," "could" or the negatives thereof. Generally, the words "anticipate," "believe," "continue," "expect," "intend," "estimate," "project," "plan" and similar expressions identify forward-looking statements. In particular, statements about our expectations, beliefs, plans, objectives, assumptions or future events or performance contained elsewhere in this Report are forward-looking statements. These forward-looking statements include statements that are not historical facts, including statements concerning our possible or assumed future actions and business strategies. We have based these forward-looking statements on our current expectations, assumptions, estimates and projections. While we believe these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks, uncertainties and other factors, many of which are outside of our control, which could cause our actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. Such factors include, among others, the following:

- payment changes, including policy considerations and changes resulting from federal and state budgetary restrictions;
- impact from or likelihood of the repeal or replacement of, or material modification to, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "***Affordable Care Act***"), as a result of legislative or court action;
- potential impact from the repeal of the penalties associated with the "individual mandate" to purchase health insurance under the Affordable Care Act, included in the Tax Cuts and Jobs Act of 2017 (the "***Tax Act***");
- impact from changes to Medicaid supplemental payment programs;
- our compliance with new and existing laws and regulations as well as costs and benefits associated with compliance;
- any potential action brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the "qui tam" or "whistleblower" provisions of the federal False Claims Act (the "***False Claims Act***");
- impact from the changes in payer mix marked by a shift of patients from private insurance to Medicare and Medicaid programs;
- our acquisition strategy, including integration risks relating to future acquisitions;
- the potential for material obligations if we acquire facilities with unknown or contingent liabilities;
- claims and legal actions relating to professional liabilities and other litigation risks;
- delayed payments and repayments resulting from reviews of claims to Medicare and Medicaid for our services;
- impact of controls imposed by payers designed to reduce inpatient services;
- risks associated with outsourcing functions to third parties;
- our relationships with our joint venture partners;
- changes in physician employment regulations;
- increases in the amount and risk of collectability of patient accounts receivable;
- our need to make investments continually in our processes and information systems to protect the privacy of patients, employees and other persons and reduce the risk of successful cybersecurity attacks;
- the emergence of and effects related to pandemics, epidemics and infectious diseases;
- damage to our reputation, regulatory penalties, legal claims and liability under state and federal laws that we could suffer upon any cybersecurity or privacy breaches;
- anticipated capital expenditures, including routing projects, investments in information systems and capital projects related to acquisitions, construction of new facilities and construction projects and the expectation that capital commitments could be a component of future acquisitions;
- effects of competition in a facility's market;
- changes in industry and general economic trends;
- recruitment and retention of senior executives, providers and other healthcare employees;
- our ability to acquire facilities on favorable terms and successfully complete asset sales and divestitures;
- effects of union organizing activities;
- potential recoupment of previously recognized income from electronic health record ("***EHR***") incentive programs;
- timeframes for completion of capital projects;
- changes in depreciation and amortization expenses;
- costs of providing care to our patients;
- accounting estimates and the impact of accounting methodologies and new accounting pronouncements;
- consolidation of commercial insurance companies and patient shifts to lower cost healthcare plans, including association health plans and short term limited duration health insurance plans, which generally provide lower payment for services provided;

- participation in the healthcare exchanges and the impact of increasing enrollment by patients in insurance plans with narrow networks, tiered networks, high deductibles or high co-payments;
- uncertainty of patient volumes and related revenues;
- governmental or third-party investigations, legal actions and voluntary self-disclosures relating to overpayments or other regulatory compliance matters;
- the ability of our local management teams to identify and meet the needs of our patients, medical staffs and their communities;
- the efforts of insurers, healthcare providers and others to contain healthcare costs;
- our ability to obtain adequate levels of general and professional liability insurance;
- our ability to implement initiatives promoting cost reductions and operational efficiencies;
- possible future indebtedness that may be incurred; and
- other factors referenced under the caption "Risk Factors" contained in this Report.

Given these uncertainties, readers are cautioned not to place undue reliance on such forward-looking statements. We disclaim any obligation to update any such factors or to announce the result of any revisions to any of the forward-looking statements contained herein to reflect future results, events or developments.

Statements in this Report are made as of the date hereof unless stated otherwise. New factors emerge from time to time, and it is not possible to predict all such factors.

EXPLANATORY INFORMATION REGARDING THIS REPORT

This Report has been prepared in accordance with the obligations of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.) (the "***Company***") under (i) Section 4.02 of the Indenture, dated as of February 13, 2020 (as amended or supplemented from time to time, the "***4.375% Secured Notes Indenture***") among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee and notes collateral agent, relating to the Company's 4.375% Senior Secured Notes due 2027 (the "***4.375% Secured Notes***") and (ii) Section 4.02 of the Indenture, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***9.75% Unsecured Notes Indenture***" and, together with the 4.375% Secured Notes Indenture , the "***Indentures***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 9.75% Unsecured Notes due 2026 (the "***9.75% Unsecured Notes***" and, together with the 4.375% Secured Notes, the "***Notes***"), (iii) Section 5.04 of the Asset-Based Revolving Credit Agreement, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***ABL Agreement***"), among the Company, as Lead Borrower, DSB Acquisition, LLC, a Delaware limited liability company ("***Holdings***"), the lenders party thereto from time to time and Citibank, N.A., as administrative agent and collateral agent, and (iv) Section 5.04 of the First Lien Credit Agreement, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***Term Loan Agreement***" and, together with the ABL Agreement, the "***Credit Agreements***"), among the Company, as Lead Borrower, Holdings, the lenders party thereto and Citibank, N.A., as administrative agent and collateral agent. This Report has been prepared in all material respects in accordance with the rules and regulations of the Securities and Exchange Commission (the "***SEC***") applicable to an Annual Report on Form 10-K for the fiscal year ended December 31, 2019, except to the extent permitted to be excluded by the Indentures and the Credit Agreements.

USE OF NON-GAAP FINANCIAL INFORMATION

In this Report, we have provided EBITDA and Adjusted EBITDA (collectively, the "***Non-GAAP Measures***") because we believe they provide the Holders with additional information to measure our performance and evaluate our ability to service our indebtedness. We believe that the presentation of Non-GAAP Measures is appropriate to provide additional information to the Holders about certain material non-cash items and about unusual items that we do not expect to continue or to continue at the same level in the future as well as other items. Further, we believe the Non-GAAP Measures provide a meaningful measure of operating profitability because we use them for evaluating our business performance and understanding certain significant items.

The Non-GAAP Measures are not presentations made in accordance with United States ("***U.S.***") generally accepted accounting principles ("***GAAP***"), and our use of these terms may vary from others in our industry. EBITDA and Adjusted EBITDA should not be considered as alternatives to operating income or any other performance measures derived in accordance with GAAP as measures of operating performance or cash flows as measures of liquidity. EBITDA and Adjusted EBITDA have important limitations as analytical tools, and you should not consider them in isolation or as substitutes for analysis of our results as reported under GAAP. Because of these limitations, we rely primarily on our GAAP results and use EBITDA and Adjusted EBITDA only as a supplement. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" for a description of the calculation and limitations of these measures.

DOCUMENT SUMMARIES AND REQUESTS

This Report contains summaries believed to be accurate with respect to certain documents, but reference is made to the actual documents for complete information. All such summaries, which do not purport to be complete, are qualified in their entirety by such reference. Copies of the documents referred to herein will be made available without cost to Holders of the Notes by making a written or oral request to us. Any such request may be made to us at the following address and telephone number:

LifePoint Health, Inc.
330 Seven Springs Way
Brentwood, Tennessee 37027
Attn: General Counsel
Tel. (615) 920-7000

FISCAL YEAR

All references to "fiscal year" are to the twelve months ended December 31 of the year referenced.

OTHER ITEMS

This Report is prepared by LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.), a Delaware corporation, which, along with each of its consolidated subsidiaries, is referred to herein as the "***Company***," "***LifePoint***," "***we***," "***our***," "***us***," and, before giving effect to the LifePoint/RCCH Merger (as defined below), "***RCCH***," in each case, unless the context otherwise requires.

References in this Report to the "***LifePoint/RCCH Merger***" refer to the merger, which was effective on November 16, 2018, of Legend Merger Sub, Inc., a Delaware corporation and wholly-owned subsidiary of RCCH ("***Legend Merger Sub***"), with and into LifePoint Health, Inc., a Delaware corporation ("***Legacy LifePoint***"), with Legacy LifePoint surviving the LifePoint/RCCH Merger as a subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

References in this Report to the "***RegionalCare/Capella Merger***" refer to the merger of Crimson Merger Sub, LLC ("***Crimson Merger Sub***"), a Delaware limited liability company and wholly-owned subsidiary of RegionalCare Hospital Partners Inc. ("***Regional Care***"), with and into Capella Health Holdings, LLC ("***Capella***"), with Capella surviving the RegionalCare/Capella Merger as a wholly-owned subsidiary of RegionalCare, which began to do business as RCCH HealthCare Partners. The RegionalCare/Capella Merger was consummated on April 29, 2016; however, for accounting purposes, the RegionalCare/Capella Merger became effective on May 1, 2016.

References in this Report to the "***Apollo/RegionalCare Acquisition***" refer to the merger, which was effective on December 3, 2015, of DSB Merger Sub Inc., a Delaware corporation and wholly-owned subsidiary of Holdings, with and into RegionalCare with RegionalCare surviving such merger as a direct wholly-owned subsidiary of Holdings, which is indirectly controlled by our Sponsor.

References in this Report to the "***Sponsor***" refer to certain funds that are affiliates of the Company (the "***Apollo Funds***") that are ultimately controlled and/or managed by Apollo Management VIII, L.P. ("***Apollo Management***" and, when acting on behalf of the Apollo Funds, "***Apollo***"), which is an affiliate of Apollo Global Management LLC.

PART I

Item 1. *Business*.

Our Company

We own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. As of December 31, 2019, we operated 88 hospital campuses in 29 states throughout the U.S., having a total of 11,493 licensed beds. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a network of hospitals and outpatient facilities.

We seek to fulfill our mission of Making Communities Healthier® by (1) delivering high quality patient care, (2) supporting our physicians, (3) creating excellent workplaces for our employees, (4) taking a leadership role in our communities and (5) ensuring fiscal responsibility. We strive to create places where people choose to come for healthcare, physicians want to practice and employees want to work.

Our Business Strategy

The key elements of our business strategy include:

- *Continue to Grow in Existing Markets by Expanding Services and Access Points to Care*. We regularly conduct in-depth strategic reviews of the major service lines offered at each of our facilities and evaluate additional services through which we could profitably grow in our markets and better serve our communities. We leverage our local market knowledge together with input and guidance from our local physician and community leaders to prioritize the healthcare services our communities are seeking. Focus areas include expansion of specialty service lines to meet unserved patient needs, expansion of access points to care, including outpatient, ancillary and retail health services, and investment in technology and equipment. We invest strategically in our markets in order to increase the quality and scope of services we provide, meet the needs of our communities and maintain our strong reputation as the healthcare provider of choice. This in turn helps us to continue recruiting physicians and growing the revenue and profitability of our facilities. We are implementing transfer centers across our portfolio to improve patient retention and drive volume growth. These transfer centers will help preserve the continuum of care, leading to better patient outcomes and higher quality care.

- *Continue to Recruit and Retain Leading Physicians*. Our physician engagement strategies drive our ability to enhance and expand our services to meet the healthcare needs of our communities. We have a comprehensive recruiting program that is directed by an experienced corporate department and is supported at the local level by our hospital system chief executive officers ("***CEOs***") and Boards of Trustees. We supplement our local teams with experienced corporate office specialists and several third party recruiting firms to assist us in identifying candidates that match the profile of our physician needs. We maintain a flexible approach to aligning our goals with our physician partners, including our willingness to recruit physicians through multi-year employment and/or income guarantee arrangements. In addition, we believe our physicians are attracted to our facilities because of several factors, including our commitment to quality care, our focus on employing and developing high quality nurses and support staff and our integration into, and support of, the communities we serve.

- *Routinely Optimize Our Portfolio to Strengthen Our Position in Existing Markets and Expand into New Markets*. We evaluate and selectively pursue acquisitions of hospitals, outpatient and ancillary clinics and other healthcare facilities in new and existing markets, with the goal of improving our operating performance and better meeting the healthcare needs of our communities. We employ a rigorous and disciplined approach to new market acquisitions and focus on a range of criteria, including expected financial returns and strategic benefits, to evaluate a target's suitability and fit within our portfolio. We seek to operate health systems that are, or have the potential to become, market leaders in non-urban communities with favorable demographic trends. We often acquire underperforming and/or undermanaged facilities where we can drive operating efficiencies in order to realize significant upside potential following an acquisition to generate attractive effective purchase multiples and strong returns on our investment. The recent market trend toward health system consolidation, particularly among underperforming not-for-profit hospital operators without the scale and/or operating discipline to compete, has benefited us and we believe will continue to support our acquisition strategy. Furthermore, we routinely evaluate our existing portfolio to assess whether we are meeting our strategic and financial objectives in our markets. We evaluate and may seek to opportunistically divest assets that do not meet our strategic and/or financial objectives and which may deliver more value to our stakeholders through a sale.

- *Commitment to the Delivery of Exceptional Quality Patient Care*. We believe providing high quality patient care is critical to attracting patients, physicians and employees to our facilities. In addition, providing high quality patient care is increasingly vital to achieving our operating and financial success, including receiving full payment from governmental and commercial payers. We believe several factors contribute to providing high quality patient care, including instilling leadership and accountability at all levels of our organization, aligning ourselves with quality physicians and medical staff, and providing a clinical environment that is satisfactory to our patients, physicians and employees. Furthermore, we strive continually to improve physician and employee satisfaction, which we believe is critical to delivering quality patient care. In addition, we also seek to partner with academic medical centers and regionally significant health systems to better serve our communities and to ensure we are delivering high quality care.

- *Continue to Engage in Strategic Relationships with Local Partners*. We partner with several academic medical centers and regionally significant health systems to better serve our communities. We have established partnerships with Duke University Health System ("***Duke***"), Norton Healthcare, Inc. ("***Norton***"), LHC Group, Inc. ("***LHC***"), University of Washington Health, Billings Clinic and Emory Healthcare ("***Emory***").

- *Continue to Focus on Cost Reduction and Operational Efficiency*. We strive to improve our operating performance by making our revenue cycle processes more efficient, making an even higher level of purchases through our group purchasing organization, operating more efficiently and effectively, and working to appropriately standardize our policies, procedures and practices across all of our affiliated facilities. As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have partnered with a third party to provide certain nonclinical business functions, including payroll processing, supply chain management and revenue cycle functions. We believe this model is the most cost effective and efficient approach to managing these nonclinical business functions across multi-facility enterprises. Additionally, in connection with our efforts to responsibly manage purchasing costs, we participate along with other healthcare companies in a group purchasing organization, HealthTrust Purchasing Group ("***HPG***"), which makes certain national supply and equipment contracts available to our facilities. As of December 31, 2019, we owned an approximate 7.0% equity interest in HPG. We also implement this operating discipline when we enter a new market through acquisitions, where we focus on optimizing staffing levels to reduce labor costs, leveraging our national scale and group purchasing organizations to reduce supply costs and standardizing revenue cycle and information technology ("***IT***") systems. We have made substantial progress implementing these initiatives consistently across our network and we believe that opportunity exists for continued improvement in the near term, particularly among our recently acquired facilities.

- *Experienced Executive Management and Leadership Teams.* Our executive management team has an average of more than 20 years of healthcare industry experience with a proven record of achieving strong operating results. The executive management team is highly respected in the hospital management industry and has significant experience in managing and acquiring hospitals. Our executive management team is led by David Dill, who serves as our Chief Executive Officer. Mr. Dill has more than 20 years of operational and financial leadership experience in the healthcare industry.

Our Background

LifePoint/RCCH Merger

Summary

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

Equity Contribution

In connection with the LifePoint/RCCH Merger, the Apollo Funds, together with certain other co-investors investing through a co-investment vehicle controlled by our Sponsor or its affiliates, indirectly contributed $1,000.0 million of newly invested capital to DSB Parent L.P., a Delaware limited partnership ("***DSB Parent***"), which is our indirect parent and is owned by the Apollo Funds, such co-investment vehicle and certain current or former directors, members of management, employees and consultants of the Company, and the $1,000.0 million of newly invested capital was further contributed to the Company to be used to partially fund the LifePoint/RCCH Merger.

Financing Transactions

Concurrently with the closing of the LifePoint/RCCH Merger, we (1) issued the 9.75% Unsecured Notes, (2) entered into the ABL Agreement, which provides a senior secured asset-based revolving credit facility (the "***ABL Facility***") in an aggregate principal amount of $800.0 million with a maturity of five years, (3) terminated our existing senior secured asset-based revolving credit facility, which we entered into on April 29, 2016 (the "***Prior ABL Facility***"), (4) entered into the Term Loan Agreement, which provides a senior secured term loan credit facility (the "***Term Loan Facility***") in an aggregate principal amount of $3,550.0 million with a maturity of seven years, and (5) repaid in full our $150.0 million term loan facility, which we entered into on April 25, 2018 (the "***Prior Term Facility***").

RegionalCare/Capella Merger and Apollo/RegionalCare Acquisition

On March 21, 2016, RegionalCare and Capella entered into an agreement and plan of merger, pursuant to which, effective on April 29, 2016 (and effective May 1, 2016 for accounting purposes), Crimson Merger Sub, merged with and into Capella, with Capella continuing as the surviving company in the merger as a wholly-owned subsidiary of RegionalCare. After the RegionalCare/Capella Merger was consummated we began to do business as RCCH HealthCare Partners. Concurrently with the closing of the RegionalCare/Capella Merger, we (i) issued 8.25% Senior Secured Notes due 2023 (the "***8.25% Secured Notes***") and 11.5% Senior Notes due 2024 (the "***11.5% Unsecured Notes***"), (ii) entered into the Prior ABL Facility and (iii) refinanced certain indebtedness of DSB Holdings, RegionalCare and Capella.

On November 11, 2015, RegionalCare entered into an agreement and plan of merger with Holdings and the other parties thereto, in which RegionalCare became a direct wholly-owned subsidiary of Holdings on December 3, 2015. Holdings is an indirect wholly-owned subsidiary of DSB Parent, which is controlled by our Sponsor.

In connection with the Apollo/RegionalCare Acquisition and the RegionalCare/Capella Merger, certain Apollo Funds directly or indirectly managed by the Sponsor contributed in the aggregate approximately $380.0 million of invested capital to DSB Parent.

Our Operations

Services

We operate health systems that provide a range of medical, surgical and behavioral health services across inpatient and outpatient settings, including general surgery, internal medicine, cardiology, radiology, oncology, orthopedics, women's services, neurology, rehabilitation services, pediatric services, emergency services and, primarily through our joint venture with LHC, home health and hospice services. In some of our health systems, we offer specialized services such as open heart surgery, skilled nursing, psychiatric care and neurosurgery. In many markets, we also provide outpatient services such as same day surgery, clinical laboratory services, diagnostic imaging services, respiratory therapy services, sports medicine services, urgent care services and lithotripsy. The services provided in any specific health system depend on many factors, including the community need for the service, whether physicians necessary to safely operate the service line are members of the medical staff of that hospital and the existence of any contractual or certificate of need restrictions.

Management and Oversight

Our executive management team has extensive experience in operating multi-facility hospital networks and plays a vital role in the strategic planning for our facilities. A hospital's local management team is typically composed of a CEO, chief operating officer, chief financial officer and a chief nursing officer. Local management teams and the hospital's Board of Trustees and our corporate management teams, develop annual operating plans setting forth growth strategies through the expansion of current services, implementation of new services and the recruitment and retention of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the needs of our patients, medical staffs and the community as a whole is critical to the success of our facilities. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including quality of care, patient satisfaction and financial measures.

The Board of Trustees at each facility, consisting of local community leaders, members of the medical staff and the facility CEO, advises the local management teams and helps develop the strategic operating plan for their facility. In addition, it plays a key role in providing the patient care excellence that we demand. Members of each Board of Trustees are identified and recommended by our local management teams. The Boards of Trustees oversee policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

The majority of our facilities have a physician engagement group ("***PEG***") or a physician leadership group ("***PLG***") comprised of key physicians and members of the facility's administrative team. The mission of the PEG or PLG is to provide ongoing dialogue between hospital facility administration and members of the medical staff and community physicians primarily in the areas of operations, quality patient care, employee satisfaction and community relations.

We also provide support to the local management teams through our corporate resources in areas such as revenue cycle, business office, legal, managed care, clinical efficiency, physician services and other administrative functions. These resources allow for sharing best practices and standardization of policies and processes among all of our facilities.

Cost Management

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

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

Attracting Patients

We believe that the most important factors affecting a patient's choice in where to receive healthcare services are the reputation of the facility, the availability and expertise of physicians and nurses and the location and convenience of the facility. Other factors that affect utilization include local demographics and population growth, local economic conditions and the facility's success in contracting with a wide range of local payers.

Outpatient Services

The healthcare industry has experienced an accelerated shift during recent years from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology also have supported the shift to outpatient utilization. However, we expect the decline in inpatient admission use rates to moderate over the long term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through expanding service offerings and increasing the throughput and convenience of our emergency departments, outpatient surgery facilities and other ancillary units in our facilities.

Sources of Revenues

General

Our facilities generate revenues by providing healthcare services to our patients. Depending upon the patient's medical insurance coverage, we are paid for these services by governmental Medicare and Medicaid programs, commercial insurance, including health maintenance organizations ("***HMOs***"), preferred provider organizations ("***PPOs***") and other private insurers, and directly by the patient. The amounts we are paid for providing healthcare services to our patients vary depending upon the payer. Governmental payers generally pay significantly less than the hospital's customary charges for the services provided. Insured patients are generally not responsible for any difference between customary hospital charges and the amounts received from commercial insurance payers. However, insured patients are responsible for payments not covered by insurance, such as exclusions, deductibles and co-payments.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2019, 2018 and 2017 (dollars in millions):

	2019		2018		2017	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,338.1	38.1 %	$ 1,105.3	39.8 %	$ 760.6	40.6 %
Medicaid	1,495.3	17.1	486.3	17.5	346.2	18.5
HMOs, PPOs and other private insurers	3,698.6	42.3	1,113.8	40.1	723.8	38.7
Self-pay	59.2	0.7	17.2	0.6	11.4	0.6
Other	143.6	1.6	49.4	1.8	26.7	1.4
Revenue from contracts with customers	8,734.8	99.8	2,772.0	99.8	1,868.7	99.8
Rental income	18.0	0.2	6.1	0.2	4.1	0.2
Revenues	$ 8,752.8	100.0 %	$ 2,778.1	100.0 %	$ 1,872.8	100.0 %

Medicare

For the year ended December 31, 2019, approximately 38.1% of our revenues related to patients participating in Medicare programs. Medicare provides hospital and medical insurance benefits, regardless of income, to persons age 65 and over, some disabled persons and persons with end-stage renal or Lou Gehrig's disease. All of our hospitals are currently certified as providers of Medicare services.

Over the years, Congress and the Centers for Medicare and Medicaid Services ("***CMS***") have made several sweeping changes to the Medicare program and its reimbursement methodologies, such as the implementation of the prescription drug benefit that was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "***MMA***") and the numerous changes contained in the Affordable Care Act. Many of these changes have resulted in decreased reimbursement to healthcare providers. For example, the Budget Control Act of 2011 ("***BCA***") imposed a 2% reduction in Medicare spending which began on April 1, 2013. The Bipartisan Budget Act of 2015 ("***BBA***"), the Bipartisan Budget Act of 2018 (the "***2018 Act***") and the Bipartisan Budget Act of 2019 extended the 2% reduction in Medicare spending through 2029. Additional reductions in Medicare reimbursement could result from changes to, or the repeal of, the Affordable Care Act, or as a result of the enactment of Medicare reform, deficit reduction, or other legislation.

Medicare Inpatient Prospective Payment System

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

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor each federal fiscal year ("***FFY***"), which begin on October 1 (for example, FFY 2020 began on October 1, 2019). The index used to adjust the base MS-DRG payment rate, which is known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. For FFYs 2019 and 2018, the hospital market basket index increased 2.9% and 2.7%, respectively. Generally, however, the percentage increase in the MS-DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the hospital market basket increases for FFYs 2020, 2019 and 2018 were each reduced by CMS by 0.75%. As also mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the Bureau of Labor Statistics' 10-year moving average of changes in annual economy-wide productivity. For FFYs 2020, 2019 and 2018, the productivity adjustment equated to a 0.4%, 0.8% and 0.6% reduction in the market basket increase, respectively. As a result of these reductions and other changes implemented by CMS, the MS-DRG-rate increased by 3.1% for FFY 2020.

On October 1, 2007, CMS replaced the previously existing 538 diagnosis related groups with 745 MS-DRGs. The MS-DRGs are intended to more accurately reflect the cost of providing inpatient services and eliminate any incentives that hospitals may have to only treat the healthiest and most profitable patients. The American Taxpayer Relief Act of 2012 ("***ATRA***") required CMS to recoup $11 billion from IPPS payments in FFYs 2014 through 2017 to offset an additional increase in aggregate payments to hospitals that Congress believes occurred from FFYs 2008 through 2013 solely as the result of the transition to the MS-DRG system. In FFYs 2014, 2015 and 2016, CMS applied negative 0.8% adjustments as part of the recovery process required by ATRA, and it applied a negative 1.5% adjustment in FFY 2017 to recover the remaining outstanding amount. CMS had previously indicated that the reductions required by ATRA would be fully restored in FFY 2018. However, under the Medicare Access and CHIP Reauthorization Act of 2015 ("***MACRA***"), those reductions were to be restored in 0.5% increments over a six year period from FFYs 2018 through 2023, which would result in a cumulative 3.0% increase in rates, which would be less than the 3.9% reduction that was imposed by CMS in FFYs 2014 through 2017. However, we note that some of that restoration has been subject to further limits, such as under the 21st Century Cures Act (the "***Cures Act***") which further reduced the restoration for FFY 2018 from 0.5% to 0.4588%.

CMS has implemented a number of programs and requirements that are intended to promote value based purchasing and to link payments to quality and efficiency. For example, the MMA required all acute care hospitals to participate in CMS' Hospital Inpatient Quality Reporting Program (the "***IQR Program***") in order to receive the full hospital market basket update. Hospitals that do not participate in the IQR Program receive a 25% reduction in their IPPS annual payment update for the applicable FFY. Our hospitals reported all quality measures required by CMS related to the IQR Program and will receive the full market basket update through FFY 2020. In addition, hospitals that are not meaningful EHR users are also subject to an additional 75% reduction of the hospital market basket increase.

In addition, the Affordable Care Act requires United States Department of Health and Human Services ("***HHS***") to implement a value-based purchasing program for inpatient hospital services. This program rewards hospitals based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period. As part of the program, the Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by 2.0% each FFY. HHS pools the amount collected from these reductions to fund payments to reward hospitals that meet and exceed certain quality performance standards established by HHS. Under the program, each hospital's performance is evaluated during a specified performance period, and hospitals receive points on each of a number of pre-determined measures based on the higher of (i) their level of achievement relative to an established standard or (ii) their improvement in performance from their performance during a prior baseline period. Each hospital's combined scores on all the measures are translated into value-based incentive payments. Hospitals that receive higher total performance scores receive higher incentive payments than those that receive lower total performance scores. Because the Affordable Care Act provides that the funds pooled and otherwise set aside for the value-based purchasing program will be fully distributed, hospitals with high scores may receive greater reimbursement under the value-based purchasing program than they would have otherwise, and hospitals with low scores may receive reduced Medicare inpatient hospital payments.

Medicare also does not allow an inpatient hospital discharge to be assigned to a higher paying MS-DRG if certain designated hospital acquired conditions ("***HACs***") were not present on admission and the identified HAC is the only condition resulting in the assignment of the higher paying MS-DRG. In those situations, the case is paid as though the secondary diagnosis was not present. In addition, hospitals that fall into the top 25.0% of national risk-adjusted HAC rates for all hospitals in the previous year receive a 1.0% reduction in their total Medicare payments.

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

Medicare Hospital Outpatient Prospective Payment System and Other Outpatient Services

CMS reimburses hospital outpatient services under the Medicare hospital outpatient prospective payment system ("***OPPS***"), and generally uses fee schedules to pay for durable medical equipment and physical, occupational and speech therapy, clinical diagnostic laboratory and independent diagnostic testing facility services. Under the OPPS, hospital outpatient services are classified into groups called ambulatory payment classifications ("***APCs***"). Services in each APC are clinically similar and are similar in terms of the resources they require. Depending on the services provided, a hospital may be paid for more than one APC for an encounter. CMS establishes a payment rate for each APC by multiplying the scaled relative weight for the APC by a conversion factor. The payment rate is further adjusted to reflect geographic wage differences. The APC conversion factors for calendar years ("***CYs***") 2020, 2019 and 2018 were $80.784, $79.490 and $78.636, respectively, after the inclusion of the productivity adjustments and other reductions that were required by the Affordable Care Act. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Reporting Program (the "***OQR Program***"). Hospitals that do not satisfy the reporting requirements of the OQR Program are subject to a reduction of 2.0% in their annual payment update under the OPPS. Our hospitals reported all quality measures required by CMS for the OQR Program and will receive the full market basket update through CY 2020.

Effective as of January 1, 2017, Section 603 of the BBA limits reimbursement for items and services that are furnished by certain off-campus outpatient provider-based departments ("***off-campus PBDs***") of hospitals. CMS included several provisions implementing Section 603 in the OPPS final rule for CY 2017. Under the final rule, CMS will continue to make OPPS payments to off-campus PBDs that were billing Medicare as hospital departments under the OPPS prior to November 2, 2015 ("***grandfathered PBDs***"). However, grandfathered PBDs will generally not be able to relocate, and CMS has indicated that it may adopt limitations on the expansion of the service lines provided at grandfathered PBDs in the future. In addition to grandfathered PBDs, CMS will also continue to reimburse all items and services that are furnished in a "dedicated emergency department" of a hospital, as such term is defined for the purposes of the Emergency Medical Treatment and Active Labor Act ("***EMTALA***"), regardless of whether the items and services are emergency items and services, and all items and services that are furnished in off-campus PBDs that are located within 250 yards of a remote location of a hospital, which is a facility that is either created or acquired by a hospital for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the hospital, under the OPPS. Beginning in CY 2019, all items and services not provided at a grandfathered or otherwise excepted off-campus PBD are generally paid by CMS under Medicare physician fee schedule ("***PFS***") rates that are approximately 40% of the applicable OPPS rate (the "***PFS Adjusted Rate***"). In addition, in 2018, CMS issued a final rule that will generally reimburse clinic visit services provided at all off-campus PBDs, including grandfathered PBDs, at a reduced Medicare PFS-equivalent payment rate. The payment reduction for clinic visit services provided at off-campus PBDs will be phased in over a two year period beginning in FFY 2019.

In December 2018, a lawsuit was filed challenging the portion of CMS' final rule that reduced reimbursement for clinic visit services provided at grandfathered PBDs to a lower Medicare PFS-equivalent payment rate. On September 17, 2019, the U.S. District Court for the District of Columbia ruled that the reduction in reimbursement for clinic services provided at grandfathered PBDs exceeded CMS' statutory authority. CMS has indicated that it will pay claims for clinic visit services provided at grandfathered PBDs in CY 2019 at the full OPPS payment rate. However, in the OPPS final rule for CY 2020, CMS noted that the court's ruling only applied to clinic visit services provided in CY 2019 and, as a result, CMS moved forward with the planning phase-in of the second year of the clinic visit service payment reduction in CY 2020 while it appeals the court's decision. A new lawsuit was filed on January 13, 2020, challenging the continued phase-in of the reduction for CY 2020.

As part of the OPPS final rule for CY 2018, CMS also finalized a change to the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B Drug Pricing Program (the "***340B Program***"). The 340B Program allows certain non-profit and governmental hospitals and other healthcare providers to obtain substantial discounts on covered outpatient drugs (prescription drugs and biologics other than vaccines) from drug manufacturers. Under the final rule, CMS pays for separately reimbursable, non-pass through drugs and biologicals (other than vaccines) purchased through the 340B Program at the average sales price ("***ASP***") minus 22.5% rather than ASP plus 6%. CMS estimated that this change reduced Medicare payments for drugs and biologicals by $1.6 billion in CY 2018. To maintain budget neutrality, CMS implemented an offsetting increase in the conversion factor, and, as a result, reimbursement rates for non-drug items and services provided by all hospitals, including those not eligible to participate in the 340B Program, that are reimbursed under the OPPS. In connection with the OPPS final rule for CY 2019, CMS expanded the 340B Program payment reductions to drugs that are obtained through the 340B Program and furnished by non-excepted, off-campus PBDs. CMS will continue these 340B Program payment reductions in CY 2020.

In September 2018, a lawsuit was filed challenging the authority of CMS to make the 340B Program payment reductions set forth in the OPPS final rule for CY 2018. On December 27, 2018, the U.S. District Court for the District of Columbia held that the payment reductions exceeded CMS's statutory authority and entered a permanent injunction against the reductions. However, because the 340B Program payment reductions were made in a budget-neutral manner and the savings derived from the reductions were used to increase reimbursement for all of the other items and services provided under the OPPS, the court ordered the parties to submit briefs as to how the issue should be remedied. The lawsuit has been expanded to include the 340B Program payment reductions that were made in CY 2019, and an additional lawsuit has been filed against the 340B Program payment reductions being made by CMS in CY 2020. CMS has appealed the District Court's rulings. We cannot predict the outcome of CMS's appeal or the remedies, if any, that may be imposed in connection with the 340B Program payment reduction litigation. If OPPS payments to hospitals are reduced (either retroactively or prospectively) as a result of the 340B Program payment reduction litigation, we would be materially adversely affected.

Medicare Disproportionate Share Hospital Payments

Hospitals may also qualify for Medicare disproportionate share hospital ("***DSH***") payments, if they treat a high percentage of low-income patients (as determined by a ratio involving Medicare and Medicaid patients eligible to receive Supplemental Security Income). DSH payments are determined annually based on certain statistical information specified by HHS and are paid as an addition to MS-DRG payments. The Affordable Care Act requires Medicare DSH payments to providers to be reduced by 75% beginning in FFY 2014, subject to adjustment if the Affordable Care Act does not decrease uncompensated care to the extent anticipated. The amount that is withheld is reduced by the percentage change in uninsured individuals under the age of 65, and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. The IPPS final rule for FFY 2020 established the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2020 at approximately $8.4 billion, an increase of approximately $78 million from FFY 2019.

Medicare Dependent and Low Volume Hospital Programs

On April 16, 2015, MACRA was enacted. Among other things, MACRA extended the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by Medicare, and the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located a certain distance from another general acute care hospital and have less than a certain number of Medicare discharges each fiscal year, through September 30, 2017. The 2018 Act extended both of these programs through FFY 2022.

Cost Reports

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

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

Medicare Bad Debt Reimbursement

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

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

Medicare Physician Fee Schedule

Professional medical services provided to Medicare beneficiaries by physicians and certain other health care practitioners, including physician assistants and nurse practitioners, are reimbursed under the PFS. Under the PFS, CMS has assigned a national relative value unit ("***RVU***") to most medical procedures and services that reflects the various resources required by a physician or practitioner to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service and the practice overhead and malpractice insurance expenses that are attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs and are then aggregated. The aggregated amount is multiplied by a conversion factor to determine the payment rate for the service. The conversion factor is updated by CMS on an annual basis.

MACRA, which was adopted in 2015, significantly changed how CMS determines the annual updates to the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased annually by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the 2018 Act, were increased by 0.25% for CY 2019. PFS payment rates are scheduled to remain at their CY 2019 levels through CY 2025.

In addition to revising the methodology that is used to update payments that are made under the PFS, MACRA also established a Quality Payment Program ("***QPP***") for incentivizing physician and practitioner care that meets certain value, quality, cost, and performance criteria. Beginning in CY 2019, amounts paid to physicians and practitioners under the PFS are subject to adjustment through the QPP and participation in either the Merit-Based Incentive Payment System ("***MIPS***") or an Advanced Alternative Payment Model ("***APM***") program. Physicians and practitioners who participate in the MIPS program, which essentially consolidated the prior Physician Quality Reporting System, the Value-Based Modifier, and the Meaningful Use of EHR incentive programs, are subject to positive, zero, or negative performance adjustments depending on how the physician's or practitioner's performance compared to a performance threshold. The payment adjustments are based on the physician's or practitioner's performance in the year that is two years prior to the current payment period. As a result, PFS payments in CY 2020 will be based on CY 2018 performance scores. HHS and CMS revise the MIPS reporting measures on an annual basis and have indicated that they intend to routinely increase the performance thresholds in connection with those revisions. In addition, from CY 2019 through CY 2024, MACRA provides $500 million per year for an additional performance adjustment for physicians and practitioners who participate in MIPS and achieve exceptional performance. Physicians and practitioners who participate in an APM program, which, among other things, requires the physician or practitioner to receive a substantial amount of their revenue from an APM, will receive, from CYs 2019 through 2024, a lump-sum payment equal to 5% of their Medicare payments in the prior year for services paid under the PFS. Beginning in CY 2026, PFS payment rates for physicians and practitioners participating in an APM program would be increased by 0.75% a year. Payments for other physicians and practitioners would be increased by 0.25% per year.

Medicaid

For the year ended December 31, 2019, approximately 17.1% of our revenues related to patients participating in the various state Medicaid programs. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. Medicaid programs are funded by both the federal government and states to provide healthcare benefits to limited categories of low-income individuals under 65 years of age. These programs and the reimbursement methodologies are administered by the states under approved plans and vary from state to state and from year to year. Amounts received under the Medicaid programs are often significantly less than the hospital's customary charges for the services provided. Most state Medicaid payments are made under a prospective payment system, fee schedule, cost reimbursement program, or some combination of these three methods. All of our hospitals are currently certified to participate in their respective state Medicaid programs.

The Affordable Care Act essentially requires states to expand medical coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level ("***FPL***"). However that portion of the Affordable Care Act was held to be unconstitutional by the U.S. Supreme Court, and, as a result, states may opt out of the expansion without losing their existing Medicaid funding. Therefore, the income level required for individuals to qualify for Medicaid varies widely from state to state. To offset the cost of the Medicaid program's expansion, the Affordable Care Act authorized the federal government to provide states with "matching funds" (referred to as "***Enhanced FMAP***") to cover the costs of covering the newly eligible individuals. The Enhanced FMAP was 100% for CYs 2014 through 2016; 95% in CY 2017; 94% in CY 2018; 93% in CY 2019; and will be 90% in CYs 2020 and thereafter.

In recent years, we have benefited from the expansion of Medicaid under the Affordable Care Act, and effective as of January 1, 2020, Idaho and Utah, two additional states in which we operate, expanded their Medicaid programs. However, a number of states in which we operate have not expanded their Medicaid programs, or are seeking waivers that could reduce their Medicaid-eligible populations. Several states have adopted or are considering legislation designed to reduce or control their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs, and imposing additional taxes on hospitals to help finance such states' Medicaid systems. Given the reductions in the Enhanced FMAP and in light of the possible repeal, replacement or modification of the Affordable Care Act, we are unable to predict how many, if any, additional states in which we operate will expand their Medicaid programs or how many, if any, of the states in which we operate that have expanded their Medicaid programs will keep their expansions in place in the future.

The Affordable Care Act also included a number of provisions that are intended to improve the quality of care that is provided to Medicaid beneficiaries. Among other things, the Affordable Care Act prohibits federal funds from being used to reimburse providers for services related to provider preventable conditions, such as HACs, wrong site surgeries and other provider preventable conditions that may be designated by each state Medicaid program.

Work Requirements

In addition to implementing value-based purchasing and quality-driven reimbursement requirements, CMS has also issued new guidance permitting states to impose work and/or community engagement requirements on certain Medicaid beneficiaries. In response to the guidance, a number of states, including several in which the Company has facilities, have requested demonstration waivers from CMS that would allow those states to impose work requirements on their Medicaid beneficiaries. CMS has approved the requests that have been made by Arizona, Arkansas, Indiana, Michigan, New Hampshire, Ohio, South Carolina, Utah and Wisconsin, and the remaining requests are still pending. However, a number of lawsuits have been filed challenging the authority of CMS to allow state Medicaid programs to impose work and/or community engagement requirements on their respective beneficiaries and, as a result, the demonstration waivers that have been approved by CMS have generally not yet been implemented. We cannot predict whether CMS will grant additional waivers that allow for the imposition of work and community engagement requirements on Medicaid beneficiaries or the impact that any such waivers will have on coverage for patients seeking care at our facilities. We also cannot predict whether the legal challenges that have been initiated against the demonstration waivers that have been approved by CMS will be successful or whether any legal challenges will be initiated against any other similar demonstration waivers that have been or may be granted by CMS in the future.

Medicaid Block Grants and Capped Federal Funding

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

On November 11, 2019, Tennessee, one of the states in which we operate, submitted an amendment to CMS for its Medicaid demonstration waiver that would convert federal funding for the Tennessee Medicaid program to a modified block grant program. We cannot predict whether the Tennessee waiver amendment will be approved by CMS or, if approved by CMS, the impact the amendment would have on Medicaid beneficiaries or our facilities in Tennessee.

Additionally, on January 30, 2020, CMS released new guidance permitting states to design Medicaid plans that would receive a block grant or capped amount of federal funding in connection with plans that expand coverage to able-bodied adults not generally eligible for benefits under traditional Medicaid, while providing states flexibility in the administration of benefits for such individuals. We cannot predict what states might submit waiver requests under the new guidance, or how such capped Medicaid plans might affect our operations.

Medicaid Supplemental Payments

Medicaid supplemental payments ("***MSPs***") are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and Upper Payment Limit ("***UPL***") payments.

Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating these patients. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. Although federal Medicaid law defines some level of hospitals that must receive Medicaid DSH funding, states have broad discretion to define additional hospitals that also may qualify for Medicaid DSH payments and the amount of such payments. However, the total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law.

Pursuant to the Affordable Care Act, as amended by subsequent legislation, funding for Medicaid DSH programs is to be reduced by $4 billion in FFY2020 and $8 billion per year from FFY 2021 through FFY 2025. Congress has delayed the reduction in funding for Medicaid DSH programs on a number of occasions, most recently through May 2020, but we cannot predict whether Congress will further delay or otherwise modify the reductions in the future. Because many of the states in which we operate have not expanded Medicaid programs as intended under the Affordable Care Act, the reduction in Medicaid DSH payments may take place without a coupled increase in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars. UPL programs have expanded in recent years, and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs.

In addition, on November 18, 2019, CMS released a proposed rule, the Medicaid Fiscal Accountability Rule, that is intended to increase federal oversight of MSPs and state Medicaid financing policies. Among other things, the proposed rule would add new review and reporting requirements on UPL payment arrangements, including the reporting of provider-level payment detail, impose limitations on UPL payments that are made to physicians and certain other practitioners, and impose certain limits on the use of healthcare provider taxes, intergovernmental transfers and certified public expenditures. We cannot predict whether the proposed rule will be adopted and, if adopted, the impact that the proposed rule would have on the MSPs that are currently received by the Company's facilities. In addition, even if the proposed rule is not adopted, we also cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease.

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

Recovery Audit and Other Review Contractors

Recovery audit contractors ("***RACs***") are used by CMS and state agencies to detect Medicare and Medicaid overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare and Medicaid claims filed by healthcare providers. RACs perform post-discharge audits of medical records to identify overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services and are paid on a contingency basis. Any claims identified as overpayments are subject to a RAC program appeals process. In 2016, in connection with the procurement of the new recovery audit contracts, CMS made a number of enhancements to the RAC program, including the establishment of a RAC program Provider Relations Coordinator, requiring RACs to maintain an overturn rate of less than 10% at the first level of appeal, requiring RACs to maintain an accuracy rate of at least 95%, and establishing additional documentation request limits based on a provider's compliance with Medicare rules, that are intended to address provider and other stakeholder concerns. CMS has also limited the number of claims that RACs may audit by limiting the number of records that RACs may request from hospitals based on each hospital's claim denial rate for the previous year.

In addition to RACs, CMS employs Unified Program Integrity Contractors ("***UPICs***"), which integrate the functions of the former Zone Program Integrity Contractors, Program Safeguard Contractors, and Medicaid Integrity Contractors, to perform post-payment audits of Medicare and Medicaid claims and identify overpayments. A number of state Medicaid agencies and other contractors have also increased their review activities.

Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our hospitals have had Medicare claims audited by the RAC program. While our hospitals have successfully appealed many of the adverse determinations raised by Medicare RAC audits, we cannot predict if this trend will continue or the results of any future audits. We cannot predict the volume or outcome of any future audits conducted by the various RACs and other review programs to which our hospitals will be subject.

Utilization and Claim Review

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

In addition to utilization reviews, CMS has also adopted a nationwide claim review and provider education program known as the Targeted Probe and Educate ("***TPE***") program, which is intended to reduce errors in the claims submission process and focuses on items and services that pose the greatest risk to the Medicare program or that have a high national error rate, such as short inpatient stays. Under the TPE program, MACs use data analysis to identify providers who, for a particular item or service, have high claim denial rates or billing practices that vary significantly from their peers. Once a provider has been identified, the MAC reviews between 20 and 40 of the provider's claims for the item or service and, if issues are noted, offers the provider an individualized education session that is based on the results of the review. The provider is then generally given 45 days to improve its systems and processes, and, after that period has ended, the MAC conducts another review of the provider's claims. If additional issues are identified, the provider is given the opportunity for another education session. Providers are typically given three rounds of review and education before being referred to CMS for further action, potentially including pre-payment review, referral for RAC review, or in some cases revocation of billing privileges.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payers including HMOs, PPOs and other private insurers. Also included in this category are the patient responsibility portions for co-payment and deductible obligations under these programs. Our revenues from HMOs, PPOs and other private insurers were approximately 42.3% of our net patient revenues for the year ended December 31, 2019. Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services or accept fixed, pre-determined fees for our services. These discounted contractual arrangements often limit our ability to increase charges or revenues in response to increasing costs. We actively negotiate with these payers in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payer with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. Additionally, plans purchased through the Affordable Care Act health insurance marketplace exchanges (the "***Exchanges***") are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when we are not a participating provider in the network, it can result in higher patient responsibility amounts that a patient may not have the ability to pay or may choose not to pay. We expect these trends to continue in the coming years.

Self-Pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Our revenues from self-pay patients were approximately 0.7% of our net patient revenues for the year ended December 31, 2019. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities experienced in prior years, which included increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. We cannot predict how administrative or judicial interpretations, legislative actions or any other modifications to the Affordable Care Act that may be implemented or adopted, such as the cessation of cost sharing reduction payments or the repeal of the individual mandate, may impact our self-pay revenues.

Surprise Medical Billing

Congress is considering legislation to limit the "surprise" medical bills that are often received by individuals receiving emergency and certain other services (such as anesthesia services) from out-of-network providers. Various proposals have been introduced in Congress that would generally limit cost sharing for insured individuals who receive emergency and certain other services from out-of-network providers to in-network co-payment and deductible amounts, and would generally prohibit out-of-network providers from balance billing patients for any additional amounts. The proposals would either set payments from payers to out-of-network providers at the median in-network rate, or would allow payers and providers to refer payment disagreements to independent dispute resolution mechanisms. A number of states are considering or have already adopted legislation to eliminate surprise medical billing. We cannot predict how legislative actions to modify or pass these proposals may be implemented or adopted, or what impact, if any, this may have on our contracts with providers or on our revenues.

Price Transparency

Under the OPPS Rule for CY 2020, CMS finalized price transparency requirements that are applicable to hospitals and, beginning January 1, 2021, require (i) public online disclosure of all standard charges for all hospital items and services and (ii) public display in a consumer-friendly manner of cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for at least 300 "shoppable" services (70 CMS-specified and 230 hospital-selected). The final rule also authorizes CMS to monitor hospital compliance with reporting requirements and to take actions to address hospital noncompliance (including issuing a warning notice, requesting a corrective action plan, and imposing civil monetary penalties). The Departments of the Treasury, Labor, and Health and Human Services have also undertaken regulatory efforts to increase price transparency with a proposal requiring health plans to publicly release all of their negotiated rates. On December 4, 2019, a lawsuit was filed challenging the final rule and CMS' new price transparency requirements. We are unable to predict the outcome of that litigation or what affect the public disclosure of hospitals' or insurance providers' negotiated rates would have on our future negotiations with payers or on our revenues.

Health Care Reform

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, requiring most Americans to obtain health insurance (the "***individual mandate***"), providing additional funding for Medicaid in states that choose to expand their programs, reducing IPPS, OPPS and Medicare and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and instituting certain private health insurance reforms. The Affordable Care Act has, however, been subject to a number of legislative and regulatory changes and court challenges and its future is uncertain.

For example, on January 20, 2017, President Trump issued an executive order that, among other things, stated that it was the intent of his administration to repeal the Affordable Care Act and, pending that repeal, instructed the executive branch of the federal government to defer or delay the implementation of any provision or requirement of the Affordable Care Act that would impose a fiscal burden on any state or a cost, fee, tax or penalty on any individual, family, health care provider, or health insurer. On October 12, 2017, President Trump issued another executive order related to the Affordable Care Act that resulted in the issuance of regulations that are intended to encourage the formation of association health plans and increase the maximum duration of and access to short-term limited duration health insurance plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. Portions of these regulations were later invalidated by the U.S. District Court for the District of Columbia, in a case that has been appealed to the D.C. Circuit Court of Appeals. In addition, a number of bills have been introduced in Congress that would repeal the Affordable Care Act and would replace it with varying health coverage plans, including plans that would allow insurers to sell health insurance across state lines, allow the use of health savings accounts ("***HSAs***") without a high-deductible plan, or give states the option to either keep the coverage framework created by the Affordable Care Act (e.g., expanded Medicaid, individual subsidies, and insurance exchanges) or utilize the increased federal funding that was intended for Medicaid expansion to be provided by the federal government under the Affordable Care Act to create HSAs that can be used by low-income individuals to purchase health insurance. Also, the Tax Act repealed the penalties associated with the individual mandate effective January 1, 2019. We cannot predict whether the Affordable Care Act will be repealed, replaced, or materially modified by Congress or the impact that the repeal of the penalties associated with the individual mandate will have on our facilities.

In addition to the administrative actions and legislative efforts to repeal, replace or modify the Affordable Care Act, there have been and will likely continue to be a number of legal challenges to various provisions of the Affordable Care Act and the regulations that have been promulgated thereunder. For example, in 2014, the U.S. House of Representatives (the "***House***") filed a lawsuit challenging the use of federal funds to pay insurance companies for cost sharing reductions that are provided to certain individuals who purchase insurance through the Exchanges. The House lawsuit was ultimately settled after HHS stopped making cost sharing reduction payments to insurance companies based on the determination that these payments had not been appropriated by Congress. A number of insurers have, however, filed litigation against HHS to recover the cost sharing reduction payments that have not been made. In addition, on December 14, 2018, the U.S. District Court for the Northern District of Texas held that, in light of the repeal of the penalties associated with the individual mandate, the entire Affordable Care Act was unconstitutional. The court did not, however, issue an injunction against the continued enforcement of the Affordable Care Act. On appeal, the U.S. Fifth Circuit Court of Appeals held that the individual mandate was unconstitutional but it remanded the case back to the U.S. District Court for the Northern District of Texas for further analysis as to whether the entire Affordable Care Act should be held to be unlawful. The U.S. Supreme Court has agreed to review the case, but it likely will not issue an opinion until 2021. We cannot predict the outcome of the litigation that has been filed by insurers relating to the cessation of HHS's cost sharing reduction payments, the impact that the cessation of HHS's cost sharing reduction payments will have on the premiums that are charged by insurers or the outcome of any of the litigation regarding the Affordable Care Act, including its constitutionality.

Unless specifically stated otherwise, our summary of provisions of the Affordable Care Act throughout the remainder of this section and elsewhere in this Report are based on the law as currently in effect. Additionally, refer to the section below captioned "Impact of the Affordable Care Act on the Company" for further discussion about the uncertainty surrounding the Affordable Care Act.

Expanded Coverage

Based on original Congressional Budget Office ("CBO") and CMS estimates, by 2020, the Affordable Care Act was originally expected to expand coverage to 32 to 34 million additional individuals (resulting in coverage of an estimated 95% of the legal U.S. population). This increased coverage was expected to occur through a combination of public program expansion and private sector health insurance and other reforms.

Public program expansion has been driven primarily by expanding the categories of individuals who are eligible for Medicaid coverage and allowing individuals with relatively higher incomes to qualify for Medicaid coverage.

The Affordable Care Act essentially made the expansion of the Medicaid program mandatory, but, in 2012, the U.S. Supreme Court held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that chose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. Based on the U.S. Supreme Court's ruling, a number of states, including several in which the Company has facilities, have opted not to expand their Medicaid programs. Public program expansion has also occurred through provisions of the Affordable Care Act that authorize the federal government to subsidize states that create non-Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL and allow Medicaid participating hospitals to make presumptive determinations of Medicaid eligibility for certain categories of individuals, such as pregnant women, infants, children, and parents and other caretaker relatives and their spouses. If an individual is found to be presumptively eligible for Medicaid benefits, the hospital will get paid for the services it provides during the temporary presumptive eligibility period, just as though the patient were already enrolled in the Medicaid program.

The expansion of health coverage through the private sector as a result of the Affordable Care Act has occurred through new requirements on health insurers, employers and individuals. For example, commencing January 1, 2014, health insurance companies were prohibited from imposing annual coverage limits, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. In addition, since January 1, 2011, each health plan has been required to keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. Also, since September 23, 2010, health insurers have not been permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old. Larger employers are subject to new requirements and incentives to provide health insurance benefits to their full time employees, and, effective January 1, 2016, all employers subject to the requirement are required to offer health insurance coverage to 95% of their full-time employees and their dependents in order to avoid penalties.

To facilitate the purchase of health insurance by individuals and small employers, each state was required to establish an Exchange by January 1, 2014. For individuals and families below 400% of the FPL, the cost of obtaining health insurance through the Exchanges is subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. Health insurers participating in the Exchange must offer a set of minimum benefits to be defined by HHS and may offer more benefits. Any benefits to us from the expansion of private sector coverage depend in large part on our success in contracting with payers whose policies are listed on the Exchanges. We currently have contracts with Exchange payers in every state in which we operate, and the reimbursement rates paid under those contracts generally are comparable to that paid to us by other private payers.

Although we expect this trend to continue, the future impact and timing of such expansion remains difficult to predict for the reasons discussed above, will be gradual and may not offset scheduled decreases in reimbursement. Additionally, we cannot predict the impact of the cessation of cost sharing reduction payments, the repeal of the individual mandate or any other modifications to the Affordable Care Act that may be adopted.

Public Program Spending

The Affordable Care Act provides for a number of Medicare, Medicaid and other federal healthcare program spending reductions. The CBO previously estimated that between 2013 and 2023, these program spending reductions would include $415 billion in Medicare fee-for-service market basket and productivity reimbursement reductions for all providers, the majority of which ($260 billion) would come from hospitals. The CBO's estimate also included an additional $56 billion in reductions of Medicare and Medicaid DSH funding. CMS had originally estimated that the Affordable Care Act would result in $64 billion in reductions of Medicare and Medicaid DSH funding, with $50 billion of the reductions coming from Medicare.

Accountable Care Organizations

The Affordable Care Act requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("***ACOs***"). ACOs are groups of hospitals, physicians and other designated professionals and suppliers who come together voluntarily to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS are eligible to share in a portion of the amounts saved by the Medicare program. There are several types of ACO programs, and as of July 1, 2019, 518 ACOs had been established to participate in the Medicare Shared Savings Program, and additional ACOs are being established by private payers. A few of our facilities currently participate in ACOs.

Bundled Payment Pilot Programs

The Affordable Care Act created the Center for Medicare & Medicaid Innovation ("***CMMI***") and made it responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs while improving quality of care. Under these projects and initiatives, participating providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care and accept accountability for costs and the quality of care that is provided. By financially rewarding providers for quality, cost-effective care and penalizing providers when costs exceed a certain amount, these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. In connection with these programs, CMMI has developed a voluntary Bundled Payment for Care Improvement Advanced Model ("***BPCI Advanced***") to test innovative payment and service delivery models that have the potential to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care for beneficiaries. Participation in bundled payments programs is generally voluntary, but CMS does currently require hospitals in certain geographic areas to participate in the Comprehensive Care for Joint Replacement model which covers certain extremity joint replacement procedures. CMS has indicated that it expects to increase opportunities for providers to participate in voluntary bundled payment models initiatives and that it may create additional mandatory bundled payment models in the future. Several of our facilities currently participate in bundled payment programs.

Specialty Hospital Limitations

Over the last decade, we have faced competition from hospitals that have physician ownership. The Affordable Care Act prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand. As of December 31, 2019, we operated four hospitals through joint ventures with physicians in which we own a controlling interest.

Impact of the Affordable Care Act on the Company

The expansion of health insurance coverage under the Affordable Care Act has resulted in an increase in the number of patients using our facilities who have either private or public program coverage. It is difficult to predict with great precision the timing or size of positive or negative impacts on revenue as a result of the Affordable Care Act, because of uncertainty surrounding a number of material factors, including the following:

- the elimination of the penalties associated with the individual mandate;
- the cessation of cost sharing reduction payments to insurers;
- the possibility that the Affordable Care Act will be repealed and/or replaced or further modified by Congress;
- even if the Affordable Care Act is not repealed, replaced or further modified, the level of disruption that may be caused by continuing legal challenges and other efforts to delay, block or eliminate specific provisions of the Affordable Care Act, including the outcome of continuing litigation relating to the constitutionality of the Affordable Care Act;
- how many previously uninsured individuals will ultimately obtain coverage as a result of the Affordable Care Act;
- what percentage of the future newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states impose work and community engagement and/or premium requirements on their Medicaid beneficiaries;
- the number of states that ultimately elect to expand their Medicaid programs and when that expansion occurs;
- whether any states that have expanded their Medicaid programs will scale back such expansion through the imposition of work or premium requirements or otherwise as the Enhanced FMAP is reduced;
- the extent to which states will enroll any new Medicaid participants in managed care programs;
- the rates charged by private payers for insurance purchased on the Exchanges;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the future rates paid to hospitals by private payers for newly covered individuals under different plans, including those covered through the Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- increasing self-pay as a result of individuals in the Exchanges who select high deductible plans, and risks presented by their ability to pay such deductibles;
- whether or not private insurers will participate in the Exchanges, and whether such participation is through the use of narrow networks that restrict the number of participating providers or tiered networks that impose significantly higher cost sharing obligations on patients that obtain services from providers in a disfavored tier; and
- whether the net effect of the Affordable Care Act, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business.

Additionally, since approximately 55.2% of our revenues in 2019 were related to patients participating in Medicare and Medicaid programs, collectively, the reductions in Medicare and Medicaid reimbursement and in the growth of spending by the Medicare and Medicaid programs that are contemplated by the Affordable Care Act will significantly impact us and could offset any positive effects of the Affordable Care Act. It is difficult to predict with great precision the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

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

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

Competition for Patients

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

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

In addition, tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, exemptions from sales, property and income taxes, and participation in the 340B Program. In certain states, some not-for-profit hospitals are permitted by law to directly employ physicians while for-profit hospitals are prohibited from doing so.

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

Competition for Professionals

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

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

Many physicians today prefer to be employed, rather than operating their own practices or joining existing medical groups. Our hospitals and affiliated entities employed more physicians during 2019 than 2018. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians and incur additional expenses as a result. We expect this trend to continue.

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

Employees

At December 31, 2019, we had approximately 55,000 employees, including approximately 12,000 part-time employees. The majority are hospital-based employees, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our facilities. Approximately 3,000 of our employees across certain of our facilities are unionized. While some of our non-unionized facilities experience union organizing activity from time to time, currently we do not expect these efforts to affect our future operations materially. Our facilities, like most facilities, have experienced rising labor costs. Our labor costs also may increase at higher rates among unionized employees. Unionized employees also may have rights under their collective bargaining agreements that restrict the ability of a facility to take certain actions with respect to these employees.

Government Regulation

Overview

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

Acute care hospitals are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing, certification and accreditation. All of our hospitals are currently licensed under appropriate state laws and are qualified to participate in the Medicare and Medicaid programs. In addition, as of December 31, 2019, with the exception of Bluegrass Community Hospital and Saline Memorial Hospital, all of our hospitals were accredited by the Joint Commission.

Fraud and Abuse Laws

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

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

Anti-kickback Statute

The Anti-kickback Statute prohibits the payment, receipt, offer or solicitation of anything of value, whether in cash or in kind, with the intent of generating referrals or orders, or recommending or arranging for services or items covered by a federal or state healthcare program. Violations of the Anti-kickback Statute are punishable by, among other things, imprisonment, criminal fines, substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation, damages equal to three times the total remuneration associated with the unlawful referrals or services, and/or possible exclusion from participating in Medicare, Medicaid or other governmental healthcare programs. Violations of the Anti-kickback Statute can also result in liability under the False Claims Act.

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

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

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

Stark Law

The Stark law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship if those entities provide certain "designated health services" unless an exception applies. The Stark law also prohibits entities that provide designated health services reimbursable by Medicare and Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires entities to refund amounts received for items and services provided pursuant to a prohibited referral on a timely basis. "Designated health services" include, among other things, inpatient and outpatient hospital services, laboratory services and radiology services. A violation of the Stark law may result in (i) a denial of payment, (ii) substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation or circumvention scheme and (iii) exclusion from participation in the Medicare and Medicaid programs and other governmental healthcare programs. In addition, violations of the Stark law could also result in penalties under the False Claims Act.

There are ownership and compensation arrangement exceptions to the self-referral prohibition. There are also exceptions for many of the customary financial arrangements between physicians and facilities, including employment contracts, leases and recruitment agreements, and there is a "whole hospital exception," which allows a physician to make a referral to a hospital if, among other things, the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. The Affordable Care Act significantly modified the requirements of the whole hospital exception and placed a number of restrictions on the ownership structure, operations, and expansion of physician owned hospitals. Four of our facilities are subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations. In recent years, CMS has issued a number of proposed and final rules modifying and/or clarifying the Stark law exceptions. While some changes have been implemented, others remain in proposed form or have been delayed. We anticipate that there will be further changes in the future, and those changes may require us to modify our activities.

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

False Claims Act

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

Changes in the Regulatory Environment

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

In addition to the changes mentioned above, the Affordable Care Act created False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. On February 11, 2016, CMS published a final rule that provides clarification around the meaning of overpayment identification and generally establishes a six year lookback period for Medicare Part A and Part B providers and suppliers. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments, accurately prepare cost reports and timely resolve credit balances. In light of the provisions of FERA and the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law, including technical violations of certain fraud and abuse laws, and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

State Laws

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

Emergency Medical Treatment and Active Labor Act

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

Administrative Simplification Provisions and Privacy and Security Requirements

We are subject to the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***") which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. Additionally, we are subject to the privacy, security and breach notification regulations promulgated under HIPAA and the Health Information Technology for Economic and Clinical Health Act (the "***HITECH Act***"), which are designed to protect the confidentiality, availability and integrity of protected health information ("***PHI***") and establish an array of patient rights with respect to such information. The HIPAA privacy, security and breach notification regulations apply to covered entities, which include health plans, health care clearinghouses, and health care providers that conduct certain standard transactions (such as billing insurance) electronically. In addition, certain provisions of the privacy, security and breach notification regulations apply to business associates, which are entities that perform certain functions or activities on behalf of covered entities that require access to or the use or disclosure of protected health information. In certain circumstances, a covered entity may be held liable for the actions of its business associate if HHS determines an agency relationship exists between the covered entity and the business associate under federal agency law.

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

Violations of the HIPAA regulations may result in criminal penalties and substantial civil monetary penalties subject to a limit for violations of the same requirement in a calendar year. The civil monetary penalties are also subject to annual inflation adjustments. In addition, state attorneys general are authorized to bring civil actions seeking either injunction or damages up to $25,000 for violations of the same requirement in a calendar year in response to HIPAA violations that affect their state residents. HHS has the discretion in many cases to resolve HIPAA violations through informal means without the imposition of penalties. However, the HIPAA privacy, security and breach notification regulations have and will continue to impose significant costs on our facilities in order to comply with these standards. We expect increased enforcement of the HIPAA regulations.

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

Corporate Practice of Medicine and Fee-Splitting

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

Certificates of Need

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

Not-for-Profit Hospital Conversion Legislation

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

State Hospital Rate-Setting Activity

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

Environmental Regulation

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

Compliance Program

We maintain a company-wide ethics and compliance program designed to ensure that we maintain high standards of ethical conduct in the operation of our business, and to meet or exceed applicable federal guidance and industry standards. We continually implement written policies and procedures for all of our employees to promote compliance with all applicable laws, regulations and Company policies, and to encourage a "culture of compliance" within the Company and its facilities. The organizational structure of our ethics and compliance program includes oversight by our Board of Directors and compliance committees at the Company and facility levels. We have compliance officers and personnel at the Company level and at our facilities. Other features of our compliance program include initial and periodic ethics and compliance training, systems for identifying and tracking compliance issues (including databases and hotlines for employees to report, without fear of retaliation, any suspected legal or ethical violations), regular auditing and monitoring of compliance issues, including coding audits and reviews of our financial relationships with physicians, and prompt review and resolution of identified issues.

Our compliance program also oversees the implementation and monitoring of the standards set forth by HIPAA for privacy. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and oversight at the Company level.

Risk Management and Insurance

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("***SIR***") and deductible levels. At December 31, 2019, our SIR for professional liability claims is $5.0 million per claim, with a $5.0 million inner aggregate, at the majority of our facilities. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2019, our deductible for workers' compensation claims was $1.0 million per claim in all states in which we operate except for Montana, Oklahoma, Ohio, Washington and Wyoming. We participate in state-specific programs for our workers' compensation claims arising in these states. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

We also maintain directors' and officers', property, some professional liability and other types of insurance coverage with unrelated commercial carriers. Our directors' and officers' liability insurance coverage for current officers and directors is a program that protects us as well as the individual director or officer. We maintain property insurance through unrelated commercial insurance companies.

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

Item 1A. ***Risk Factors.***

Any of the following risks could materially and adversely affect our business, financial condition or results of operations. In addition, the risks described below are not the only risks that we face. The following information should be read in conjunction with Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations." Additional risks and uncertainties not currently known to us or those that we currently view to be immaterial could also materially and adversely affect our business, financial condition or results of operations.

Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments on the Notes.

We are a highly leveraged company. As of December 31, 2019, we had total outstanding debt of approximately $6,100.0 million, excluding capital and financing leases and unamortized debt issuance costs.

Our substantial indebtedness could have important consequences for the lenders and holders of our indebtedness. For example, it could:

- limit our ability to borrow money for our working capital, capital expenditures, debt service requirements, strategic initiatives or other purposes;
- make it more difficult for us to satisfy our obligations with respect to our indebtedness, including the Notes, and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the indentures governing the Notes and the agreements governing other indebtedness;
- require us to dedicate a substantial portion of our cash flow from operations to the payment of interest and the repayment of our indebtedness, thereby reducing funds available to us for other purposes;
- limit our flexibility in planning for, or reacting to, changes in our operations or business;
- make us more highly leveraged than some of our competitors, which may place us at a competitive disadvantage;
- make us more vulnerable to downturns in our business, our industry or the economy;
- restrict us from making strategic acquisitions, engaging in development activities, introducing new technologies or exploiting business opportunities;
- cause us to make non-strategic divestitures;
- limit, along with the financial and other restrictive covenants in our indebtedness, among other things, our ability to borrow additional funds or dispose of assets;
- prevent us from raising the funds necessary to repurchase all Notes tendered to us upon the occurrence of certain changes of control, which failure to repurchase would constitute an event of default under the Indentures; or
- expose us to the risk of increased interest rates, as certain of our borrowings, including borrowings under the ABL Facility and the Term Loan Facility, are at variable rates of interest.

In addition, the ABL Agreement, the Term Loan Agreement and the Indentures contain restrictive covenants that limit or will limit our ability to engage in activities that may be in our long-term best interest. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of substantially all of our existing and future indebtedness.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.

Our ability to pay principal and interest and to satisfy our other debt obligations will depend upon, among other things:

- our future financial and operating performance (including the realization of any cost savings described herein), which will be affected by prevailing economic, industry and competitive conditions and financial, business, legislative, regulatory and other factors, many of which are beyond our control; and
- our future ability to borrow under the ABL Facility, the availability of which depends on, among other things, our complying with the covenants in the ABL Agreement.

We cannot assure you that our business will generate cash flow from operations, or that we will be able to draw under the ABL Facility or otherwise, in an amount sufficient to fund our liquidity needs, including the payment of principal and interest on the ABL Facility, the Term Loan Facility and the Notes.

If our cash flows and capital resources are insufficient to service our indebtedness, we may be forced to reduce or delay capital expenditures, sell assets, seek additional capital or restructure or refinance our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. In addition, the terms of existing or future debt agreements, including the ABL Agreement, the Term Loan Agreement and the Indentures, may restrict us from adopting some of these alternatives. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to dispose of material assets or operations to meet our debt service and other obligations. We may not be able to consummate those dispositions for fair market value or at all. Furthermore, any proceeds that we could realize from any such dispositions may not be adequate to meet our debt service obligations then due. The Sponsor and its affiliates have no continuing obligation to provide us with debt or equity financing. Our inability to generate sufficient cash flow to satisfy our debt obligations, or to refinance our indebtedness on commercially reasonable terms or at all, could result in a material adverse effect on our business, results of operations and financial condition and could negatively impact our ability to satisfy our obligations under our indebtedness.

If we cannot make scheduled payments on our indebtedness, we will be in default, and the lenders under the Term Loan Facility and the holders of the Notes could declare all outstanding principal and interest to be due and payable, the lenders under the ABL Facility could terminate their commitments to loan money, our secured lenders (including the lenders under the ABL Facility and the Term Loan Facility) could foreclose against the assets securing their loans and the Notes and we could be forced into bankruptcy or liquidation. All of these events could cause you to lose all or part of your investment in the Notes.

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

For the year ended December 31, 2019, approximately 55.2% of our revenues related to patients participating in Medicare and Medicaid programs, collectively. Numerous factors could materially decrease, or delay timing of, Medicare and Medicaid payments to our facilities. These factors include statutory and regulatory changes, administrative rulings and determinations concerning patient and provider eligibility and requirements for utilization review. Furthermore, the Affordable Care Act and related federal laws provide for material scheduled reductions in the growth rate of Medicare and Medicaid program spending, including reductions in market basket updates and Medicare and Medicaid DSH funding.

Medicaid programs, which are jointly funded by federal and state governments and are administered by states, provide healthcare benefits to qualifying individuals who are unable to afford care. A number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs. States may also impose additional taxes on hospitals to help finance such states' Medicaid systems. Some states have also taken steps to implement work and/or community engagement requirements for Medicaid beneficiaries, which could have the effect of reducing the number of individuals eligible for Medicaid in those states.

Recent executive and legislative actions to amend or impede the implementation of the Affordable Care Act and ongoing efforts to repeal, replace or further modify the Affordable Care Act may adversely affect our business, financial condition and results of operations.

The Affordable Care Act dramatically altered the U.S. healthcare system, and we have expended substantial cost and effort to prepare for and comply with the Affordable Care Act. Since its adoption into law in 2010, the Affordable Care Act has been challenged before the U.S. Supreme Court, and several bills have been and continue to be introduced in Congress to delay, defund or repeal implementation of or amend significant provisions of the Affordable Care Act. In addition, there continues to be ongoing litigation over the interpretation, implementation and constitutionality of the law. The net effect of the Affordable Care Act, as currently in effect, on our business is subject to a number of variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. Additional variables of the Affordable Care Act impacting our business will be how the litigation regarding the law is ultimately resolved and how states, providers, insurance companies, employers, and other market participants respond during this period of uncertainty surrounding the future of the Affordable Care Act.

In 2017, President Trump issued executive orders that, among other things, expressed the administration's intent to repeal the Affordable Care Act, instructed the executive branch of the federal government to defer or delay the implementation of any provisions of the Affordable Care Act that would impose a fiscal burden on any state or a cost, fee, tax or penalty on any individual, family, health care provider, or health insurer. On October 12, 2017, President Trump issued another executive order related to the Affordable Care Act that resulted in the issuance of regulations that were intended to encourage the formation of association health plans, and increase the maximum duration of and access to short-term limited duration health insurance plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. Portions of these regulations were later invalidated by the U.S. District Court for the District of Columbia in a case that has been appealed to the D.C. Circuit Court of Appeals. In 2017, the United States Department of Justice ("***DOJ***") also announced that HHS was immediately ceasing its cost sharing reduction payments to insurance companies based on a determination that those payments had not been appropriated by Congress, and Congress enacted the Tax Act that, in addition to overhauling the federal tax system, repealed the penalties associated with the individual mandate effective as of January 1, 2019. In addition, in December 2019, the U.S. Fifth Circuit Court of Appeals found that the individual mandate set forth in the Affordable Care Act was unconstitutional and ordered the U.S. District Court for the Northern District of Texas to conduct further analysis as to whether the entire Affordable Care Act should be held to be unlawful. The U.S. Supreme Court has agreed to review the case, but it likely will not issue an opinion until 2021.

We cannot predict the impact that the President's executive orders and other administrative actions will have on the implementation and enforcement of the provisions of the Affordable Care Act or the current or pending regulations adopted to implement the law. In addition, we cannot predict the impact that the repeal of the penalties associated with the individual mandate and the cessation of cost sharing reduction payments to insurers will have on the availability and cost of health insurance and the overall number of uninsureds. We also cannot predict the outcome of litigation challenging the constitutionality of the Affordable Care Act or whether the Affordable Care Act will be repealed, replaced, or modified. If the Affordable Care Act is found to be unconstitutional or if it is repealed, replaced or modified, we cannot predict what, if any, the replacement plan or modifications would be, when any such replacement plan or modifications would become effective, or whether any of the existing provisions of the Affordable Care Act would remain in place.

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

MSPs are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and UPL payments. Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating these patients. The total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law. Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars.

The Affordable Care Act called for significant reductions in Medicaid DSH funding to account for decreases in uncompensated care anticipated under the health insurance coverage expansion. Subsequent changes in the law have delayed the implementation of these reductions, but they are scheduled to take effect in FFY 2020. Reductions in Medicaid DSH payments may take place without increases in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

UPL programs have expanded in recent years and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs. In addition, on November 18, 2019, CMS released a proposed rule that is intended to increase federal oversight of MSPs and state Medicaid financing policies. Among other things, the proposed rule would add new review and reporting requirements on UPL payment arrangements, including the reporting of provider-level payment detail, impose limitations on UPL payments that are made to physicians and certain other practitioners, and impose certain limits on the use of healthcare provider taxes, intergovernmental transfers and certified public expenditures. We cannot predict whether the proposed rule will be adopted and, if adopted, the impact that the proposed rule would have on the MSPs that are currently received by the Company's facilities. In addition, even if the proposed rule is not adopted, we also cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease.

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

All participants in the healthcare industry are required to comply with numerous overlapping laws and regulations at the federal, state and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to relationships with providers and other referral sources, the adequacy and quality of medical care, inpatient admission criteria, privacy and security of health information, standards for equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, compliance with building codes and environmental protection, among other matters. Many of the laws and regulations applicable to the healthcare industry are complex and may be violated inadvertently, and there are numerous enforcement authorities, including CMS, the OIG, the DOJ, state attorneys general, and contracted auditors, as well as private plaintiffs.

There are also heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. Recent enforcement actions have focused on, among other things, financial arrangements between hospitals and providers, billing for services without adequately documenting the medical necessity for such services and billing for services outside the coverage guidelines for such services. Hospitals continue to be one of the primary focal areas of the OIG and other governmental fraud and abuse programs, as described in the OIG Work Plan. Dealing with investigations can be time and resource consuming and can divert management's attention from the business. Any such investigation or settlement could increase our costs or otherwise have an adverse effect on our business. In addition, because of the potential for large monetary exposure under the False Claims Act, which provides for treble damages and substantial civil monetary penalties for each separate false claim or statement, healthcare providers often resolve allegations without admissions of liability for significant and material amounts to avoid the uncertainty of damages and penalties that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree, settlement agreement or corporate integrity agreement. These additional requirements can result in significant additional and ongoing expenditures. Given the significant size of actual and potential settlements, it is expected that the government will continue to devote substantial resources to investigating healthcare providers' compliance with the healthcare payment rules and fraud and abuse laws. Certain of our facilities have received inquiries and subpoenas from various governmental agencies regarding these matters, and we are also subject to various claims and lawsuits relating to these and other matters.

The laws and regulations with which we must comply continually change. In the future, different interpretations or enforcement of these laws and regulations could subject our business practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws and regulations, many of these laws and regulations are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable laws and regulations. If we fail to comply with applicable laws and regulations, we could suffer substantial civil or criminal penalties, including the loss of our licenses to operate our facilities or loss of our ability to participate in the Medicare, Medicaid and other governmental programs.

Additionally, we are subject to a variety of different federal, state and local employment and wage and hour laws. While we strive to comply with those laws, if we fail to do so, we may be subject to lawsuits by governmental authorities or private plaintiffs. In addition, the Internal Revenue Service ("***IRS***") and/or state taxing authorities may successfully challenge positions taken on our tax returns.

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

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

The False Claims Act prohibits healthcare facilities and providers, as well as other entities or individuals from, among other things, knowingly submitting false claims for payment to the federal government, or knowingly causing the submission of such claims. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are generally entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. We are required to provide information to our employees and certain contractors about state and federal false claims laws and whistleblower provisions and protections. Defendants found to be liable under the False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus substantial civil monetary penalties, that are subject to annual inflation adjustments, for each separate false claim.

There are many potential bases for liability under the False Claims Act, including reckless or intentional acts or omissions. The government has used the False Claims Act to prosecute Medicare and other government healthcare program violations such as coding errors, billing for services not provided, submitting false cost reports, and providing care that is not medically necessary or that is substandard in quality. The Affordable Care Act also (i) created potential False Claims Act liability for failing to report and repay identified overpayments within sixty (60) days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later, and (ii) provided that claims submitted in connection with patient referrals that result from violations of the Anti-kickback Statute constitute false claims for the purposes of the False Claims Act. Violations of the Stark law can result in False Claims Act liability, as well. In addition, a number of states have adopted their own false claims and whistleblower provisions whereby a private party may file a civil lawsuit in state court.

Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws, many of these laws are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable fraud and abuse laws.

The emergence and effects related to a pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations and financial condition.

If a pandemic, epidemic, outbreak of an infectious disease or other public health crisis were to occur in an area in which we operate, our operations and financial condition could be adversely affected. In reaction to such a crisis or the fear of exposure to infection, patients might cancel elective procedures or fail to seek needed care at our facilities, which could result in reduced patient volumes and operating revenues, potentially over an extended period of time. Furthermore, a pandemic, epidemic or outbreak might adversely affect our operations by causing a temporary shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. Additionally, such a crisis could diminish the public trust in health care facilities, especially hospitals that fail to accurately or timely diagnose, or are treating (or have treated) patients affected by infectious diseases, and negatively affect the reputation at our facilities.

Although we have disaster plans in place and operate pursuant to infectious disease protocols, the extent to which the potential emergence of a pandemic, epidemic or outbreak would impact our business and operations is difficult to predict and would depend on many factors beyond our control, including the speed of the contagion, the development and implementation of effective preventative measures and possible treatments, the scope of governmental and other restrictions on travel and other activities, and public reactions to these factors. For example, we own and operate facilities in areas impacted by the recent outbreak of respiratory illness caused by a novel coronavirus known as COVID-19. We are actively monitoring the situation, which evolves daily, and carefully following guidance from the Center for Disease Control and Prevention and the World Health Organization; however, we cannot predict with certainty the extent of any impact that COVID-19 may have on our operations or financial condition.

Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may limit our revenues and profitability.

The amounts we receive for services provided to patients are determined by a number of factors, including the payer mix of our patients and the reimbursement methodologies and rates utilized by our payers. In recent years, we have seen shifts of patients from commercial and private insurance to Medicare and Medicaid programs and from "traditional" fee-for-service Medicare and Medicaid programs to "managed" Medicare and Medicaid programs. Some presidential candidates and members of Congress have also recently proposed measures that would expand government-sponsored coverage, including "Medicare-for-all" or other single-payer proposals. Reimbursement rates generally are lower for (i) Medicare and Medicaid beneficiaries than they are for patients whose care is covered by commercial and private insurance and (ii) managed Medicare and Medicaid beneficiaries than they are for traditional Medicare and Medicaid beneficiaries. We also experience demographic pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs. Our revenues and results of operations may be adversely affected by these shifts.

In addition, our revenues from negotiated rates with HMOs, PPOs, insurance companies, employers and other private payers may decline based on renegotiations and the respective bargaining power of the parties. There is a general trend towards further consolidation among private payers, which may increase their bargaining power over fee structures. As a result, payers increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk related to paying for care provided. These changes include moving away from a percent of charge payment structure to a fixed payment for an episode of care, which typically reduces our payment rate and limits our ability to raise prices going forward. Furthermore, low cost plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices, restrict or exclude our facilities or impose significantly higher cost sharing obligations for care provided by our facilities if they are classified in a disfavored tier. In addition, other healthcare providers, including some with greater financial resources, greater geographic coverage or a wider range of services, may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care plans to contract with us.

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

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

We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations or it could diminish the anticipated value of the acquired facility.

We may be unable to timely and effectively integrate facilities that we acquire with our ongoing operations. Many of the facilities we have acquired had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced delays in improving the operating margins or effectively integrating the operations of our acquired facilities and we may experience such delays in implementing operating procedures and systems in newly or future acquired facilities. Integrating an acquired facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel. Additionally, we may experience delays in reimbursement from governmental and third-party payers as a result of the change of ownership of our acquired facilities.

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

Facilities we have acquired, including in connection with the LifePoint/RCCH Merger, or facilities we acquire in the future, may have unknown or contingent liabilities for historical activities or conditions, including liabilities for failure to comply with laws and regulations, retroactive payment adjustments or recoupments from payer audits, medical and general professional malpractice liabilities, unfunded pension liabilities, workers' compensation or other employee-related liabilities, previous tax or environmental liabilities, regulatory and compliance related liabilities, and unacceptable business or accounting practices. Although we endeavor to obtain contractual indemnification from sellers covering these matters in connection with some acquisitions, we have not obtained contractual indemnifications in connection with all of them, and any indemnification obtained from sellers may be insufficient to cover material claims or liabilities for past activities of acquired businesses and the sellers may have insufficient funds to satisfy any claims or liabilities for which we may otherwise be entitled to be reimbursed.

We typically retain and rely on existing local management teams at newly acquired facilities to implement changes to operating procedures and systems. Integrating local management teams can involve cultural and systems challenges that may demand a disproportionate share of our resources and senior management's attention, and we may experience turnover of providers and other key personnel. Our acquisitions have become, and may continue to become larger, and may occur in communities with competing facilities. As a result, the issues surrounding integration may become more complex, expensive and time-consuming and may have a greater impact on our financial performance when we experience delays or difficulties.

If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.

As of December 31, 2019, we had approximately $3,034.7 million of goodwill and other intangible assets and approximately $3,859.4 million of long-lived assets, net of accumulated depreciation. We expect to recover the carrying values of both our goodwill as well as our long-lived assets through our future cash flows. We evaluate the carrying value of our goodwill at least annually, based on our fair value, to determine whether it is impaired. We evaluate our long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows. If the carrying value of our goodwill or our long-lived assets is impaired, we may incur a material non-cash charge to earnings.

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

We will be subject to medical malpractice lawsuits and other legal actions arising out of the operations of our facilities and the activities of our employed or affiliated providers. As a matter of policy, we typically notify patients of any potential harms they may have suffered at our facilities, regardless of whether such notifications are required by law and notwithstanding our uncertainty as to the severity of such harms or whether they even took place. This may lead to class actions or other multi-plaintiff lawsuits or whistleblower reports. These actions may involve large claims and significant defense costs and, if we or our facilities are found liable, any judgments against us may be material. Furthermore, some states in which we operate do not impose caps on non-economic malpractice damages and, even in the states that have imposed caps on such damages, litigants may seek recoveries under alternative theories of liability that might not be subject to such caps. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement whether or not we believe we are liable. Amounts we pay to settle any of these matters also may be material.

Although we maintain professional and general liability insurance with unrelated commercial insurance carriers, each individual plaintiff's claim is generally subject to an SIR insurance program administered in-house by our risk department with assistance from our insurance brokers. Any successful claim against us that is within our SIR amounts could have an adverse effect on our results of operations or liquidity. Some of these claims could exceed the scope of the excess coverage in effect, or coverage of particular claims could be denied, and any amounts not covered by insurance could be material.

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

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

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare and Medicaid for payment for our services. These post-payment reviews may increase as a result of government cost-containment initiatives, including enhanced medical necessity reviews for patients admitted as inpatients to general acute care hospitals for certain procedures and audits of claims under the RAC programs to detect overpayments not identified through existing claims review mechanisms. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those claims most likely to contain overpayments, such as incorrectly coded services, short stays, incorrect payment amounts, non-covered services and duplicate payments. The claims review strategies used by the RACs generally include a review of high dollar claims, including inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals.

In addition, CMS and the states use UPICs to perform post-payment audits of claims and identify Medicare and Medicaid overpayments. Third party audits or investigations of Medicare or Medicaid claims could result in increases or decreases in operating revenues to be recognized in periods subsequent to when the related services were performed, which may have a material adverse effect on our results of operations.

Controls designed to reduce inpatient services may reduce our revenues.

Over the last several years, payers have instituted policies and procedures to reduce or limit the use of inpatient services. Controls imposed by Medicare, Medicaid, and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for payment are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by QIOs, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of the MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. QIOs may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider that is in substantial noncompliance with quality standards be excluded from participation in the Medicare program.

Utilization review is also a requirement of most non-governmental managed care organizations and other third-party payers. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Additionally, in some states in which we operate, commercial third-party payers and Medicaid managed care plans have instituted policies that retroactively limit or deny patient coverage for emergency department and certain other services provided at hospitals if the payers believe the services could have been provided in less expensive settings. For example, such payers are increasingly seeking to pay relatively low "triage fees" for patients seen in emergency departments when the payers retrospectively determine the patients' treatment did not qualify as an emergency service. Significant limits on the scope of services reimbursed or on the amounts paid for such services could have a material adverse effect on our revenues and results of operations.

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

We outsource selected business functions to third parties. We take steps to monitor and regulate the performance of independent third parties to whom we delegate selected functions, including revenue cycle management, patient access, billing, cash collections, payment compliance and support services, project implementation, supply chain management, payroll system services and parts of cybersecurity. Arrangements with third party service providers may make our operations vulnerable if vendors fail to satisfy their obligations to us as a result of their performance, changes in their own operations, financial condition, or other matters outside of our control. We may also face legal, financial or reputational harm for the actions or omissions of such providers, including for violations of HIPAA and other privacy and security laws applicable to healthcare providers, and we may not have effective recourse against the providers for those harms. The expanding role of third party providers may also require changes to our existing operations and the adoption of new procedures and processes for retaining and managing these providers, as well as redistributing responsibilities as needed. Effective management, development and implementation of our outsourcing strategies are important to our business and strategy. If there are delays or difficulties in enhancing business processes or our third party providers do not perform as anticipated, we may not fully realize on a timely basis the anticipated economic and other benefits of the outsourcing projects or other relationships we enter into with key vendors, which could result in substantial costs, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us. Terminating, transitioning or renegotiating arrangements with key vendors or failure to renegotiate on favorable terms could result in additional costs and a risk of operational delays, potential errors and possible control issues as a result of the termination or during the transition or renegotiation phase.

We conduct a significant portion of our operations through joint ventures. We cannot provide assurances that relationships with our joint venture partners will remain strong, which could negatively affect our joint ventures, affiliations and other strategic alliances as well as our overall business.

We have completed a number of joint ventures, affiliations and other strategic alliances as part of our business strategy. We expect to enter into similar transactions in the future, including joint ventures where we may have a minority or non-controlling interest. Any changes in our relationships with our joint venture partners could disrupt ongoing business, negatively affect cash flow and distract management and other key personnel.

In the event of a material disagreement with any of our joint venture partners or the breach of any of our joint venture agreements, a joint venture may be subject to dissolution, unwinding or purchase of either party's interest, which could have a material adverse effect on our revenues and results of operations or result in reputational harm.

As a general matter, our joint venture partners may have investment and operational goals that are not consistent with our company-wide objectives, including the timing, terms and strategies for future growth and development opportunities, and we could reach an impasse on certain decisions, which may hinder our ability to pursue preferred strategies for growth and development, could require significant resources and attention from management and key employees to resolve and could have an adverse effect on our operations, cash flow and revenue growth. In addition, our joint venture relationships with not-for-profit partners and the agreements that govern these relationships are structured based on current provisions of the Internal Revenue Code of 1986, as amended (the "***Code***") (and the Treasury Regulations thereunder), published rulings by the IRS, as well as case law relevant to joint ventures between for-profit and not-for-profit entities. Material changes in these legal authorities could adversely affect our relationships with not-for-profit partners and related joint venture arrangements.

Furthermore, joint ventures in which we have a minority equity interest and minority investments inherently involve a lesser degree of control over business operations, thereby potentially increasing the financial, legal, operational and compliance risks associated with the joint venture or minority investment. We may be dependent on joint venture partners or management who may have business interests, strategies or goals that are inconsistent with ours. Business decisions or other acts or omissions of the joint venture partner or management may adversely affect the value of our investment, result in litigation or regulatory action against us, result in reputational harm to us or adversely affect the value of our investment or partnership. To the extent another party makes decisions that negatively impact the joint venture or internal control issues arise within the joint venture, we may have to take responsive or other actions or we may be subject to penalties, fines or other related actions for these activities.

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

We employ a large number of physicians. Physician employment by health systems and acute care facilities, where permissible, is a trend in the industry and has become more common as a result of actual and potential reductions in payment amounts for physician services and increasing costs to physicians, such as EHR implementation and professional liability insurance expenses. Employed physicians generally present more direct risks to us than those presented by independent members of our hospitals' medical staffs, such as risks of unsuccessful physician integration, challenges associated with physician practice management and compliance risks arising from the increased billing and coding activities associated with the employment of physicians, the possibility of legal claims under federal and state employment law, and governmental scrutiny of physician employment arrangements. Employed physicians also require us to incur additional expenses, such as increased salary and benefit costs, medical malpractice expense and rent expense. Payments received by us for services provided by our employed physicians, the physicians to whom our facilities have provided recruitment assistance, and the physician members of our medical staffs could be adversely affected as physician payment methodologies move toward pay-for-performance as hospital payment models are doing. The combination of payment cuts, potential liabilities and increased expenses could have an adverse effect on our results of operations.

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

The primary collection risks associated with our accounts receivable relate to uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (exclusions, deductibles and co-payments) remain outstanding. The provision for doubtful accounts relates primarily to amounts due directly from patients. The amount of our provision for doubtful accounts is based on management's assessment of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage, the rate of growth in uninsured patient admissions and other collection indicators. While we have experienced a reduction in uninsured patients as a result of the Affordable Care Act, the risk of collection from insured patients, and the amounts due, have increased, and will likely continue to increase, as more individuals are enrolled in insurance plans with larger deductibles and/or co-payments, including those purchased on insurance exchanges.

If we experience growth in self-pay volume and revenue, including increased acuity levels for uninsured patients and increases in co-payments and deductibles for insured patients, our revenues and results of operations could be adversely affected. Although we have experienced a reduction in uninsured patients since 2014 as a result of the Affordable Care Act and the expansion of state Medicaid programs, we are unable to predict whether that trend will continue in light of the repeal of the penalties associated with the individual mandate, the cessation of the cost sharing reduction payments to insurers, and the decision by some states not to expand their Medicaid programs. In addition, the risk of collection from insured patients (and the amounts due) has increased, and will likely continue to increase, as a result of more individuals being enrolled in insurance plans with high deductibles and high co-payments. Furthermore, our ability to improve co-insurance collections and collections from self-pay patients may be limited by legislative developments, such as federal and state legislation designed to reduce "surprise billing," or by other regulatory or investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

An increase in the proportion of our accounts receivable being comprised of uninsured accounts and a deterioration in the collectability of these both insured and uninsured accounts could adversely affect our results of operations and revenues. Even if the Affordable Care Act remains implemented in its current form, we may continue to experience bad debts and be required to provide uninsured discounts and charity care for patients who choose not to purchase coverage, are undocumented immigrants who are not permitted to enroll in the Exchanges or government healthcare programs or live in states that do not expand or maintain the expansion of their Medicaid programs.

We are subject to potential legal and reputational risk as a result of our access to personal information of our patients and employees.

HIPAA and numerous other federal and state laws and regulations govern the collection, dissemination, use, privacy, security, confidentiality, integrity, and availability of personally identifiable information ("***PII***") and PHI. HIPAA imposes privacy and security requirements on healthcare providers who are covered entities such as us, including to implement reasonable and appropriate administrative, physical and technical safeguards to protect PHI, including PHI maintained, used and disclosed in electronic form, and data breach notification requirements for certain unauthorized access, acquisition, use or theft of PHI. The safeguards include employee training, identifying "business associates" with whom we need to enter into HIPAA-compliant contractual arrangements, and various other measures. We are required to develop and adopt a comprehensive set of policies and procedures to comply with HIPAA and other privacy and information security laws. Ongoing implementation and oversight of these measures involves significant time, effort and expense. In the ordinary course of our business, we, and vendors acting on our behalf, collect, transmit, share and store sensitive data, including PHI and PII of our patients and employees. Such information is at risk of accidental or intentional misuse or disclosure, and is often targeted by criminal organizations. The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. If, in spite of our security and compliance efforts we or any of our business associates were to experience a breach, loss, or other compromise of PHI or PII, such event could disrupt our operations, result in increased data protection costs, damage our reputation, or result in regulatory penalties, legal claims and civil or criminal liability under HIPAA and other state and federal laws, which could have a material adverse effect on our results of operations.

HHS requires covered entities to report breaches of unsecured PHI to affected individuals without unreasonable delay and in no case later than 60 days after the discovery of the breach by the covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HIPAA creates a presumption that all non-permitted uses or disclosures of unsecured PHI are breaches unless the covered entity establishes that there is a low probability the information has been compromised. HHS has imposed substantial mandatory civil and criminal penalties for violations of HIPAA's requirements, with potential civil penalties exceeding $1.7 million in a calendar year for multiple violations of the same requirement in a single year. Moreover, because a single breach incident can result in multiple violations of multiple requirements, potential penalties can range much higher. We are also subject to state breach notification laws which may differ from HIPAA. In addition, state attorneys general and private plaintiffs have brought civil actions seeking injunctions and damages in response to violations of state or federal privacy laws or HIPAA's privacy, security and breach notification rules, as applicable. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA's requirements, its standards have been used as a basis for the duty of care in state civil suits, such as those for negligence or recklessness in the handling of PHI. In addition, HIPAA mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities such as us, and has reserved the right to initiate enforcement actions where it discovers noncompliance.

In addition, many states in which we operate may impose laws that are more protective of the privacy and security of PII than HIPAA. Where these state laws are more protective of individual privacy than HIPAA, we have to comply with their stricter provisions. Not only may some of these state laws impose fines and penalties upon violators, but some may also afford private rights of action to individuals who believe their PII has been misused. Both state and federal laws are subject to modification or enhancement of privacy protection at any time. Our facilities will continue to remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These statutes vary and could impose additional requirements on us and more severe penalties for disclosures of confidential health information. New health information standards could have a significant effect on the manner in which we do business, and the cost of complying with new standards could be significant. We may not remain in compliance with the diverse privacy requirements in all of the jurisdictions in which we do business. If we fail to comply with HIPAA or similar state laws, we could incur substantial civil monetary or criminal penalties.

A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

We rely extensively on our information systems and certain systems operated by us and third-parties to manage clinical, financial and employee data, communicate with our patients, payers, vendors and other third parties and summarize and analyze operating results. These systems are at risk from cybersecurity attacks and other intrusions, including attempts to gain unauthorized access to and theft of our confidential data, misuse, corruption or destruction of confidential data and damage, disruptions or shutdowns of these systems due to viruses, malware, ransomware, employee error or malfeasance, and other electronic security breaches. Our systems, which transmit and store sensitive and confidential data, including PHI and other PII of our patients, employees and others, and our proprietary and confidential business performance and other data, will continue to be a target for attempts to gain unauthorized access and data theft due to the valuable nature of the information they contain, as well as at risk for accidental exposure. In addition, certain third-party medical devices and equipment are used at our facilities, and may be vulnerable to cybersecurity attacks or other breaches which could negatively impact our systems or our patients.

Cybersecurity breaches and other unauthorized access to our data can sometimes be difficult to discern, and any delays in detection may lead to increased harm. Such attacks or breaches are common in the healthcare sector and could result in the compromise of health information or other data subject to protection by HIPAA and other laws and regulations, or disrupt our IT systems or business. While we are not aware of having experienced a material cybersecurity breach, there can be no assurance that we will not be subject to material cyber-attacks or security breaches in the future, or that the preventive actions we take to reduce the risk of such incidents and protect our IT and data will be sufficient. We continue to prioritize cybersecurity and the development of practices and controls to protect our systems. However, regardless of the nature, extent and timing of our actions, these measures may not prevent security breaches. If our services are subject to cyber-attacks that impair or deny the ability of patients to access our services, current and potential patients may become unwilling to provide us the information necessary for them to become users of our services or may curtail or stop using our services. As cyber-threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures and to investigate and remediate any information security vulnerabilities. As we are subjected to cyber-attacks and possible security breaches in the future, this could have an adverse impact on our business, reputation, financial condition and results of operations. See "—We are subject to potential legal and reputational risk as a result of our access to personal information of our patients and employees" for more information.

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

We require substantial capital resources to fund our growth strategy and ongoing capital expenditure programs, including capital expenditure programs for renovation, expansion and construction at our facilities and the addition of equipment and technology at our facilities. We often commit to significant capital expenditures well in advance of the time these expenditures will be made. Our cash flows and available capital resources may be insufficient to fund our capital expenditure programs and commitments, and we may be forced to reduce or delay planned and required capital expenditures. Additionally, we may experience delays or impediments in satisfying the schedule for capital expenditure commitments because of a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions. The failure to satisfy our capital expenditure commitment obligations could also damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities, lessors or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions.

At December 31, 2019, we estimated our total remaining capital expenditure commitments to be approximately $1,523.1 million, which generally have remaining terms of one to six years. Of this amount, more than one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time. The failure to satisfy our capital expenditure commitment obligations could damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities, lessors or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions. As a result, if our cash flows and available capital resources are not sufficient to fund all of our anticipated capital expenditures, it may be necessary for us to give priority to contractual capital expenditure commitment obligations over other elective capital expenditure programs.

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

Competition among hospitals and other healthcare service providers, including outpatient facilities, has intensified in recent years. We also have acquired, and may continue to acquire, larger facilities in more concentrated population centers, which experience greater competition for healthcare services. We compete with other facilities, including larger tertiary and quaternary care centers located in metropolitan areas. Although the facilities with which we compete may be a significant distance away from our facilities, patients in our markets may migrate on their own to, may be referred by local providers to, or may be required by their health plan to travel to these facilities. Furthermore, some of the facilities with which we compete may offer more or different services than those available at our facilities, may have more advanced equipment or technology or may have a medical staff that is perceived to be better qualified. We also compete with facilities and health systems that are implementing physician and other provider alignment strategies, such as employing providers, acquiring physician practice groups and participating in ACOs or other clinical integration models, which may impact our competitive position. Also, many of the facilities that compete with our facilities are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions and are eligible to participate in the 340B Program. These facilities, in most instances, are also exempt from paying sales, property and income taxes and have the ability to issue tax-exempt bonds for financing.

Quality of care and value-based purchasing have also become significant trends and competitive factors in the healthcare industry. CMS makes public the performance data relating to multiple quality measures that facilities submit in connection with their Medicare payment. CMS also requires every Medicare participating hospital to establish and update annually a public online listing of the hospital's standard charges for items and services and recently issued new regulations that would significantly increase hospital charge reporting requirements. If the publicly-available performance and charge data become a primary factor in where patients choose to receive care, and if competing facilities have lower charges or better results than our facilities on those measures, our revenues and/or patient volumes could decline.

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

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

There is a trend in the healthcare industry toward value-based purchasing of healthcare services and bundled payment arrangements. Value-based purchasing programs include both public reporting of quality data and payment limitations tied to the incidence of preventable adverse events or the quality and efficiency of care provided by facilities. For example, Medicare, Medicaid and many large commercial payers may require facilities to report certain quality data to receive full payment updates or avoid payment reductions. They may also impose payment reductions in connection with HACs and excessive readmissions for certain conditions designated by HHS. Our revenue may be negatively impacted by the application of one or more of these measures. Bundled payment arrangements generally set target payment amounts for all healthcare services provided to patients during particular episodes of care. They are intended to create incentives for physicians, hospitals and other providers to work together to provide higher quality and more coordinated care at a lower cost. We currently participate in a few ACOs as well as a number of bundled payment programs, and we expect value-based purchasing programs, including programs that condition payment on patient outcome measures, to become more common and to involve a higher percentage of payment amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively affect our revenues.

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

The success of our business operations depends on the number and quality of the physicians and other healthcare providers who perform services at our facilities. Our ability to recruit and retain quality providers in turn depends on several factors, including the actual and perceived quality of services furnished by our facilities, our ability to meet demands for new technology, our ability to identify and communicate with providers who want to practice in our communities and our ability to provide competitive financial compensation packages. Our ability to attract and retain providers is increasingly dependent on the ability of our facilities to offer and sustain employment arrangements. In particular, we face intense competition in the recruitment and retention of specialists and primary care providers. We may not be able to recruit all of the providers we target. In addition, we may incur increased malpractice, compliance or insurance expense depending on the quality of providers' clinical outcomes.

Additionally, our ability to recruit and employ providers is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the Stark law, the Anti-kickback Statute, state anti-kickback and self-referral statutes, and related regulations. The Stark law requires, among other things, that recruitment assistance can only be provided to physicians who meet certain geographic and practice requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit physicians currently in practice in the community beyond recruitment costs actually incurred by them. All arrangements with physicians must also be fair market value and commercially reasonable.

In addition to these legal requirements, there is competition from other communities and facilities for these providers, and this competition continues after the provider is practicing in one of our communities. For example, integrated ACOs and other kinds of "narrow" provider networks or organizations may exclude our providers from their plans' networks of healthcare providers. These contracting networks often organize hospitals, providers and ancillary healthcare providers into exclusive networks involving fewer healthcare providers. If our affiliated providers are excluded from such networks, we may have difficulty recruiting new providers or retaining existing providers.

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

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

We may have difficulty acquiring or divesting facilities on favorable terms. Furthermore, our business could be negatively affected if acquisitions or divestitures are not successfully completed or if contingent liabilities materialize in connection with such transactions.

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

The cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired facility's results of operations, allocation of purchase price, effects of subsequent legislation and limitations on rate increases. As part of our acquisition strategy, we may commit to making significant capital improvements at acquired facilities. Such improvements may be difficult to achieve in the anticipated timeframe, if at all, due to a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions.

Our ability to engage in certain acquisitions in several states may be limited due to exclusivity, non-competition and non-solicitation provisions that we have agreed to in connection with our joint ventures and previous acquisitions and divestiture transactions. Additionally, certain acquisitions may require the consent of and collaboration with our joint venture partners based upon the applicable governing documents. If we cannot obtain the cooperation of our joint venture partners in certain instances, we may not be able to pursue these opportunities.

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

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

We regularly evaluate the potential disposition of assets and facilities that may no longer help us attain our objectives. When we decide to sell assets or facilities, we may encounter difficulties in finding buyers or alternative exit strategies on acceptable terms or in a timely manner, which could delay the achievement of our strategic objectives. Additionally, the terms of our master leases entered into pursuant to sale leaseback transactions may make it more difficult to dispose of certain facilities. We may also dispose of assets or a facility at a price, or on terms, less desirable than we anticipated. In addition, we may experience greater dis-synergies than expected. After reaching an agreement with a buyer for the disposition of assets or a facility, we will be subject to satisfaction of pre-closing conditions as well as to necessary regulatory and governmental approvals on acceptable terms, which, if not satisfied or obtained, may prevent us from completing the transaction. Dispositions may also involve continued financial involvement in the divested facilities, such as through continuing equity ownership, guarantees, indemnities, transition service agreements or other financial and commercial obligations, and inability to avoid retention of certain regulatory and compliance risks. There can be no assurance that the anticipated benefits of our future divestiture strategies will be realized. Furthermore, we may be exposed to contingent liabilities in connection with completed divestitures. Finally, certain acquisition agreements and joint venture arrangements contain covenants that restrict our ability to dispose of certain facilities without first seeking consent of a joint venture partner or other third parties, which may affect our ability to take advantage of business opportunities that may be in our interest. If we do not realize the anticipated benefits of such divestitures, if contingent liabilities related to such divestitures materialize or if we are unable to divest certain properties on favorable terms or at all, this could have a material adverse effect on our results of operations.

Many of the non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies intended to generate organic growth and improve operating results at our facilities.

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

- defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for facilities; or
- purchase a high-deductible insurance plan or no insurance at all, which increases a facility's dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms.

Additionally, non-urban communities are experiencing a much slower rate of growth, if any, as compared to more concentrated population centers. As a result, we may experience payer mix pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs.

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

If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results could be negatively impacted.

We have initiated a multi-year business initiative to standardize certain processes, policies and systems throughout our facilities, including migrating our multiple IT platforms to a smaller number of enterprise-wide systems solutions. If we do not allocate and effectively manage the resources necessary to build and sustain the proper IT infrastructure and implement standardized systems, or if we fail to achieve the expected benefits from this initiative, it may impact our ability to operate profitably and efficiently, and comply in a timely manner with changing regulatory requirements and with the requests of patients, payers and business partners. The failure to transition to these systems on time, or anticipate necessary readiness and training needs, could lead to business disruption and loss of revenue. In addition, the operating results of newly acquired facilities could be impacted if such facilities are not integrated on a timely basis into our new systems. The actions we take to resolve compliance or regulatory issues within acquired facilities may affect our revenue or results of operations.

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

If access to our information systems or those provided by our third party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

Our business depends heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and to develop new systems in order to keep pace with continuing changes in information processing technology. In addition to our own systems, we rely on multiple third party providers of financial, clinical, supply chain, patient accounting and network information services and, as a result, we face operational challenges in maintaining multiple provider platforms and facilitating the interface of such systems with one another. The third party providers may not have appropriate controls to protect confidential information. We do not control the information systems of third party providers, and in some cases we may have difficulty accessing information archived on third party systems, which could subject us to liability for failure to respond to legal, regulatory or payer obligations or information requests. Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, flood, hurricane, telecommunications failure, terrorist attack or other catastrophic event. If these systems fail or are interrupted, if our access to these systems is limited in the future or if providers develop systems more appropriate for more urban healthcare markets and not suited for our facilities, our operations could suffer.

We intend to expand our operations, including by acquiring more facilities, which will require us to integrate and transition certain existing information systems. In addition, as new information systems are developed in the future, we will need to integrate them into our existing systems. Evolving industry and regulatory standards, such as the HITECH Act, HIPAA and EHR meaningful use regulations, also may require changes to our information systems in the future. System conversions are costly, time consuming and disruptive for providers, staff and, in some cases, patients. If such conversions occurred on a large scale or if we are unable to properly integrate other information systems or expand or update our current information systems, the costs and disruptions could have a material adverse effect on our revenues or results of operations.

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

In addition to depending on our physicians and other providers, the operations of our facilities are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians. We compete with other healthcare facilities in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our facilities, including physician assistants, nurses and other non-physician healthcare professionals. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue and the competition for experienced and talented hospital management personnel is intense. This may result in employee turnover, require us to enhance wages and benefits to recruit and retain management, nurses and other medical support personnel, recruit personnel from foreign countries (which may be limited by changes in immigration law, regulation and policy), and hire more expensive temporary or contract personnel. In addition, the states in which we operate could adopt mandatory nurse staffing ratios or could increase mandatory nurse-to-patient staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. Some of the employees at some of our facilities are represented by a union, and others may be in the future, which can also increase the cost of labor. If our labor costs increase, we may not be able to raise rates to offset these increased costs. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs could have a material adverse effect on our revenues or results of operations.

Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and subject to the terms of collective bargaining agreements.

Increased or ongoing labor union activity is another factor that could adversely affect our labor costs or otherwise adversely impact us. Several of our facilities have unionized employees. When a new collective bargaining agreement with a union must be negotiated, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur, and our operations could be disrupted or our labor costs increased as a result of these disruptions. Our labor costs also could increase significantly if a substantial number of other employees at our facilities unionize.

If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained.

The terms of the collective bargaining agreements also set forth certain requirements related to the respective facility's employment practices, seniority, hours of work, overtime, holidays, use and redemption of paid time off, extended illness bank, vacation scheduling, compensation, pay practice, health and non-health benefits, leaves of absence, grievance procedures, disability accommodations and the facility's drug and alcohol policies. If these facilities fail to fulfill any of these requirements, it could result in discussions with union representatives or the filing of a grievance that could be costly and time-consuming for those facilities. Furthermore, the terms of the collective bargaining agreements constrain our flexibility with respect to these and other employee issues. The inability to negotiate future collective bargaining agreements on favorable terms with these employees or with other unionized employees could have a material adverse effect on our business, results of operations and financial condition.

If we fail to implement and maintain certified electronic health record and coding systems in an effective and timely manner, our operations could be adversely affected.

The Medicare and Medicaid Promoting Interoperability Programs (formerly known as the Medicare and Medicaid EHR Incentive Programs for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals, and formerly referred to as "***Meaningful Use***") was established in 2011 to encourage eligible professionals, eligible hospitals, and critical access hospitals to adopt, implement, upgrade and demonstrate meaningful use of certified health information technology ("***Certified HIT***") for the purposes of advancing care coordination and improving the quality of care. In 2018, CMS merged the Meaningful Use program into the programs that are being created under MACRA, included this technology requirement as one of the four components of MIPS, and changed the name of the Meaningful Use program to the Promoting Interoperability Program. Each year, HHS and CMS revise standards required for use of Certified HIT, and they periodically revise standards required for a technology's designation as a Certified HIT. In order to meet the requirements for the Promoting Interoperability Program, we must implement, maintain and use technology that meets the Certified HIT standards. In addition, use of specific Certified HIT is required for reporting under other CMS payment programs, such as ACOs and bundled payment programs. Certain of our EHR's will require software upgrades in the future in order to continue being categorized as Certified HIT as designated by HHS. Failure to effectively comply with the new requirements of the Promoting Interoperability Program, implement EHR systems or maintain current requirements for EHR systems effectively and in a timely manner could have a material adverse effect on our revenue generated from Medicare Part B claims and other CMS QPPs in which we participate.

Under Meaningful Use, we received certain incentive payments related to our efforts to implement our EHR. Incentive payments we have received in prior years for EHR implementation were materially reduced over the program's life to immaterial amounts in 2018 and 2019. EHR incentive payments that we have previously recognized are subject to audit by CMS and potential recoupment if it is determined that we did not meet the applicable Meaningful Use standards required in connection with such incentive payments. To the extent a CMS audit determines that we did not meet the reporting requirements for Meaningful Use, the Company would be subject to the potential recoupment of the incentive and other payments previously received in connection with the Meaningful Use program. In addition, reporting under MIPS results in either a negative or positive per claim payment adjustment by CMS and potential bonus payments, as well. To the extent a CMS audit determines that we did not meet the reporting requirements of the Promoting Interoperability Program, the Company would be subject to potential recoupment of any positive adjustments or bonus payments that were previously made. Finally, certain CMS payment programs and alternative payment models, such as ACOs or bundled payment programs, in which the Company participates may require implementation and use of a specific Certified HIT. Failure to use the required Certified HIT may negatively impact the Company's participation payments, and the Company could be subject to recoupment of participation payments if CMS determines that the Company's Certified HIT did not meet the applicable requirements. A determination by CMS that the Company has made a false attestation regarding its Meaningful Use or Promoting Interoperability Program participation could also potentially be grounds for liability under the False Claims Act or other applicable federal fraud and abuse laws.

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

Some states require prior approval for the purchase, construction and expansion of healthcare facilities, based on the state's determination of need for additional or expanded healthcare facilities or services. Certain states in which we operate facilities require a certificate of need for the purchase, construction or expansion of hospital facilities, capital expenditures exceeding a prescribed amount, changes in bed capacity or services, or for other hospital-related activities. We may not be able to obtain certificates of need required for expansion activities or to effectively compete with competing healthcare providers in the future. In addition, all of the states in which we operate facilities require hospitals, other healthcare facilities, and most healthcare providers to maintain one or more licenses. If we fail to obtain any required certificate of need or license, our ability to operate or expand operations in those states could be impaired.

In the states in which we operate that do not require certificates of need for the purchase, construction and expansion of hospital facilities, competing healthcare facilities face lower regulatory barriers to entry and expansion. If competing healthcare entities are able to purchase, construct or expand healthcare facilities without the need for regulatory approval, we may face decreased market share and revenues in those markets.

The implementation of participation and quality measurement requirements under the MACRA's Merit-Based Incentive Payment System may affect our revenues.

Under MACRA, CMS updates payment rates for physician and practitioner services on an annual basis, and implements the QPP that rewards value and outcomes through participation in MIPS or an APM program. Beginning in 2017, MIPS started measuring provider performance under four categories: quality, improvement activities, promoting interoperability and cost, and annually establishes a point threshold for each category and overall performance. In 2019, MIPS began rewarding or penalizing providers based on performance reported in CY 2017 and subsequent years. The MIPS adjustment has a more significant impact on payment for physician and practitioner services than the annual inflationary update to the Medicare PFS.

Physicians are required to participate in MIPS unless they are participants of an APM, are newly enrolled in Medicare, or see a low volume of Medicare patients (i.e., no more than 200 patients in a calendar year, 200 covered professional services, or $90,000 in charges for professional services). MIPS eligible clinicians were subject to a payment adjustment of plus or minus 4% in CY 2019 (based on CY 2017 performance) and are subject to a payment adjustment of plus or minus 5% in CY 2020 (based on CY 2018 performance) with the payment adjustment increasing each year until it reaches plus or minus 9% in CY 2022 and beyond. In addition, MIPS eligible clinicians with exceptional performance may receive up to 10% bonus payment from $500 million that has been specifically allocated for this purpose. For CY 2020, which is based on CY 2018 reporting, CMS projects that 98% of participating MIPS eligible clinicians will receive a positive adjustment of 0% to 2%. It also projects that an additional positive adjustment of 1.86% for exceptional performance will be awarded to 84% of eligible clinicians. The remaining clinicians will likely receive a negative adjustment of up to 5%. MACRA requires MIPS to be operated in a budget neutral manner, and the current low performance thresholds have resulted in a large number of clinicians being eligible for a modest positive payment adjustment. However, CMS has indicated that performance thresholds will be increased over time, which will likely result in a smaller number of clinicians receiving larger positive payment adjustments and more clinicians receiving neutral or negative payment adjustments in the future. Providers participating in an APM may be eligible for more advantageous adjustments under MIPS (or avoid any negative adjustment) and receive a 5% bonus. At this time, we have limited participation in APMs.

If an eligible clinician has not been satisfactorily participating in MIPS (and is not qualified to participate in an APM), his or her claims for Medicare Part B services are likely to be subject to negative payment adjustments in CY 2020 (which is based on CY 2018 performance), CY 2021 (which will be based on CY 2019 performance) and CY 2022 (which will be based on CY 2020 performance). For participating eligible clinicians that meet or exceed the MIPS threshold or APM requirements, claims for payment are likely to be subject to positive adjustments as well as a share of an additional pool of bonus payments. At this time, and as CMS continues to modify MIPS payment policies, it is unclear how MIPS will impact our overall physician payments under the Medicare program. If we have not timely and effectively implemented policies and procedures, quality programs and appropriate clinician contracting to ensure compliance with MACRA and other QPP requirements, we would experience a negative effect on future revenues related to Medicare Part B claims.

MACRA requires that CMS publish each eligible clinician's MIPS score and performance category scores on its Physician Compare website. Publishing of MIPS scores could have an adverse reputational effect on us if our employed physicians have low scores or scores that are lower than those of the other clinicians in the relevant communities.

If current or future laws or regulations force us or cause us to restructure our arrangements with physicians and other providers, we may incur additional costs, lose contracts and suffer a reduction in net revenue under existing contracts, and we may need to refinance our debt or obtain consent from our lenders.

A number of laws bear on our relationships with our physicians and other providers. There is a risk that state authorities in some jurisdictions may find that our contractual relationships with our physicians violate laws prohibiting the corporate practice of medicine and fee-splitting. These laws generally prohibit the practice of medicine by lay entities or persons and are intended to prevent unlicensed persons or entities from interfering with or inappropriately influencing the physician's professional judgment. They may also prevent the sharing of professional services income with non-professional or business interests. In states that have enacted corporate practice of medicine and fee-splitting prohibitions, we believe that we have structured our physician contracts in an effort to remain compliant with such laws. A regulatory agency, however, could still make a determination that our arrangements constitute a corporate practice of medicine or fee splitting violation. A review or action by regulatory authorities or the courts could force us to terminate or modify our contractual relationships with physicians and affiliated medical groups or revise them in a manner that could be materially adverse to our business.

In addition, we have also entered into a number of joint venture arrangements with physicians and other providers (e.g., hospitals and hospital operators) that are subject to state and federal fraud and abuse laws, including the Anti-kickback Statute and False Claims Act. See "We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may reduce our revenues and profitability." To the extent applicable, regulatory agencies may view these transactions as prohibited arrangements that must be restructured, or discontinued, or for which we could be subject to other significant penalties, including debarment, suspension or exclusion from state and federal government healthcare programs. Although compliance programs can mitigate the risk of investigation and prosecution for violations of these laws, the risks cannot be entirely eliminated. Any action against us for violation of these laws, even if we successfully defend against it, could cause us to incur significant legal expenses and loss of revenue from those joint ventures and divert our management's attention from the operation of our business.

We are dependent on our executive management team and the loss of the services of one or more of our executive management team could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our executive management team. In addition, we depend on the ability of our executive officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our executive management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our executive management team, we could experience a significant disruption in our operations and failure of the affected facilities to adhere to their respective business plans.

Difficulties with major expansion projects may involve delays and significant capital expenditures that could have an adverse impact on our operations and liquidity.

We may decide to construct major expansion projects to existing facilities or new facilities, including replacement facilities, in order to achieve our growth objectives. Our ability to complete new expansion projects on budget and on schedule would depend on a number of factors, including, but not limited to:

- our ability to control construction costs;
- adverse weather conditions;
- shortages of labor or materials;
- our ability to obtain necessary licensing and other required governmental authorizations; and
- other unforeseen problems and delays.

As a result of these and other factors, we cannot assure you that if we decide to pursue major expansion projects we will not experience greater construction or other expansion or replacement costs than originally planned in connection with such expansion or replacement projects. Additionally, we cannot assure you that such expansion or replacement projects will be completed in a timely manner. Any delays or other difficulties in our ability to complete new expansion or replacement projects on budget and on schedule could have a material adverse effect on our results of operations and liquidity.

Under the A&R Capella Master Lease and the 2019 Master Lease that each separately governs certain of our facilities, a default with respect to one facility could cause a default under all of the facilities subject to the A&R Capella Master Lease or the 2019 Master Lease, as applicable, which would have a material adverse effect on our business, results of operations and financial condition.

If there is a default under that certain Amended and Restated Master Lease Agreement (including cross-defaulted separate affiliate leases for facilities operated by joint ventures, the "***A&R Capella Master Lease***") with MPT Camaro OpCo, LLC, a Delaware limited liability company and wholly-owned subsidiary of Medical Properties Trust, Inc. ("***MPT***"), dated as of March 21, 2016, or that certain Master Lease Agreement (the "***2019 Master Lease***") with certain subsidiaries of MPT, dated as of December 17, 2019 (together, the "***Master Leases***" and each a "***Master Lease***"), even if such default relates to one facility, it may terminate the applicable Master Lease in its entirety with respect to all of the facilities governed by such Master Lease.

Under each Master Lease, we are subject to financial covenants based on certain fixed charges, and the failure to meet such covenants results in an event of default. Other events that could trigger a default under the Master Lease if not cured within the time periods required by the Master Lease include, without limitation, (i) failure to pay rent or other amounts due under the lease, (ii) failure to comply with the non-financial covenants under the lease, (iii) the bankruptcy of any facility lessee under a Master Lease or the guarantor of the facility lessees under the applicable Master Lease, (iv) termination of any licenses necessary for operation of a facility or required for certification under Medicare or Medicaid, (v) a change of control (as defined in the applicable Master Lease) in violation of the Master Lease and (vi) a default under any material documents between any lessee of the facilities and any lessor of any facility. Each Master Lease contains cross-default provisions so that certain defaults with respect to one of the facilities subject to such Master Lease may cause a default under the entire Master Lease. Accordingly, a default under a Master Lease that results in a termination of such Master Lease would cause us to lose the ability to operate all of the facilities subject to such Master Lease and to incur substantial costs in restoring the premises, which would have a material adverse effect on our business, results of operations and financial condition. The A&R Capella Master Lease and the 2019 Master Lease are not cross defaulted to one another.

If either Master Lease is terminated prior to its expiration because of a default and the applicable affiliate of MPT, as lessor, exercises its rights thereunder, in addition to losing the ability to operate our facilities, we may be liable for (i) damages and incur charges such as continued lease payments through the end of the lease term (or such shorter period as proscribed in the applicable Master Lease or by law) and (ii) maintenance costs for the leased property. Upon termination of either Master Lease, we are obligated to restore the applicable premises to its original condition and repair all damage caused by the installation or removal of our personal property, ordinary wear and tear excepted. We also have restoration obligations with respect to certain casualty and condemnation events. In addition, upon termination of a Master Lease, the lessor has the option to purchase all of our personal property at fair market value.

Because many of the facilities we operate are subject to long-term leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises.

The rights to use many of our facilities are based upon long-term leases, including the Master Leases. Pursuant to the terms of these leases, we are required to pay all rent due and comply with all other lessee obligations. As of December 31, 2019, the remaining term of these leases (including renewal options) ranged from approximately 6 months to 76 years. A pledge of our interest in some of these leases may also require the consent of the respective lessor and its lenders. As a result, we may not be able to sell, assign, transfer or convey our interest in certain facilities subject to such leases in the future absent consent of such third parties even if such transactions may be in our best interest. Most of the leases require that, upon the expiration or termination of the leases, we must surrender any improvements to the land to lessor. In addition, some of our leases include early termination provisions. We are typically responsible for all taxes, insurance, assessments and maintenance obligations under the leases. The leases also generally require the lessee to either reconstruct or restore the premises to its original condition following a casualty and to apply in a specified manner any proceeds received in connection therewith. In some leases the lessor has the option to purchase some or all of the assets owned by us and used in connection with the operation of the applicable facility. Accordingly, failure to comply with the terms of such leases, the invalidity of or default or termination under such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises, which could have a material adverse effect on our business, results of operations and financial condition.

If certain sale-leaseback transactions are not characterized as "operating leases" under GAAP, this could adversely affect our results of operations and our financial condition.

We have entered into sale-leaseback transactions in the past and may enter into similar sale-leaseback transactions for properties that we acquire in the future, including pursuant to that certain Strategic Agreement, dated as of March 21, 2016, with MPT Operating Partnership, L.P. ("***MPT Op***"), which grants MPT Op and its affiliates certain rights and options to provide future sale-leaseback funding or real estate loans for certain acquisitions of additional properties. Although we may intend, in some cases, for such leases to be accounted for as an "operating lease" pursuant to GAAP, depending on the terms of any specific transaction, our auditors might take the position that the leases should be accounted for as "financing obligations" under Accounting Standards Codification ("***ASC***") 840, "Leases" ("***ASC 840***"). In that event, this may materially affect assets and liabilities in our balance sheet and certain expenses in our income statement, which could have a material adverse effect on our results of operations and our financial condition.

Our debt agreements contain restrictions that will limit our flexibility in operating our business.

The ABL Agreement, the Term Loan Agreement and the Indentures contain, and any other existing or future indebtedness of ours would likely contain, a number of covenants that impose significant operating and financial restrictions on us, including restrictions on our and our subsidiaries ability to, among other things:

- incur additional debt, guarantee indebtedness or issue certain preferred shares;
- pay dividends on or make distributions in respect of, or repurchase or redeem, our capital stock or make other restricted payments;
- prepay, redeem or repurchase certain debt;
- make loans or certain investments;
- sell certain assets;
- create liens on certain assets;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates;
- alter the businesses we conduct;
- enter into agreements restricting our subsidiaries' ability to pay dividends; and
- designate our subsidiaries as unrestricted subsidiaries.

As a result of these covenants, we are limited in the manner in which we conduct our business, and we may be unable to engage in favorable business activities or finance future operations or capital needs.

In addition, the ABL Facility requires us to maintain a minimum fixed charge coverage ratio at any time when the average availability is less than the greater of $65.0 million and 10% of the lesser of the aggregate amount of revolving facility commitments and the borrowing base at such time. In that event, we must satisfy a minimum fixed charge ratio of 1.0 to 1.0. At December 31, 2019 we were in compliance with this financial maintenance covenant.

A failure to comply with the covenants under the ABL Facility, the Term Loan Facility, the Notes or any of our other future indebtedness could result in an event of default, which, if not cured or waived, could have a material adverse effect on our business, financial condition and results of operations. In the event of any such default, the lenders thereunder:

- will not be required to lend any additional amounts to us;
- could elect to declare all borrowings outstanding, together with accrued and unpaid interest and fees, to be due and payable and terminate all commitments to extend further credit;
- could require us to apply all of our available cash to repay these borrowings; or
- could effectively prevent us from making debt service payments on the Term Loan Facility and the Notes (due to a cash sweep feature under the ABL Facility).

Such actions by the lenders could cause cross defaults under our other indebtedness. If we were unable to repay those amounts, the lenders and holders under the ABL Facility, the Term Loan Facility and the Notes could proceed against the collateral granted to them to secure the ABL Facility, the Term Loan Facility or the Notes, respectively. If any of our outstanding indebtedness under the ABL Facility, the Term Loan Facility, the Notes or any of our other existing or future indebtedness were to be accelerated, there can be no assurance that our assets would be sufficient to repay such indebtedness in full.

Repayment of our debt is dependent on cash flow generated by our subsidiaries.

Repayment of our indebtedness, including the ABL Facility, the Term Loan Facility and the Notes, is dependent on the generation of cash flow by our subsidiaries and their ability to make such cash available to us, by dividend, debt repayment or otherwise. Unless they are guarantors of the indebtedness, our subsidiaries do not have any obligation to pay amounts due on such indebtedness or to make funds available for that purpose. Our subsidiaries may not be able to, or may not be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each subsidiary is a distinct legal entity and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries. While our debt agreements will limit the ability of our restricted subsidiaries to incur consensual restrictions on their ability to pay dividends or make other intercompany payments to us, these limitations are subject to certain qualifications and exceptions. In the event that we do not receive distributions from our subsidiaries, we may be unable to make required principal and interest payments on our indebtedness. In the event we require restructuring or refinancing, we cannot assure you that we will be able to restructure or refinance any of our debt on commercially reasonable terms or at all.

Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.

We and our subsidiaries may be able to incur substantial indebtedness in the future. Although the terms of the ABL Agreement, the Term Loan Agreement and the Indentures contain restrictions on our and our subsidiaries' ability to incur additional indebtedness, these restrictions are subject to a number of important qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. As of December 31, 2019, we would have had approximately $547.3 million available for additional borrowing under the ABL Facility (without giving effect to letters of credit), all of which would be secured. In addition to the Notes and our borrowings under the ABL Facility and the Term Loan Facility, the covenants under any other existing or future debt instruments could allow us to incur a significant amount of additional indebtedness and, subject to certain limitations, such additional indebtedness could be secured. The more leveraged we become, the more we, and in turn our security holders, will be exposed to certain risks described above under "—Our debt agreements contain restrictions that will limit our flexibility in operating our business."

Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. Assuming the ABL Facility is fully drawn at December 31, 2019 and, prior to giving effect to the Interest Rate Swap (defined below), each 1% change in variable interest rates would result in an approximate $43 million change in aggregate annual interest expense on indebtedness under the ABL Facility and the Term Loan Facility. To manage this risk, we entered into an interest rate swap agreement on December 21, 2018 with Citibank, N.A. as counterparty (the "***Interest Rate Swap***"). The terms of the Interest Rate Swap require us to pay a fixed rate of 2.63% on a notional amount of $1,100.0 million and, in exchange, we receive one-month London Interbank Offered Rate ("***LIBOR***"). The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. We have not designated our Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging" ("***ASC 815***"). Therefore, all changes in the fair value of our Interest Rate Swap will be recognized through interest expense in our results of operations. Changes in the fair value of our Interest Rate Swap could result in a material effect on our consolidated results of operations and financial position; however, we do not anticipate that changes in the fair value of our Interest Rate Swap will have any impact on our cash flows.

Discontinuation, reform or replacement of LIBOR may adversely affect our results of operations.

The U.K. Financial Conduct Authority announced in 2017 that it intends to phase out LIBOR by the end of 2021. Changes to LIBOR or any other benchmark rate may impact credit markets. Borrowings under our Term Loan Facility and ABL Facility bear interest at rates based on LIBOR. The administrative agent for those facilities may approve a comparable or successor rate with respect to LIBOR or, if not feasible, another accommodation as reasonably determined by the agent. The replacement of LIBOR with a comparable or successor rate could cause the amount of interest payable on our Term Loan Facility and ABL Facility to be different than expected.

Additionally, the notional amount associated with our Interest Rate Swap is based on LIBOR. If LIBOR becomes unavailable, it is unclear how payments under our Interest Rate Swap would be calculated. Relevant industry groups are seeking to create a standard protocol addressing the expected discontinuation of LIBOR, but there can be no assurance that such a protocol will be developed or implemented with respect to our Interest Rate Swap.

Our ability to utilize our net operating loss carryforwards may be limited, and we may not be able to utilize our net operating loss carryforwards as a result of recent U.S. federal tax reform legislation.

As of December 31, 2019, we had net operating loss carryforwards ("***NOLs***") of approximately $388.7 million for federal income tax purposes, which expire at various dates between 2028 through 2037 for NOLs generated prior to 2018, and indefinite lives for NOLs generated in 2018 and future periods. Additionally, we had approximately $2.9 billion in state and local net operating loss carryforwards that expire at various dates between 2020 through 2038. To the extent available and not otherwise utilized, we intend to use any NOL carryforwards to reduce the applicable U.S. or state corporate income tax liability associated with our operations. However, our ability to utilize our NOL carryforwards is based on the extent to which we generate future taxable income and on prevailing corporate income tax rates, and we cannot provide any assurance as to when and to what extent we will generate sufficient future taxable income to realize our deferred tax assets, whether in whole or in part. Furthermore, the utilization of our NOL carryforwards may become subject to an annual limitation under Section 382 of the Code (and similar state provisions) in the event of certain cumulative changes in the ownership interest of significant shareholders in excess of 50 percent over a three-year period. This could limit the amount of NOL carryforwards that can be utilized annually to offset taxable income. The amount of the annual limitation is determined based on the value of a company immediately prior to the ownership change. Subsequent ownership changes may further affect the limitation in future years. For these reasons, our ability to utilize our NOLs may be limited.

Item 2. ***Properties.***

The table below presents certain information with respect to our hospital campuses as of December 31, 2019:

Facility Name	City	Licensed Beds	Ownership and Real Property Status
Alabama			
Andalusia Regional Hospital	Andalusia	88	Own
North Alabama Medical Center	Florence	263	Own
Shoals Hospital	Muscle Shoals	198	Own
Vaughan Regional Medical Center (a)	Selma	175	JV/Own
Arizona			
Canyon Vista Medical Center	Sierra Vista	100	Lease
Havasu Regional Medical Center (b)	Lake Havasu City	171	JV/Own
Valley View Medical Center	Fort Mohave	84	Own
Arkansas			
National Park Medical Center (c) (d)	Hot Springs	163	JV/Lease
Saline Memorial Hospital (a)	Benton	177	JV/Own
St. Mary's Regional Medical Center	Russellville	170	Own
Colorado			
Colorado Plains Medical Center	Fort Morgan	50	Lease
Georgia			
St. Francis Hospital (e)	Columbus	376	Own
Idaho			
St. Joseph Regional Medical Center (d)	Lewiston	145	Lease
Indiana			
Clark Memorial Hospital (f)	Jeffersonville	236	JV/Own
Scott Memorial Hospital (f)	Scottsburg	25	JV/Own
Iowa			
Ottumwa Regional Health Center (d)	Ottumwa	217	Lease
Kansas			
Western Plains Medical Complex (d)	Dodge City	99	Lease
Kentucky			
Bluegrass Community Hospital	Versailles	25	Own
Bourbon Community Hospital	Paris	58	Own
Clark Regional Medical Center	Winchester	79	Own
Fleming County Hospital	Flemingsburg	25	Own
Georgetown Community Hospital	Georgetown	75	Own
Jackson Purchase Medical Center	Mayfield	107	Own
Lake Cumberland Regional Hospital	Somerset	295	Own
Logan Memorial Hospital	Russellville	75	Own
Meadowview Regional Medical Center	Maysville	100	Own
Spring View Hospital	Lebanon	75	Own
Michigan			
UP Health System - Bell	Ishpeming	25	Own
UP Health System - Marquette (g)	Marquette	222	JV/Own
UP Health System - Portage (a)	Hancock	96	JV/Own
Mississippi			
Bolivar Medical Center	Cleveland	199	Lease
Montana			
Community Medical Center (a)	Missoula	151	JV/Own
Nevada			
Northeastern Nevada Regional Hospital	Elko	75	Own
New Mexico			
Los Alamos Medical Center	Los Alamos	47	Own
Memorial Medical Center of Las Cruces	Las Cruces	199	Lease

Facility Name	City	Licensed Beds	Ownership and Real Property Status
North Carolina			
Central Carolina Hospital (g)	Sanford	137	JV/Own
Frye Regional Medical Center (g)	Hickory	355	JV/Lease
Harris Regional Hospital (g)	Sylva	86	JV/Own
Haywood Regional Medical Center (g)	Clyde	154	JV/Own
Maria Parham Medical Center (h)	Henderson	185	JV/Own
Person Memorial Hospital (g)	Roxboro	98	JV/Own
Rutherford Regional Medical Center (h)	Rutherfordton	143	JV/Own
Swain County Hospital (g)	Bryson City	48	JV/Own
Wilson Medical Center (h)	Wilson	384	JV/Own
Ohio			
Clinton Memorial Hospital	Wilmington	141	Own
Oklahoma			
Southwestern Medical Center (d)	Lawton	107	Lease
Southwestern Behavioral Health Center (d)	Lawton	92	Lease
Oregon			
Willamette Valley Medical Center (d)	McMinnville	60	Lease
Pennsylvania			
Conemaugh Memorial Medical Center (d) (g)	Johnstown	537	JV/Lease
Meyersdale Medical Center (d) (g)	Meyersdale	20	JV/Lease
Miners Medical Center (d) (g)	Hastings	30	JV/Lease
Nason Medical Center (d)	Roaring Spring	45	Lease
South Carolina			
Carolina Pines Regional Medical Center (c) (d)	Hartsville	116	JV/Lease
KershawHealth (d)	Camden	119	Lease
Providence Hospital - Downtown	Columbia	258	Own
Providence Hospital - Northeast	Columbia	74	Own
Tennessee			
Livingston Regional Hospital	Livingston	114	Own
Riverview Regional Medical Center	Carthage	35	Own
Southern Tennessee Regional Health System - Lawrenceburg	Lawrenceburg	99	Own
Southern Tennessee Regional Health System - Pulaski	Pulaski	95	Own
Southern Tennessee Regional Health System - Sewanee	Sewanee	41	Own
Southern Tennessee Regional Health System - Winchester	Winchester	157	Own
Starr Regional Medical Center - Athens	Athens	118	Own
Starr Regional Medical Center - Etowah	Etowah	160	Own
Sumner Regional Medical Center	Gallatin	167	Own
Trousdale Medical Center	Hartsville	25	Own
Texas			
Ennis Regional Medical Center	Ennis	60	Lease
Palestine Regional Medical Center (d)	Palestine	156	Lease
Paris Regional Medical Center	Paris	154	Own
Parkview Regional Hospital	Mexia	58	Lease
Utah			
Ashley Regional Medical Center	Vernal	39	Own
Castleview Hospital	Price	39	Own
Virginia			
Clinch Valley Medical Center	Richlands	175	Own
Fauquier Health	Warrenton	210	Own
Sovah Health - Danville	Danville	250	Own
Sovah Health - Martinsville	Martinsville	220	Own
Twin County Regional Hospital (h)	Galax	141	JV/Own
Wythe County Community Hospital	Wytheville	100	Lease

Facility Name	City	Licensed Beds	Ownership and Real Property Status
Washington			
Capital Medical Center (d) (i)	Olympia	107	JV/Lease
Lourdes Health - Medical Center (d)	Pasco	95	Lease
Lourdes Health - Counseling Center (d)	Pasco	32	Lease
Trios Health - Southridge Hospital (j) (k)	Kennewick	74	JV/Lease
Trios Health - Women's and Children's Hospital (j) (k)	Kennewick	37	JV/Lease
West Virginia			
Logan Regional Medical Center	Logan	140	Own
Raleigh General Hospital	Beckley	300	Own
Wisconsin			
Watertown Regional Medical Center (a)	Watertown	95	JV/Own
Wyoming			
SageWest Healthcare - Lander (d)	Lander	76	Lease
SageWest Healthcare - Riverton (d)	Riverton	70	Lease
		11,493	

(a) This facility is owned and operated by a joint venture between us and an unrelated third party. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(b) This facility is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest. The real property on which this facility is located is owned by the LifePoint member and leased to the joint venture.
(c) This facility is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest.
(d) This facility is subject to a sale-leaseback arrangement with affiliates of MPT.
(e) Effective January 1, 2020, this facility is owned and operated by St. Francis Holding Company, LLC ("***SFHC***"), a joint venture between us and Emory. Effective January 1, 2020, a wholly-owned LifePoint affiliate owns the real property of this facility and leases the real property to SFHC.
(f) This facility is owned and operated by the Regional Health Network of Kentucky and Southern Indiana ("***RHN***"), a joint venture between us and Norton. A wholly-owned LifePoint affiliate owns a controlling interest in RHN.
(g) This facility is owned and operated by Duke LifePoint Healthcare (or a joint venture between affiliates of the members of Duke LifePoint Healthcare). A wholly-owned LifePoint affiliate owns a controlling interest in Duke LifePoint Healthcare and such other joint venture.
(h) This facility is owned and operated by a joint venture between a local not-for-profit entity and Duke LifePoint Healthcare.
(i) This facility is owned and operated by a joint venture among us, physicians and a joint venture between us and University of Washington. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(j) This facility is owned and operated by a joint venture between us and University of Washington. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(k) This facility is subject to a sale-leaseback arrangement with a third-party for a hospital building whose rent is contingent on the financial performance of the hospital and a sale-leaseback arrangement for a medical office building.

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

Item 3. ***Legal Proceedings.***

Healthcare facilities are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, medical malpractice, breach of contracts, wrongful restriction of or interference with physicians' staff privileges and employment related claims. In certain of these actions, plaintiffs request payment for damages, including punitive damages, that may not be covered by insurance. We are currently not a party to any pending proceedings, which, in management's opinion, would have a material adverse effect on our business, financial condition or results of operations.

For more information about legal proceedings and general liability claims, refer to Note 14 to our accompanying consolidated financial statements included elsewhere in this Report.

Item 4. ***Mine Safety Disclosures*****.**

Not applicable.

PART II

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

All of our equity securities are held by Holdings, whose indirect parent is DSB Parent. As of December 31, 2019, our Sponsor beneficially owned approximately 98.6% of the capital units of LifePoint with the remaining approximate 1.4% owned by current or former directors, members of management, employees and consultants of the Company. Because our equity securities are privately held, there is no established public trading market for our equity securities.

Equity Compensation Plan Information

Refer to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by DSB Parent to our employees and directors.

Recent Sales of Unregistered Securities

There have been no recent sales of unregistered equity securities of the Company within the period covered by this Report.

Item 6. ***Selected Financial Data.***

Set forth below is the selected historical consolidated financial data of the Company for the periods and as of the dates indicated.

On December 3, 2015, the Apollo/RegionalCare Acquisition was completed. For periods prior to the Apollo/RegionalCare Acquisition, our operations are referred to as the "***Predecessor***". For periods after the Apollo/RegionalCare Acquisition, our operations are referred to as the "***Successor***". Additionally, on April 29, 2016, the RegionalCare/Capella Merger was completed, which, for accounting purposes, became effective on May 1, 2016. Furthermore, on November 16, 2018, the LifePoint/RCCH Merger was completed, which, for accounting purposes became effective on November 17, 2018.

The RegionalCare/Capella Merger and LifePoint/RCCH Merger were significant transactions which affect the comparability of the selected financial data. The following information should be read in conjunction with "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations," as well as our accompanying consolidated financial statements included elsewhere in this Report.

($ in millions)	Successor					Predecessor
	Year Ended December 31, 2019	Year Ended December 31, 2018	Year Ended December 31, 2017	Year Ended December 31, 2016	Period From 12/4/2015 through 12/31/2015	Period From 1/1/2015 through 12/3/2015
Statements of Operations Data:						
Revenues	$ 8,752.8	$ 2,778.1	$ 1,872.8	$ 1,502.7	$ 64.0	$ 770.1
Net (loss) income attributable to LifePoint Health, Inc.	(42.7)	(293.7)	(45.4)	(44.0)	1.3	(59.3)
Balance Sheet Data (as of end of year):						
Cash and cash equivalents	$ 748.1	$ 58.9	$ 16.9	$ 30.4	$ 8.0	$ -
Working capital	1,231.0	570.3	121.2	199.9	72.5	-
Total assets	9,680.9	8,991.7	2,057.5	2,060.2	1,043.6	-
Long-term debt, including current maturities	7,176.1	6,477.8	1,434.0	1,340.8	567.1	-
Total LifePoint Health, Inc. equity	863.8	923.4	220.0	305.1	301.8	-
Statements of Cash Flows Data:						
Net cash provided by (used in) operating activities	$ 413.6	$ (73.0)	$ 105.6	$ 54.8	$ (14.1)	$ 35.7
Purchases of property and equipment	(336.7)	(319.7)	(145.1)	(67.5)	(3.6)	(31.2)
Net cash used in investing activities	(310.1)	(5,645.7)	(151.1)	(715.6)	(3.5)	(88.4)
Net cash provided by financing activities	585.7	5,760.7	32.0	683.2	6.4	47.3

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

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

The following management's discussion and analysis of our financial condition and results of operations covers periods prior to the consummation of the LifePoint/RCCH Merger, which was effective November 16, 2018, and for accounting purposes, became effective November 17, 2018. In this management's discussion and analysis, (i) the results of operations from January 1, 2019 to December 31, 2019 are those of the Company on a consolidated basis, (ii) the results of operations from January 1, 2018 to November 16, 2018 are those of RCCH only, and (iii) the results of operations from November 17, 2018 to December 31, 2018 are those of Legacy LifePoint and RCCH on a combined basis. Additionally, in this management's discussion and analysis under "Supplemental Results of Operations for Legacy LifePoint and RCCH on a Combined Basis for the Year Ended December 31, 2018 and for LifePoint on a Consolidated Basis for the Year Ended December 31, 2019," we are providing results of operations on a combined basis for the year ended December 31, 2018 as if the LifePoint/RCCH Merger had occurred on January 1, 2018. GAAP does not allow for such a combination of results of operations; however, we believe the combined results provide information that is useful in evaluating our financial performance.

Management's discussion and analysis of our financial condition and results of operations for the year ended December 31, 2017 has been omitted as permitted by Instruction 1 to Item 303(a) of Regulation S-K. Refer to "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations - Results of Operations for the Years Ended December 31, 2018 and 2017" in our Annual Report for the year ended December 31, 2018, dated March 28, 2019, for management's discussion and analysis of changes in financial condition and results of operations as of and for the years ended December 31, 2018 and 2017.

Overview

We own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. As of December 31, 2019, we operated 88 hospital campuses in 29 states throughout the U.S., having a total of 11,493 licensed beds. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a network of hospitals and outpatient facilities.

We seek to fulfill our mission of Making Communities Healthier® by (1) delivering high quality patient care, (2) supporting our physicians, (3) creating excellent workplaces for our employees, (4) taking a leadership role in our communities and (5) ensuring fiscal responsibility. We strive to create places where people choose to come for healthcare, physicians want to practice and employees want to work.

We generated $8,752.8 million, $2,778.1 million and $1,872.8 million in revenues during the years ended December 31, 2019, 2018 and 2017, respectively. In 2019, approximately 55.2% of our revenues related to patients participating in Medicare and Medicaid programs, collectively. Payments made to our facilities pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payers, together with certain limited services provided to Medicare recipients, to generate an operating profit. The healthcare industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payers. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our facilities.

Recent Developments

LifePoint/RCCH Merger

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. Our consolidated results of operations for the year ended December 31, 2018 include the results of Legacy LifePoint beginning on November 17, 2018. For more information about the LifePoint/RCCH Merger, refer to "Part 1, Item 1. Business—Our Background" and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Acquisitions & Divestitures

The following table summarizes our hospital acquisitions and divestitures completed during the years ended December 31, 2019, 2018 and 2017:

Facility	Location	Effective Date
Acquisitions:		
Lourdes Health ("***Lourdes***") (two hospital campuses)	Pasco, Washington	September 1, 2018
Trios Health ("***Trios***") (two hospital campuses) (JV)	Kennewick, Washington	August 4, 2018
St. Joseph Regional Medical Center ("***St. Joseph***")	Lewiston, Idaho	May 1, 2017
Divestitures:		
Sharon Hospital ("***Sharon***")	Sharon, Connecticut	August 1, 2017
EaStar Health System ("***EaStar***")	Muskogee, Oklahoma	April 1, 2017
Teche Regional Medical Center ("***Teche***")	Morgan City, Louisiana	October 1, 2019

Additionally, effective April 1, 2018, we acquired Pacific Medical Data Solutions ("***PMDS***"). PMDS is a healthcare technology and software services company that provides revenue cycle, billing automation and software solutions to multi-specialty physician groups, ambulatory surgery centers and urgent care clinics.

For additional information regarding our recent acquisitions and divestitures, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

2019 MPT Sale-Leaseback Transaction

On November 4, 2019, certain of our subsidiaries (collectively, the "***LifePoint Entities***") entered into a Real Property Asset Purchase Agreement (the "***Real Property APA***") with certain subsidiaries of MPT. On December 17, 2019, pursuant to the Real Property APA, the LifePoint Entities sold the real estate of certain medical facilities (the "***2019 Master Lease Facilities***") to affiliates of MPT, and immediately thereafter certain LifePoint Entities leased or subleased the land and the buildings associated with the 2019 Master Lease Facilities from affiliates of MPT in accordance with the terms of the 2019 Master Lease. Such sale-leaseback transaction is referred to as the "***Sale Leaseback Transaction***". For additional information regarding the Sale Leaseback Transaction, refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

Joint Ventures

Emory Healthcare Joint Venture

Effective January 1, 2020, we formed a new joint venture with Emory to operate St. Francis Hospital ("St. Francis") located in Columbus, Georgia. LifePoint holds a controlling interest in St. Francis such that it will continue to be included in our consolidated financial statements. For additional information regarding the Emory joint venture, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

In-Home Healthcare Partnership

We maintain a joint venture with a wholly-owned subsidiary of LHC, In-Home Healthcare Partnership ("IHHP"), the purpose of which is to own and operate our home health agencies and hospices and certain of LHC's home health agencies and hospices, leveraging our combined expertise with LHC to enhance home health and hospice services in the communities served by our hospitals.

During the year ended December 31, 2019, we expanded our partnership with LHC by transferring ownership and management of one of our home health agencies and two of our hospices to IHHP effective December 1, 2019. Additionally, effective January 1, 2020, we transferred the ownership of one additional home health agency and one additional hospice to IHHP and subsequently sold a portion of our ownership interest in IHHP to LHC for cash proceeds of approximately $23.6 million. For additional information regarding IHHP, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Health Care Reform Efforts

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, requiring most Americans to obtain health insurance (the "***individual mandate***"), providing additional funding for Medicaid in states that choose to expand their programs, reducing Medicare inpatient prospective payment system, Medicare outpatient prospective payment system, and Medicare and Medicaid disproportionate share hospital payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and instituting certain private health insurance reforms. The Affordable Care Act has, however, been subject to a number of legislative and regulatory changes and court challenges, and its future is uncertain.

The net effect of the Affordable Care Act, as currently adopted, on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access and quality. Additional variables related to the Affordable Care Act impacting our business will be how, if at all, Congress repeals, replaces, or otherwise modifies the Affordable Care Act, whether the Affordable Care Act is found to be unconstitutional after the repeal of the penalties associated with the individual mandate, and how states, providers, insurance companies, employers and other market participants respond during this period of uncertainty. As a result, we are unable to predict the effect on our business, financial condition or results of operations, the availability of adequate insurance coverage for patients seeking healthcare at our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions potentially impacted by the repeal of the penalties associated with the individual mandate, the cessation of the cost sharing reduction payments, and the possible repeal, replacement or modification of the Affordable Care Act.

Refer to "Part I, Item 1. Business—Health Care Reform" included elsewhere in this Report for more information about the Affordable Care Act.

Competitive and Structural Environment

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

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

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

In addition to competitive concerns, many of our communities are experiencing slow growth, and in some cases, population losses. We believe this trend has occurred mainly as a result of recent challenging economic conditions because the economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves. In addition, other economic factors, including, potentially, self-rationing of healthcare services, have made it more difficult to increase the number of patients who seek care at many of our facilities.

Regulatory Environment

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

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

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

On October 8, 2019, CMS and the OIG issued proposed rules that would modify the regulations that implement and interpret the federal anti-kickback and civil monetary penalty for beneficiary inducement statutes and the Stark law. Among other things, the proposed rules would create new anti-kickback and beneficiary inducement statute safe harbors and Stark law exceptions for certain value based arrangements and arrangements that involve the donation of cybersecurity technology. In addition, the proposed rules would also provide additional guidance on several key requirements, including fair market value and commercial reasonableness, that must be met in order for physicians and healthcare providers to comply with the Stark law. CMS and the OIG have indicated that the proposed rules are intended to reduce unnecessary regulatory barriers and accelerate the transformation of the healthcare system into one that betters pay for value and promotes the coordination of care among providers. We cannot predict whether the proposed rules will be adopted and, if adopted, whether the proposed rules will be adopted in their current forms or the impact that the proposed rules would have on the Company.

Revenue Sources

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

Medicare and Medicaid Reimbursement

Revenues from governmental payers, such as Medicare and Medicaid, are controlled by complex rules and regulations that stipulate the amount a hospital is paid for providing healthcare services. We must comply with these rules and regulations to continue to be eligible to participate in the Medicare and Medicaid programs. These rules and regulations are subject to frequent changes as a result of legislative and administrative action and annual payment adjustments on both the federal and the state levels. In addition, Medicare payment methodologies have been, and are expected to continue to be, revised significantly based on cost containment and policy considerations.

For more information about Medicare and Medicaid reimbursement matters, refer to "Part I, Item 1. Business—Sources of Revenue" included elsewhere in this Report.

Physician & Non-Physician Practitioner Services

We employ an increasing number of physicians and non-physician practitioners, such as physician assistants and nurse practitioners, in our hospital markets. Medicare pays us for services provided by our employed physicians and non-physician practitioners under the PFS system. MACRA, which was adopted in 2015, significantly changed how CMS determines the annual updates to the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased annually by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the 2018 Act, were increased by 0.25% for CY 2019. PFS payment rates are scheduled to remain at their CY 2019 levels through CY 2025. In addition, MACRA also established the QPP for incentivizing physician and practitioner care that meets certain value, quality, cost, and performance criteria, and, beginning in CY 2019, amounts paid to physicians and practitioners under the PFS are subject to adjustment through the QPP and participation in either MIPS or an APM. For more information, refer to "Part I, Item 1. Business—Sources of Revenue—Medicare Physician Fee Schedule" included elsewhere in this Report.

HMOs, PPOs and Other Private Insurers

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

Self-pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities have experienced in prior years, which included increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. We cannot predict how administrative or judicial interpretations, legislative actions or any other modifications to the Affordable Care Act that may be implemented or adopted, such as the cessation of cost sharing reduction payments or the repeal of the individual mandate, may impact our self-pay revenues.

Surprise Medical Billing

Congress is considering legislation to limit the "surprise" medical bills that are often received by individuals receiving emergency and certain other services (such as anesthesia services) from out-of-network providers. Various proposals have been introduced in Congress that would generally limit cost sharing for insured individuals who receive emergency and certain other services from out-of-network providers to in-network co-payment and deductible amounts, and would generally prohibit out-of-network providers from balance billing patients for any additional amounts. The proposals would either set payments from payers to out-of-network providers at the median in-network rate, or would allow payers and providers to refer payment disagreements to independent dispute resolution mechanisms. A number of states are considering or have already adopted legislation to eliminate surprise billing. We cannot predict how legislative actions to modify or pass these proposals may be implemented or adopted, or what impact, if any, this may have on our contracts with providers or on our revenues.

Price Transparency

Under the OPPS Rule for CY 2020, CMS finalized price transparency requirements that are applicable to hospitals and, beginning January 1, 2021, require (i) public online disclosure of all standard charges for all hospital items and services and (ii) public display in a consumer-friendly manner of cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for at least 300 "shoppable" services (70 CMS-specified and 230 hospital-selected). The final rule also authorizes CMS to monitor hospital compliance with reporting requirements and to take actions to address hospital noncompliance (including issuing a warning notice, requesting a corrective action plan, and imposing civil monetary penalties). The Departments of the Treasury, Labor, and Health and Human Services have also undertaken regulatory efforts to increase price transparency with a proposal requiring health plans to publicly release all of their negotiated rates. On December 4, 2019, a lawsuit was filed challenging the final rule and CMS' new price transparency requirements. We are unable to predict the outcome of that litigation or what affect the public disclosure of hospitals' or insurance providers' negotiated rates would have on our future negotiations with payers or on our revenues.

Results of Operations

Certain Definitions

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

Adjusted EBITDA. EBITDA adjusted to exclude unusual items and other adjustments required or permitted in calculating debt covenant compliance under the Indentures governing the Notes and/or the Term Loan Facility and ABL Facility. We believe that this inclusion of supplementary adjustments to EBITDA applied in presenting Adjusted EBITDA are appropriate to provide additional information to investors about the impact of certain non-cash items, unusual items that we do not expect to continue at the same level in the future and other items.

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

Combined. Combined information for the year ended December 31, 2018 includes the results of Legacy LifePoint and RCCH as if the LifePoint/RCCH Merger had occurred on January 1, 2018.

Consolidated. Consolidated information includes the results of all hospital operations and corporate overhead costs, including the results of our recent acquisitions and divestitures, and the results of Legacy LifePoint beginning on November 17, 2018.

EBITDA. Earnings before interest, taxes, depreciation and amortization.

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

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

Outpatient factor. The sum of gross inpatient revenue and gross outpatient revenue divided by gross inpatient revenue.

Same-hospital. Same-hospital information includes the results of the same 84 hospital campuses operated during the years ended December 31, 2019 and 2018 on a combined basis as if the LifePoint/RCCH Merger had occurred on January 1, 2018. Same-hospital information excludes the results of our recent acquisitions and divestitures completed in 2019 and 2018.

Summary

The following table summarizes our results of operations for the years ended December 31, 2019 and 2018 (dollars in millions):

	Years Ended December 31,			
	2019		2018	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 8,752.8	100.0 %	$ 2,778.1	100.0 %
Salaries and benefits	4,044.0	46.2	1,329.4	47.9
Supplies	1,471.7	16.8	484.5	17.4
Other operating expenses, net	2,140.6	24.4	709.2	25.6
Depreciation and amortization	378.7	4.4	129.0	4.6
Interest expense, net	577.6	6.6	186.1	6.7
Merger, acquisition and other transaction-related costs	76.9	0.9	141.5	5.1
Impairments of goodwill and long-lived assets	3.3	-	78.4	2.8
Other non-operating losses, net	5.5	0.1	7.8	0.3
	8,698.3	99.4	3,065.9	110.4
Income (loss) before income taxes	54.5	0.6	(287.8)	(10.4)
Provision for (benefit from) income taxes	77.9	0.9	0.2	-
Net loss	(23.4)	(0.3)	(288.0)	(10.4)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(19.3)	(0.2)	(5.7)	(0.2)
Net loss attributable to LifePoint Health, Inc.	$ (42.7)	(0.5) %	$ (293.7)	(10.6) %

For the Years Ended December 31, 2019 and 2018

Revenues

The following table summarizes our key revenue metrics on a consolidated basis for the years ended December 31, 2019 and 2018:

	Years Ended December 31,		Increase	% Increase
	2019	2018	(Decrease)	(Decrease)
Consolidated:				
Number of hospital campuses at end of period	88	89	(1)	(1.1)%
Revenues (in millions)	$ 8,752.8	$ 2,778.1	$ 5,974.7	215.1 %
Admissions	339,571	118,366	221,205	186.9 %
Equivalent admissions	888,331	287,619	600,712	208.9 %
Revenues per equivalent admission	$ 9,853	$ 9,659	$ 194	2.0 %
Medicare case mix index	1.58	1.60	(0.02)	(1.3)%
Inpatient surgeries	92,908	33,360	59,548	178.5 %
Outpatient surgeries	344,919	109,759	235,160	214.3 %
Total surgeries	437,827	143,119	294,708	205.9 %
Emergency department visits	1,961,459	616,150	1,345,309	218.3 %

For the year ended December 31, 2019, our consolidated revenues increased $5,974.7 million, or 215.1%, to $8,752.8 million compared to $2,778.1 million for the prior year. The increase in our revenues was primarily a result of the LifePoint/RCCH Merger and our 2018 acquisitions, net of the impact of our 2019 divestiture of Teche. Refer to *"Supplemental Results of Operations for Legacy LifePoint and RCCH on a Combined Basis for the Year Ended December 31, 2018 and for LifePoint on a Consolidated Basis for the Year Ended December 31, 2019"* included elsewhere in this Report for a more comparable analysis of our revenues on a combined basis as if the LifePoint/RCCH Merger had occurred on January 1, 2018.

During the year ended December 31, 2018, we recorded a decrease to revenues of $17.0 million as a result of a change in our accounting estimate of the collectability of accounts receivable. During the year ended December 31, 2018, we identified additional information which indicated that our current collection estimates might be different from our historical collection estimates. We utilized this new information to further refine our estimation procedures to more precisely estimate the collectability of accounts receivable. The change in our estimation procedures of the collectability of our accounts receivable is considered a change in accounting estimate in accordance with ASC 250, "Accounting Changes and Error Corrections" ("***ASC 250***").

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2019 and 2018:

	Years Ended December 31,			
	2019		2018	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,338.1	38.1 %	$ 1,105.3	39.8 %
Medicaid	1,495.3	17.1	486.3	17.5
HMOs, PPOs and other private insurers	3,698.6	42.3	1,113.8	40.1
Self-pay	59.2	0.7	17.2	0.6
Other	143.6	1.6	49.4	1.8
Revenue from contracts with customers	8,734.8	99.8	2,772.0	99.8
Rental income	18.0	0.2	6.1	0.2
Revenues	$ 8,752.8	100.0 %	$ 2,778.1	100.0 %

Salaries and Benefits

For the year ended December 31, 2019, our consolidated salaries and benefits expense was $4,044.0 million, or 46.2% of revenues, compared to $1,329.4 million, or 47.9% of revenues, for the prior year. The increase in our salaries and benefits expense was primarily a result of the LifePoint/RCCH Merger and our 2018 acquisitions, net of the impact of our 2019 divestiture of Teche.

Supplies

For the year ended December 31, 2019, our consolidated supplies expense was $1,471.7 million, or 16.8% of revenues, compared to $484.5 million, or 17.4% of revenues, for the prior year. The increase in our supplies expense was primarily a result of the LifePoint/RCCH Merger and our 2018 acquisitions, net of the impact of our 2019 divestiture of Teche.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the year ended December 31, 2019, our consolidated other operating expenses were $2,140.6 million, or 24.4% of revenues, compared to $709.2 million, or 25.6% of revenues, for the prior year. The increase in our other operating expenses was primarily a result of the LifePoint/RCCH Merger and our 2018 acquisitions, net of the impact of our 2019 divestiture of Teche.

Depreciation and Amortization

For the year ended December 31, 2019, our consolidated depreciation and amortization expense was $378.7 million, or 4.4% of revenues, compared to $129.0 million, or 4.6% of revenues, for the prior year. The increase in our depreciation and amortization expense was primarily a result of the LifePoint/RCCH Merger and our 2018 acquisitions, net of the impact of our 2019 divestiture of Teche.

Interest Expense, Net

For the year ended December 31, 2019, our consolidated interest expense was $577.6 million, or 6.6% of revenues, compared to $186.1 million, or 6.7% of revenues, for the prior year. The increase in our interest expense was primarily a result of the debt financing activities in connection with the LifePoint/RCCH Merger. For a further discussion of our debt and corresponding interest rates, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Merger, Acquisition and Other Transaction-Related Costs

For the year ended December 31, 2019, we recognized costs of $76.9 million, primarily related to employee severance and retention costs and other integration-related expenses in connection with the LifePoint/RCCH Merger, as well as costs related to the Sale Leaseback Transaction. For the year ended December 31, 2018, we recognized costs of $141.5 million, primarily related to legal and transaction advisory services as well as employee severance and retention costs in connection with the LifePoint/RCCH Merger, as well as costs related to our 2018 acquisitions.

Impairments of Goodwill and Long-lived Assets

For the year ended December 31, 2019, we recognized a goodwill impairment charge of $3.3 million related to one of our facilities. For the year ended December 31, 2018, we recognized impairment charges in the aggregate of $78.4 million, comprised of $53.9 million of goodwill impairments related to three of our facilities, and $24.5 million of long-lived asset impairments primarily related to the write-down of certain assets to their estimated fair values at one of our facilities. For a further discussion of impairments of goodwill and other long-lived assets, refer to Note 1 and Note 5 to our accompanying consolidated financial statements included elsewhere in this Report.

Other Non-Operating Losses, Net

For the year ended December 31, 2019, we recognized net other non-operating losses of $5.5 million, primarily related to miscellaneous asset disposals, partially offset by gains recognized in connection with the transfer of one home health agency and two hospices to IHHP. For the year ended December 31, 2018, our net other non-operating losses were primarily related to the write-off of $8.2 million of previously capitalized debt issuance costs in connection with the termination of our Prior ABL Facility and Prior Term Facility, partially offset by other miscellaneous gains and losses.

Income Taxes

For the year ended December 31, 2019, we recorded a provision for income taxes of $77.9 million, primarily related to a gain recognized for tax purposes only resulting from the Sale Leaseback Transaction. For the year ended December 31, 2018, we recorded a provision for income taxes of $0.2 million, primarily related to the non-deductibility of certain merger and acquisition costs and an increase in the valuation allowance against our deferred tax assets. For a further discussion of our income taxes, refer to Note 6 to our accompanying consolidated financial statements included elsewhere in this Report.

Supplemental Results of Operations for Legacy LifePoint and RCCH on a Combined Basis for the Year Ended December 31, 2018 and for LifePoint on a Consolidated Basis for the Year Ended December 31, 2019

As discussed above, the results of operations in this section for the year ended December 31, 2018 are presented on a combined basis as if the LifePoint/RCCH Merger had occurred on January 1, 2018. GAAP does not allow for such a combination of results of operations; however, we believe the combined results provide information that is useful in evaluating our financial performance.

The following table summarizes our key revenue metrics on a consolidated and same-hospital basis for the year ended December 31, 2019 and on a combined and same-hospital basis for the year ended December 31, 2018:

	Years Ended December 31,		Increase	% Increase
	2019	2018	(Decrease)	(Decrease)
	(Consolidated)	(Combined)		
Number of hospital campuses at end of period	88	89	(1)	(1.1)%
Revenues (in millions) (a)	$ 8,752.8	$ 8,364.9	$ 387.9	4.6 %
Admissions	339,571	343,109	(3,538)	(1.0)%
Equivalent admissions	888,331	888,441	(110)	(0.0)%
Revenues per equivalent admission (a)	$ 9,853	$ 9,415	$ 438	4.6 %
Medicare case mix index	1.58	1.55	0.03	1.9 %
Inpatient surgeries	92,908	94,044	(1,136)	(1.2)%
Outpatient surgeries	344,919	347,227	(2,308)	(0.7)%
Total surgeries	437,827	441,271	(3,444)	(0.8)%
Emergency department visits	1,961,459	1,958,745	2,714	0.1 %
Same-hospital:				
Number of hospital campuses at end of period	84	84	-	- %
Revenues (in millions) (a)	$ 8,432.1	$ 8,162.0	$ 270.1	3.3 %
Admissions	329,788	333,943	(4,155)	(1.2)%
Equivalent admissions	861,227	862,365	(1,138)	(0.1)%
Revenues per equivalent admission (a)	$ 9,791	$ 9,465	$ 326	3.4 %
Medicare case mix index	1.58	1.55	0.03	1.9 %
Inpatient surgeries	89,815	91,468	(1,653)	(1.8)%
Outpatient surgeries	336,390	338,437	(2,047)	(0.6)%
Total surgeries	426,205	429,905	(3,700)	(0.9)%
Emergency department visits	1,891,097	1,881,896	9,201	0.5 %

(a) Revenues and revenues per equivalent admission for the year ended December 31, 2018 have been adjusted to exclude a charge of $17.0 million related to a change in our accounting estimate of the collectability of accounts receivable. The change in our estimation procedures of the collectability of our accounts receivable is considered a change in accounting estimate in accordance with ASC 250.

For the year ended December 31, 2019, our consolidated revenues increased $387.9 million, or 4.6%, compared to the prior year. The increase in our revenues was primarily attributable to a 3.3% increase in our same-hospital revenues and our 2018 acquisitions, partially offset by certain Legacy LifePoint divestitures completed in 2019 and 2018. The increase in our same-hospital revenues for the year ended December 31, 2019 was primarily attributable to improvements in commercial and governmental pricing as well as the continuation of increases in higher acuity cases treated during the year ended December 31, 2019 compared to the prior year. Our same-hospital admissions and equivalent admissions for the year ended December 31, 2019 declined by 1.2% and 0.1%, respectively, compared to the prior year on a combined basis. The decrease in our same-hospital admissions was partially attributable to isolated physician coverage challenges in a few of our markets that resulted in a decline in certain lower acuity medical admissions, including deliveries. Additionally, we experienced declines in inpatient surgeries in areas such as orthopedics as well as certain lower acuity endoscopy and obstetrics related procedures. Our same-hospital equivalent admissions declined less significantly than admissions as a result of growth in emergency department visits, partially due to a higher number of flu related cases as well as the positive impact of certain recent strategic capital investments that we have made in a few of our markets.

Our revenues by payer and approximate percentages of revenues on a consolidated basis for the year ended December 31, 2019 and on a combined basis for the year ended December 31, 2018 were as follows:

	Years Ended December 31,			
	2019		2018	
	Amount	% of Revenues	Amount	% of Revenues
	(Consolidated)		(Combined)	
Medicare	$ 3,338.1	38.1 %	$ 3,169.7	37.9 %
Medicaid	1,495.3	17.1	1,388.8	16.6
HMOs, PPOs and other private insurers	3,698.6	42.3	3,572.5	42.7
Self-pay	59.2	0.7	75.0	0.9
Other	143.6	1.6	141.0	1.7
Revenue from contracts with customers	8,734.8	99.8	8,347.0	99.8
Rental income	18.0	0.2	17.9	0.2
Revenues (a)	$ 8,752.8	100.0 %	$ 8,364.9	100.0 %

(a) Revenues for the year ended December 31, 2018 have been adjusted to exclude a charge of $17.0 million related to a change in our accounting estimate of the collectability of accounts receivable. The change in our estimation procedures of the collectability of our accounts receivable is considered a change in accounting estimate in accordance with ASC 250.

Non-GAAP Measures

Adjusted EBITDA

The following table presents a reconciliation of net loss to EBITDA and Adjusted EBITDA on a consolidated basis for the year ended December 31, 2019 and on a combined basis for the year ended December 31, 2018 (in millions):

	Years Ended December 31,	
	2019	2018
	(Consolidated)	(Combined)
Net loss	$ (23.4)	$ (424.0)
Interest expense, net	577.6	315.9
Income taxes	77.9	0.3
Depreciation and amortization	378.7	413.5
EBITDA	1,010.8	305.7
(a) Stock-based compensation	7.6	91.8
(b) Change in accounting estimate of collectability of accounts receivable	-	17.0
(c) Merger, acquisition and other transaction-related costs	76.9	321.0
(d) Impairments of goodwill and long-lived assets	3.3	204.2
(e) Facility lease expense	(31.8)	(28.2)
(f) Discontinued operations	2.3	5.2
(g) Non-cash and other items	12.1	39.3
(h) One-time costs and non-recurring items	27.9	18.2
Subtotal	1,109.1	974.2
(i) Pro forma EBITDA from in-market investments and acquisitions	30.7	60.3
(j) Pro forma cost savings	13.5	67.5
Subtotal	1,153.3	1,102.0
(k) Pro forma facility lease expense	(48.7)	(50.8)
Adjusted EBITDA	$ 1,104.6	$ 1,051.2

* *Footnote references included on the following page.*

(a) Represents the exclusion of stock-based compensation expense.
(b) Represents the exclusion of one-time, non-cash charges recognized in the fourth quarter of 2018 related to changes in our accounting estimates of the collectability of accounts receivable.
(c) Represents costs associated with the LifePoint/RCCH Merger, the Sale Leaseback Transaction and certain other transactions, including legal, financing and transaction advisory services, employee severance and retention costs and other integration-related expenses associated with such transactions.
(d) Represents the exclusion of non-cash impairment charges related to goodwill and long-lived assets.
(e) Represents cash interest expense in connection with certain leases that are recorded as capital and financing leases within our accompanying consolidated financial statements included elsewhere in this Report. Pursuant to the terms of our financial covenants contained in our debt agreements, we are required to consider cash interest expense on hospital-related capital and financing leases within the definition of Adjusted EBITDA. Additionally, differences between cash payments and reported rent expense for facility operating leases are reflected within this adjustment in accordance with our debt agreements.
(f) Represents the elimination of EBITDA associated with facilities that have been divested.
(g) Represents the exclusion of certain non-cash gains and losses and other items.
(h) Represents the exclusion of certain one-time costs and non-recurring items.
(i) Represents the EBITDA of acquired facilities for periods prior to the acquisition date, inclusive of certain run rate cost savings for implemented headcount reductions. Additionally, the net pro forma EBITDA from new or expanded service lines and newly constructed facilities are included within this adjustment.
(j) Represents the unrealized annual cost savings related to certain corporate integration, operational improvements and synergies anticipated from the LifePoint/RCCH Merger.
(k) Represents the unrealized incremental annual lease expense associated with the Sale Leaseback Transaction. This incremental expense is also included for the year ended December 31, 2018 on a pro forma basis for comparative purposes.

Leverage

The following table illustrates our indebtedness and certain leverage ratios prepared in accordance with the calculations set forth in the Indentures and the ABL Agreement and the Term Loan Agreement as of and for the years ended December 31, 2019 and 2018 (dollars in millions):

	December 31, 2019	December 31, 2018
Cash and cash equivalents	$ 748.1	$ 58.1
ABL Facility	$ -	$ 20.0
Term Loan Facility	3,523.4	3,550.0
8.25% Secured Notes	800.0	800.0
Total Secured Debt (a)	$ 4,323.4	$ 4,370.0
Net Secured Debt (a)	$ 3,575.3	$ 4,311.9
9.75% Unsecured Notes	$ 1,425.0	$ 1,425.0
11.5% Unsecured Notes	350.0	350.0
Total Debt (a)	$ 6,098.4	$ 6,145.0
Net Debt (a)	$ 5,350.3	$ 6,086.9
Adjusted EBITDA (b)	$ 1,104.6	$ 1,102.0
Total Secured Debt (a) / Adjusted EBITDA (b)	3.91x	3.97x
Net Secured Debt (a) / Adjusted EBITDA (b)	3.24x	3.91x
Total Debt (a) / Adjusted EBITDA (b)	5.52x	5.58x
Net Debt (a) / Adjusted EBITDA (b)	4.84x	5.52x

(a) Excludes capital and financing leases, which are not considered indebtedness for purposes of calculating the ratios set forth in the Indentures, the ABL Agreement and the Term Loan Agreement, as well as subordinated debt and unamortized debt issuance costs.
(b) Adjusted EBITDA and the resulting ratios above for the year ended December 31, 2019 are presented on a consolidated basis after giving effect to the Sale Leaseback Transaction, and Adjusted EBITDA and the resulting ratios above for the year ended December 31, 2018 are presented on a combined basis and as originally reported prior to giving effect to the Sale Leaseback Transaction.

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash generated by operations and borrowings under the ABL Facility. Our primary uses of cash are working capital requirements, debt service requirements and capital expenditures. Based on our current level of operations and available cash, we believe our cash flows from operations, combined with availability under the ABL Facility, will provide sufficient liquidity to fund our current obligations, projected working capital requirements, debt service requirements and capital spending requirements over the next twelve months. We cannot assure you, however, that our business will generate sufficient cash flows from operations or that future borrowings will be available to us under the ABL Facility, which is subject to a borrowing base, in an amount sufficient to enable us to pay principal and interest on the ABL Facility, the Term Loan Facility and the Notes, or to fund other liquidity needs. Our ability to do so depends on prevailing economic conditions, many of which are beyond our control. In addition, upon the occurrence of certain events, such as a change of control, we could be required to repay or refinance our indebtedness. We cannot assure you that we will be able to refinance any of our indebtedness on commercially reasonable terms or at all. Any future acquisitions, joint ventures or other similar transactions will likely require additional capital, and there can be no assurance that any such capital will be available to us on acceptable terms or at all.

The following table presents summarized cash flow information for the years ended December 31, 2019 and 2018 (in millions):

	2019	2018
Net cash provided by (used in) operating activities	$ 413.6	$ (73.0)
Net cash used in investing activities	(310.1)	(5,645.7)
Net cash provided by financing activities	585.7	5,760.7
Net change in cash and cash equivalents	$ 689.2	$ 42.0

Operating Activities

For the year ended December 31, 2019, our cash flows from operating activities increased by $486.6 million compared to the prior year, primarily as a result of our strong operating performance, in addition to the collection of income tax refunds and less merger, acquisition and other transaction-related expenses during the year ended December 31, 2019 compared to the prior year. For the year ended December 31, 2018, our cash flows from operating activities decreased by $178.6 million compared to the prior year, primarily as a result of merger-related expenses including legal and transaction advisory services as well as employee severance and retention costs in connection with the LifePoint/RCCH Merger.

Investing Activities

For the year ended December 31, 2019, our net cash used in investing activities primarily consisted of purchases of property and equipment.

We invested $336.7 million and $319.7 million in purchases of property and equipment for the years ended December 31, 2019 and 2018, respectively. Refer to "*Capital Expenditures*" for further information.

Additionally, for the year ended December 31, 2018, we invested $5,345.9 million primarily related to the LifePoint/RCCH Merger in addition to our acquisitions of Lourdes, Trios and PMDS.

Financing Activities

For the year ended December 31, 2019, our net cash provided by financing activities primarily consisted of proceeds from our Sale-Leaseback Transaction, net repayments of loans outstanding on our ABL Facility and installment payments on our Term Loan Facility. Additionally, for the year ended December 31, 2019, we made cash distributions to DSB Parent L.P., a Delaware limited partnership ("***DSB Parent***"), which is our indirect parent, of $10.9 million, primarily in connection with DSB Parent's repurchase of certain previously issued capital units and profits units that were held by former employees and executives. For the year ended December 31, 2018, net cash provided by financing activities related primarily to the net increase in borrowings and equity to effectuate the LifePoint/RCCH Merger. Refer to "*Capital Resources*" for further information regarding our recent debt transactions.

Capital Expenditures

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

The following table summarizes our capital expenditures as a percentage of revenues and as a percentage of depreciation expense for the years ended December 31, 2019 and 2018 (dollars in millions):

	2019		2018	
	Amount	% of Revenues	Amount	% of Revenues
Capital expenditures	$ 336.7	3.8 %	$ 319.7	11.5 %
Depreciation expense	376.9		128.5	
Ratio of capital expenditures to depreciation expense	89.3 %		248.8 %	

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

Capital Resources

ABL Facility

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we entered into the ABL Facility in an aggregate principal amount of up to $800.0 million with a maturity of five years and we terminated our Prior ABL Facility. For further information regarding the ABL Facility, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Term Loan Facility

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we entered into the Term Loan Facility with an original aggregate principal amount of $3,550.0 million with a maturity of seven years and we repaid in full our Prior Term Facility. The Term Loan Facility was amended in connection with a refinancing transaction during the first quarter of 2020. For further information regarding the Term Loan Facility, including certain restrictive covenants and the refinancing transaction, refer to Note 4 and Note 15 to our accompanying consolidated financial statements included elsewhere in this Report.

9.75% Unsecured Notes

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we issued the 9.75% Unsecured Notes in an aggregate principal amount of $1,425.0 million with a maturity of eight years. For further information regarding the 9.75% Unsecured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

8.25% Secured Notes

Effective April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, we issued the 8.25% Secured Notes in an aggregate principal amount of $800.0 million with a maturity of seven years. The indenture governing the 8.25% Secured Notes was satisfied and discharged on March 9, 2020 in connection with a refinancing transaction during the first quarter of 2020. For further information regarding the 8.25% Secured Notes, including the refinancing transaction, refer to Note 4 and Note 15 to our accompanying consolidated financial statements included elsewhere in this Report.

11.5% Unsecured Notes

Effective April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, we issued the 11.5% Unsecured Notes in a private offering in an aggregate principal amount of $350.0 million with a maturity of eight years. The indenture governing the 11.5% Unsecured Notes was satisfied and discharged on March 9, 2020 in connection with a refinancing transaction during the first quarter of 2020. For further information regarding the 11.5% Unsecured Notes, including the refinancing transaction, refer to Note 4 and Note 15 to our accompanying consolidated financial statements included elsewhere in this Report.

A roll-forward of our long-term debt, including current portions, during 2019 is as follows (in millions):

	December 31, 2018	Net Change in ABL Facility	Payments of Borrowings	Amortization of Debt Issuance Costs	Reclassification of Debt Issuance Costs	New Capital and Financing Leases	Amortization of Capital and Financing Leases	December 31, 2019
Senior borrowings:								
ABL Facility	$ 20.0	$ (20.0)	$ -	$ -	$ -	$ -	$ -	$ -
Term Loan Facility	3,550.0	-	(26.6)	-	-	-	-	3,523.4
9.75% Unsecured Notes	1,425.0	-	-	-	-	-	-	1,425.0
8.25% Secured Notes	800.0	-	-	-	-	-	-	800.0
11.5% Unsecured Notes	350.0	-	-	-	-	-	-	350.0
Unamortized debt issuance costs	(227.4)	-	-	26.6	9.0	-	-	(191.8)
Capital and financing leases	557.2	-	-	-	-	722.4	(11.7)	1,267.9
Subordinated borrowings, net	3.0	-	(1.7)	0.3	-	-	-	1.6
	$ 6,477.8	$ (20.0)	$ (28.3)	$ 26.9	$ 9.0	$ 722.4	$ (11.7)	$ 7,176.1

We monitor the capital markets and our capital structure and make changes from time to time, with the goal of maintaining financial flexibility, preserving or improving liquidity and/or achieving cost efficiency. From time to time, we may elect to repurchase amounts of our outstanding debt, including any of the Notes, for cash through open market repurchases or privately negotiated transactions with certain of our debt holders, although there is no assurance we will do so.

Liquidity and Capital Resources Outlook

We continue to have ongoing capital commitments in connection with several of our acquired facilities. At December 31, 2019, we estimated our total remaining capital expenditure commitments to be approximately $1,523.1 million, which generally have remaining terms of one to six years. Of this amount, more than one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the ABL Facility.

Our business strategy contemplates the selective acquisition of additional hospitals and other healthcare service providers, and we regularly review potential acquisitions. These acquisitions may, however, require additional financing. Our primary sources of liquidity are cash flows provided by our operations and our borrowings available under the ABL Facility. We believe that our internally generated cash flows and borrowing availability under the ABL Facility will be adequate to service existing debt, finance internal growth and fund capital expenditures and small to mid-size hospital acquisitions over the next twelve months and into the foreseeable future prior to maturity dates of our outstanding debt. Certain larger hospital acquisitions may, however, require additional financing.

Inflation

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

Contractual Obligations, Commitments and Off-Balance Sheet Arrangements

Contractual Obligations and Commitments

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

The following table summarizes our significant contractual obligations as of December 31, 2019 and the future periods in which such obligations are expected to be settled in cash (in millions):

	Payments Due by Period				
Contractual Obligations	**Total**	**2020**	**2021 - 2022**	**2023 - 2024**	**After 2024**
Long-term debt obligations [(a)]	$ 8,776.4	$ 525.2	$ 1,012.5	$ 2,024.2	$ 5,214.5
Capital expenditure obligations [(b)]	1,523.1	178.6	319.9	253.9	770.7
Capital and financing lease obligations [(c)]	3,063.8	118.2	283.6	218.8	2,443.2
Operating lease obligations [(d)]	251.6	46.4	78.9	43.6	82.7
Other liabilities [(e)]	282.8	77.4	99.1	53.4	52.9
Purchase obligations [(f)]	982.3	451.2	379.4	145.4	6.3
Total	$ 14,880.0	$ 1,397.0	$ 2,173.4	$ 2,739.3	$ 8,570.3

(a) Included in long-term debt obligations are future cash principal and interest on our outstanding debt obligations as of December 31, 2019 excluding unamortized debt issuance costs and related non-cash amortization. These obligations are explained further in Note 4 to our accompanying consolidated financial statements included elsewhere in this Report. Additionally, the amounts included above are presented prior to giving effect to the refinancing activities occurring in the first quarter of 2020 which are described further in Note 15 to our accompanying consolidated financial statements included elsewhere in this Report.

(b) We are subject to annual capital expenditure commitments in connection with many of our facilities. Additionally, we had projects under construction with an estimated additional cost to complete of approximately $91.5 million as of December 31, 2019. However, because we can terminate substantially all of the related construction contracts at any time without paying a termination fee, these costs are excluded from the above table except for amounts contractually committed by us.

(c) Included in capital and financing lease obligations are the future cash payments, including interest, due under our capital and financing lease agreements. These obligations are explained further in Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

(d) This reflects our future minimum operating lease payments. These obligations are explained further in Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

(e) Included in other liabilities are the current and long-term portions of our reserves for self-insurance claims of $64.5 million and $196.5 million, respectively, but excluding the portion of the reserve related to our estimate of recoveries for certain claims in excess of our self-insured retention levels that do not require us to make cash payments. Refer to Note 1 to our accompanying consolidated financial statements included elsewhere in this Report for more information on our reserves for self-insurance claims. Additionally, included in other long-term liabilities are the estimated cash contributions we expect to make to our defined benefit pension plans sufficient to meet our minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended, and our other long-term obligations which require the delivery of cash and for which we can reasonably estimate the timing of such payments.

(f) The following table summarizes our significant purchase obligations as of December 31, 2019 and the future periods in which such obligations are expected to be settled in cash (in millions):

	Payments Due by Period				
Purchase Obligations	**Total**	**2020**	**2021 - 2022**	**2023 - 2024**	**After 2024**
Shared centralized resource model agreements [1]	$ 251.6	$ 85.7	$ 165.9	$ -	$ -
IT Services [2]	368.0	97.7	139.4	130.9	-
GEMS obligations [3]	69.5	69.5	-	-	-
Other purchase obligations [4]	293.2	198.3	74.1	14.5	6.3
Total	$ 982.3	$ 451.2	$ 379.4	$ 145.4	$ 6.3

(1) We have various arrangements with a third party to provide certain nonclinical business functions to us, including payroll, supply chain management and revenue cycle management under a shared centralized resource model for periods ranging from one to three years.

(2) We have various arrangements with third parties to provide information technology services, including, but not limited to, financial, clinical, patient accounting and other information services to us under contracts ranging from one to five years.

(3) General Electric Medical Services ("GEMS") provides diagnostic imaging equipment maintenance and bio-medical services to us pursuant to a contract that expires on December 31, 2020.

(4) Reflects our minimum commitments to purchase other miscellaneous goods or services under non-cancelable contracts as of December 31, 2019.

Off-Balance Sheet Arrangements

We had letters of credit outstanding of approximately $44.1 million as of December 31, 2019, primarily related to the self-insured retention level of our general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements.

Recently Issued Accounting Pronouncements

Refer to Note 1 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of recently issued accounting standards.

Critical Accounting Estimates

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

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

Our critical accounting estimates include the following areas:

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

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

Revenue Recognition and Accounts Receivable

We recognize revenues in the period in which performance obligations are satisfied. Generally, we bill patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. Amounts we receive for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, HMOs, PPOs and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in our financial statements are recorded at the net consideration to which we expect to be entitled to receive in exchange for providing patient care.

Approximately 98.2%, 98.0% and 98.4% of our patient revenues recognized during the years ended December 31, 2019, 2018 and 2017, respectively, related to discounted charges, which were comprised of the following sources (as a percentage of our net patient revenues):

	2019	2018	2017
Medicare	38.1 %	39.8 %	40.6 %
Medicaid	17.1 %	17.5	18.5 %
HMOs, PPOs and other private insurers	42.3 %	40.1	38.7 %
Self-pay	0.7 %	0.6	0.6 %

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

We monitor our processes for calculating contractual allowances through:

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

Medicare and Medicaid

The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e. gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under the Medicaid program's prospective reimbursement systems, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates.

Discounts for retrospectively cost-based revenues are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under these programs are subject to adjustment based on administrative review and audit by third party intermediaries, which can take several years to resolve completely.

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

HMOs, PPOs and Other Private Insurers

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

The process of determining the allowance requires us to estimate the amount expected to be received based on payer contract provisions, historical collection data as well as other factors and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts for managed care plans would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. The Company evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. The Company estimates the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that the Company utilizes include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that the Company expects to collect. Because the Company provides care to patients regardless of their ability to pay, the Company has determined that the differences between the amounts it bills based on gross or discounted charges and the amounts the Company expects to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and the Company accounts for this variable consideration in accordance with the provisions of ASC 606. Self-pay accounts receivable are written off after collection efforts have been followed in accordance with the Company's policies.

Goodwill Impairment Analysis

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired businesses. Our goodwill included in our consolidated balance sheet as of December 31, 2019 was $2,961.2 million. Refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report for a detailed rollforward of our goodwill.

In accordance with ASC 350, "Intangibles — Goodwill and Other" ("***ASC 350***") goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. Prior to the LifePoint/RCCH Merger, we historically determined that each of our hospitals represented a reporting unit in accordance with ASC 280, "Segment Reporting" ("***ASC 280***") and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on our management team and business operations, we re-evaluated our reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that our consolidated business comprises a single reporting unit for goodwill impairment testing purposes. For the annual impairment evaluation, we determine fair value using a discounted cash flow ("***DCF***") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing our assumptions. The cash flows employed in the DCF analysis are based on our most recent financial budgets and business plans and, when applicable, various growth rates for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the respective reporting unit.

If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. Refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report for further discussion of the results of our annual goodwill impairment evaluation procedures.

Accounting for Income Taxes

Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or increase this allowance, we must include an expense as part of the income tax provision in our results of operations. Our deferred tax asset balances in our consolidated balance sheets were $550.1 million and $456.4 million as of December 31, 2019 and 2018, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $495.5 million and $274.4 million as of December 31, 2019 and 2018, respectively.

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

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

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

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

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

Our deferred tax assets exceeded our deferred tax labilities by $489.3 million as of December 31, 2019, excluding the impact of valuation allowances. Historically, we have not produced federal taxable income, and in connection with the LifePoint/RCCH Merger, the Company became highly leveraged. As such, we believe it is likely that the deferred tax assets will not be realized and thus have established a valuation allowance against the deferred tax assets as of December 31, 2019. In addition, we do have subsidiaries with a history of tax losses in certain state jurisdictions and, based upon those historical tax losses, we assumed that the subsidiaries would not be profitable in the future for those states’ tax purposes. If our assertion regarding the future profitability of those subsidiaries was incorrect, then our deferred tax assets would be understated by the amount of the state valuation allowance of $202.3 million at December 31, 2019.

Additionally, on December 22, 2017, the Tax Act was signed into law. The Tax Act significantly revises the U.S. corporate income tax by, among other things, lowering the statutory corporate tax rate from 35% to 21% and eliminating certain deductions. Due to the timing of the enactment and the complexity involved in applying the provisions of the Tax Act, we made reasonable estimates of the effects of the Tax Act on our existing deferred tax assets and liabilities and recognized a provisional benefit for income taxes of $57.7 million during the year ended December 31, 2017. We completed our analysis during the year ended December 31, 2018 and determined that no additional adjustment was needed to the $57.7 million provisional expense that we recorded for the year ended December 31, 2017.

Reserves for Self-Insurance Claims

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers’ compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers’ compensation claims exceeding SIR and deductible levels. At December 31, 2019, our SIR for professional liability claims is $5.0 million per claim, with a $5.0 million inner aggregate, at the majority of our facilities. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2019, our deductible for workers’ compensation claims was $1.0 million per claim in all states in which we operate except for Montana, Oklahoma, Ohio, Washington and Wyoming. We participate in state-specific programs for our workers’ compensation claims arising in these states. Our SIR and deductible levels are evaluated annually as a part of our insurance program’s renewal process.

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

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

Our reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. Our reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. We have discounted our reserves for self-insured claims to their present value using a discount rate of 1.9% at December 31, 2019, 1.8% at December 31, 2018 and in a range of 1.4% to 2.4% at December 31, 2017. We select a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

The following table provides information regarding our reserves for self-insured claims at December 31, 2019 and 2018 (in millions):

	2019	2018
Undiscounted	$ 275.8	$ 279.0
Discounted (as reported)	$ 261.0	$ 264.7

As of December 31, 2019 and 2018, we estimated less than 1% of our reserves for self-insured claims represent reserves for settled and unpaid claims. Our average lag time between the settlement and payment of a self-insured claim ranges from 1 to 2 weeks.

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

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

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

Ultimately, from an actuarial standpoint, the sensitivity in the estimates of reserves for self-insured claims is reflected in the various actuarial confidence levels. Our best estimate of our reserves for self-insured claims utilizes an actuarial central estimate, which employs a statistical confidence level that approximates 50%. Higher statistical confidence levels, while not representative of our best estimate, reflect reasonably likely outcomes upon the ultimate resolution of related claims. Using a higher statistical confidence level would increase the estimated reserves for self-insured claims. At a 75% statistical confidence level, our estimated reserve would increase by $28.9 million. Changes in our estimates of reserves for self-insured claims are non-cash charges and accordingly, do not impact our liquidity or capital resources.

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of our quarterly and semi-annual actuarial calculations resulted in changes to our reserves for self-insured claims for prior years. As a result, for the year ended December 31, 2019, our related self-insured claims expense increased by $6.7 million and for the years ended December 31, 2018 and 2017, our related self-insured claims expense decreased by $3.9 million and $12.1 million, respectively.

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

Market Risk

Market risk is defined as the risk of loss resulting from changes in market prices as a result of changes in interest rates, credit and liquidity or general economic conditions. Our principal market risks in the ordinary course of business are credit risk, liquidity risk and interest rate risk. We currently do not have direct exposure to either market risk from trading activities or foreign currency exchange rate risk.

Credit Risk

We define credit risk as the risk that amounts payable by uninsured patients and remaining patient responsibility amounts (deductibles and co-payments) for patient accounts where the primary insurance carrier has paid the amounts covered by the applicable agreements will not be paid. The provision for doubtful accounts relates primarily to amounts due directly from patients. While we have experienced a reduction in uninsured patients, the risk of collection from insured patients and the amounts due, may increase as more individuals are enrolled in insurance plans with larger deductibles and/or co-payments, including those purchased on insurance exchanges. Additionally, the counterparty to our Interest Rate Swap exposes us to credit risk in the event of nonperformance. However, we do not anticipate nonperformance by our counterparty. We do not hold or issue derivative financial instruments for trading purposes.

Liquidity Risk

We define liquidity risk as the risk that we will not meet our payment obligations in a timely manner or the risk that market conditions or institution-specific events may reduce our ability to raise funds from market counterparties. An adverse institution-specific event such as a major loss that causes a perceived or actual deterioration in our financial condition or an adverse systemic event could affect our funding liquidity.

Interest Rate Risk

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. To manage this risk, we entered into an Interest Rate Swap. The terms of the Interest Rate Swap require us to pay a fixed rate of 2.63% on a notional amount of $1,100.0 million and, in exchange, we receive one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. We have not designated our Interest Rate Swap as a cash flow hedge in accordance with ASC 815. Therefore, all changes in the fair value of our Interest Rate Swap will be recognized through interest expense in our results of operations. Changes in the fair value of our Interest Rate Swap could result in a material effect on our consolidated results of operations and financial position; however, we do not anticipate that changes in the fair value of our Interest Rate Swap will have any impact on our cash flows.

As of December 31, 2019, we had total outstanding debt of approximately $6,100.0 million, excluding capital and financing leases and unamortized debt issuance costs, of which $2,423.4 million, or 39.7%, was subject to variable rates of interest after giving effect to our Interest Rate Swap. If the interest rate on our variable rate long-term debt outstanding as of December 31, 2019, not subject to our Interest Rate Swap, were to increase by 100 basis points during any annual period, our cash flows would be negatively impacted by approximately $24.2 million.

Item 8. ***Financial Statements and Supplementary Data.***

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

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

None.

Item 9A. ***Controls and Procedures.***

The information that would be required to be disclosed under Part II, Item 9A of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a**)** of each of the Indentures.

Item 9B. ***Other Information.***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance*.**

The following table provides information regarding our executive officers and the members of our Board of Directors (ages as of March 12, 2020):

Name	Age	Position(s)
David M. Dill	51	President and Chief Executive Officer
Michael S. Coggin	50	Executive Vice President and Chief Financial Officer
Victor E. Giovanetti	56	Executive Vice President, Hospital Operations
Robert F. Jay	52	Executive Vice President, Integrated Operations
Jennifer C. Peters	48	Executive Vice President, General Counsel and Corporate Secretary
Terry W. Terrill, Jr.	53	Executive Vice President, Administration
J. Michael Grooms	41	Senior Vice President and Chief Accounting Officer
Matthew H. Nord	40	Director and Chairman
William F. Carpenter III	65	Director and Chairman Emeritus
Norman Brownstein	76	Director
Christopher J. Christie	57	Director
Maxwell David	29	Director
Michael P. Haley	69	Director
Steve Levin	54	Director
Holly McMullan	43	Director
Daniel Morissette	54	Director
Eric L. Press	54	Director
Martin S. Rash	65	Director
Olivia Wassenaar	40	Director
G. Rodney Wolford	73	Director

David M. Dill became our Chief Executive Officer upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Dill served in various roles at Legacy LifePoint as President since January 2011 and as Chief Operating Officer since April 2009. Mr. Dill served as Executive Vice President from February 2008 to January 2011. Mr. Dill joined Legacy LifePoint in July 2007 as Chief Financial Officer and continued to serve in that role until April 2009. From March 2006 until Mr. Dill joined Legacy LifePoint, he served as executive vice president of Fresenius Medical Care North America and as chief executive officer of one of two United States divisions of Fresenius Medical Care Services, a wholly owned subsidiary of Fresenius Medical Care AG & Co. KGaA. Mr. Dill previously served as executive vice president, chief financial officer and treasurer of Renal Care Group, Inc., a publicly-traded dialysis services company, from November 2003 until Renal Care Group was acquired by Fresenius Medical Care in March 2006. From 1996 to November 2003, Mr. Dill served in various finance and accounting roles with Renal Care Group, Inc. Mr. Dill served as a member of the board of directors of Psychiatric Solutions, Inc., a behavioral health services company, from 2005 until 2010.

Michael S. Coggin became our Executive Vice President and Chief Financial Officer upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Coggin served in various roles at Legacy LifePoint as Executive Vice President, Chief Financial Officer and Chief Accounting Officer, since September 2016. From December 2008 until September 2016, Mr. Coggin served as Senior Vice President and Chief Accounting Officer of Legacy LifePoint. From September 2007 until December 2008, Mr. Coggin served as chief financial officer of Specialty Care Services Group, a multi-service line healthcare provider primarily focused on providing perfusion and auto-transfusion services to hospitals. Mr. Coggin was a senior vice president in the finance, accounting and internal audit groups of Renal Care Group, Inc. from April 2004 until its acquisition by Fresenius Medical Care AG & Co. KGaA in March 2006. Following the acquisition, Mr. Coggin provided finance and accounting oversight for business units within the East Division of Fresenius. Prior to that time, Mr. Coggin was an audit manager at KPMG Peat Marwick in Nashville, Tennessee.

Victor E. Giovanetti became our Executive Vice President, Hospital Operations upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Giovanetti served as President of Legacy LifePoint's Eastern Group since January 2017. From July 2015 to January 2017, Mr. Giovanetti served as President of Legacy LifePoint's Western Group. Mr. Giovanetti joined Legacy LifePoint in July 2013 as Chief Operating Officer of Legacy LifePoint's Eastern Group. Mr. Giovanetti has more than 25 years of management experience in operations, financial, clinical and strategic aspects of healthcare administration. Prior to joining the Company, his positions included president of HCA Lewis-Gale Regional Health System in Roanoke, Virginia, chief executive officer and chief operating officer of Southern Hills Medical Center in Nashville, Tennessee, and various management roles with HCA, Symbion and other healthcare organizations in Georgia.

Robert F. Jay became our Executive Vice President, Integrated Operations upon consummation of the LifePoint/RCCH Merger. Mr. Jay previously served as RCCH's Executive Vice President and Chief Operating Officer, a position he held from January 2018. Mr. Jay has served in various roles with RCCH, including Executive Vice President Operations Support from May 2016 to September 2016 and Division President from September 2016 to January 2018. Prior to that he served as Chief Operating Officer for RCCH from January 2014 until May 2016. Prior to joining RCCH, he spent seven years at Vanguard Health Systems in a variety of operations and development positions. He joined Vanguard Health Systems as its Corporate Director Operations and Financial Analysis where he was responsible for managing and reporting operational, clinical, and financial results. In 2008, Mr. Jay was promoted to Vice President, Supply Chain Management of Vanguard where he oversaw the overall strategic direction and tactical execution of supply chain operations. In 2009 he transitioned to Vice President, Development of Vanguard where he led acquisition teams that closed on hospital transactions with combined net revenues of over $2.2 billion. Prior to joining Vanguard Health Systems, Mr. Jay worked as the Corporate Controller for Health Management Associates, Inc. in Naples, Florida. He has also served as a Controller in a not-for-profit hospital and also spent time at KPMG as an auditor.

Jennifer C. Peters became our Executive Vice President and General Counsel upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Ms. Peters served as Legacy LifePoint's General Counsel since April 2017 and Corporate Secretary since June 2017. Prior to that, Ms. Peters served as senior vice president and chief operations counsel of Legacy LifePoint, where she was responsible for overseeing the Company's operations lawyers and contract management team to ensure consistent legal guidance across all operational units. Prior to joining Legacy LifePoint in November 2013, Ms. Peters served as general counsel, secretary and chief compliance officer for Simplex Healthcare from October 2010 through November 2013. Ms. Peters has also served as vice president and associate general counsel at Community Health Systems. In addition, Ms. Peters has experience as a hospital administrator.

Terry W. "Sonny" Terrill, Jr. joined the Company in April 2019 as Executive Vice President, Human Resources. Mr. Terrill is responsible for providing leadership in developing and executing human resources strategies in support of the overall business plan and strategic direction of the organization. Mr. Terrill has three decades of HR experience, including executive coaching, full-cycle talent management and management of large scale system and organizational integration. Before joining the Company, he served in a number of leadership roles, most recently as executive vice president, chief human resources officer for BrightSpring Health from August 2017 to March 2019 and human resources officer for CIGNA- HealthSpring from May 2005 to August 2017. He is also a Six Sigma Black Belt.

J. Michael Grooms became our Senior Vice President and Chief Accounting Officer upon consummation of the LifePoint/RCCH Merger. Mr. Grooms previously served as Chief Accounting Officer of Legacy LifePoint from June 2018 and as Vice President of Accounting and Financial Reporting from March 2012. Additionally, Mr. Grooms served in various other accounting financial reporting roles since joining Legacy LifePoint in September 2006. Prior to that time, he served as controller with Delek US from 2005 to 2006, and as an auditor with KPMG from 2001 to 2005.

Matthew H. Nord has been our Director since consummation of the Apollo/RegionalCare Acquisition in December 2015 and became Chairman of the Board in December 2018. Mr. Nord is Co-Lead Partner of Private Equity at Apollo Global Management, Inc., where he has been employed since 2003. From 2001 to 2003, Mr. Nord was a member of the Investment Banking division of Salomon Smith Barney Inc. Mr. Nord serves on several boards of directors, including Intrado Corporation and ADT Inc. Mr. Nord also serves on the Board of Trustees of Montefiore Health System and on the Board of Overseers of the University of Pennsylvania's Weitzman School of Design. During the past five years, Mr. Nord has also served as a director of Affinion Group Holdings, Inc. (from October 2006 to November 2015), Constellium N.V. (from May 2010 to November 2015), Noranda Aluminum Holding Corporation (from March 2007 to December 2015) Novitex Holdings, Inc. (from October 2013 to July 2017), Exela Technologies, Inc. (from July 2017 to October 2019), and Presidio, Inc. (from November 2014 to December 2019). Mr. Nord graduated summa cum laude with a B.S. in Economics from the Wharton School of the University of Pennsylvania. Between his work at Apollo and his prior experience in investment banking, Mr. Nord has approximately 15 years of experience analyzing, financing and investing in public and private companies.

William F. Carpenter III became our Director and Chairman Emeritus upon consummation of the LifePoint/RCCH Merger. Mr. Carpenter was a founding member of Legacy LifePoint, having served in various roles as Executive Vice President, Senior Vice President, General Counsel, Secretary and Corporate Governance Officer. In 2006, Mr. Carpenter was appointed Chief Executive Officer and elected to the Board of Directors of Legacy LifePoint and, in 2010, was appointed Chairman of the Board. In 2019, Mr. Carpenter was appointed by Tennessee Governor Bill Lee as co-chair of the Governor's Health Care Modernization Task Force. In January 2020, Mr. Carpenter was elected to the Board of Directors of FB Financial Corporation (NYSE: FBK), a bank holding company headquartered in Nashville, Tennessee. Additionally, Mr. Carpenter formerly served on the board of directors of the American Hospital Association, and as Chairman and a member of the board of the Federation of American Hospitals, the national public policy organization for investor-owned hospitals. Mr. Carpenter previously served on the board of directors of the Nashville Area Chamber of Commerce, is also a member and past chairman of the Nashville Health Care Council Board of Directors and serves on the boards of directors of NashvilleHealth, the Center for Medical Interoperability, United Way of Nashville, and Nashville Public Radio. A recognized leader in the healthcare industry, he has appeared on *Modern Healthcare* magazine's annual "100 Most Influential People in Healthcare" list numerous times, and was the recipient in 2019 of the *Nashville Business Journal*'s Lifetime Achievement Award.

Norman Brownstein became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Brownstein is the founding member and chairman of the board of the law firm of Brownstein Hyatt Farber Schreck, LLP. Mr. Brownstein is nationally recognized for his extensive experience in real estate law, commercial transactions and public policy advocacy, which spans the economic spectrum, extending to telecommunications, financial services, agriculture, tax and health care interests. Mr. Brownstein's firm is one of the leading lobbying firms in the United States. Mr. Brownstein serves on the board of directors of National Jewish Health and the Simon Wiesenthal Center, and during the past five years has also served as a director of Ardent Healthcare Services. Mr. Brownstein received a B.S. from the University of Colorado and a J.D. from the University of Colorado Law School.

Christopher J. Christie became our Director in December 2018. Mr. Christie served two terms as Governor of New Jersey from 2010 to 2018. Prior to that, Mr. Christie served as U.S. Attorney for the District of New Jersey from 2002 to 2008. During his governorship, Mr. Christie chaired the President's Commission on Combating Drug Addiction and the Opioid Crisis in 2017. He currently serves as a legal and political commentator for ABC News. Mr. Christie is a graduate of the University of Delaware and Seton Hall University School of Law.

Maxwell David became our Director in December 2018. Mr. David is a Principal in Apollo Global Management's Private Equity business, having joined in 2014. Prior to that time, Mr. David was a member of the Investment Banking division of Bank of America Merrill Lynch. Mr. David serves on the board of directors of CareerBuilder and Aris Mortgage Holding Company, LLC (more commonly known as Amerihome). Mr. David graduated cum laude from Dartmouth College with a B.A. in Economics.

Michael P. Haley became our Director in December 2018. Prior to that time, Mr. Haley served as a director of Legacy LifePoint since 2005 and as chair of its Audit Committee since 2016. Mr. Haley is also a member of the board of directors of American National Bankshares, Inc., a bank holding company. From 2005 until April 2018, Mr. Haley served as a director of Ply Gem Holdings, Inc., a producer of window, door and siding products for the residential construction industry. Mr. Haley served as an advisor to Fenway Partners, LLC, a private equity investment firm, from April 2006 to June 2015, and was a managing director of its affiliate, Fenway Resources, from 2008 to June 2015. Mr. Haley's previous executive leadership experience includes service as executive chairman of Coach America, a transportation services operator, and as chairman, president and chief executive officer of MW Manufacturers, Inc., a subsidiary of Ply Gem Industries, Inc. In addition, Mr. Haley has served on the Board of Trustees of Roanoke College (Virginia) since 2010 and previously served on the board of the Martinsville-Henry County United Way and as chairman of the board of trustees of Memorial Hospital of Martinsville and of the Martinsville-Henry County Economic Development Corporation.

Steven Levin became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Levin was the chief strategy officer of Waystar, a healthcare revenue cycle technology platform. In 2018, Waystar acquired Connance, an analytics company that delivers workflow optimization technology for healthcare providers, which Mr. Levin founded in collaboration with Tenet Healthcare, FICO and Northbridge Venture Partners. Prior to Connance, Mr Levin was a Partner at Monitor Company (now Monitor Deloitte) working with hospitals, HCIT companies and health insurers. Mr. Levin holds a B.A. from Dartmouth College and an M.B.A. from Harvard Business School.

Holly McMullan became our Director in December 2018. Ms. McMullan is a Partner in Apollo Global Management's Client and Product Solutions group, where she is responsible for fundraising efforts for Apollo's private equity and capital markets businesses, having joined in 2008. Prior to that time, Ms. McMullan was a Senior Vice President at Pequot Capital Management and was previously a member of Guggenheim Advisors, Bear Stearns, and Robertson Opportunity Capital. She currently serves on the following advisory boards: 30 % Coalition, McCombs Advisory Council, New York for McCombs (Chair) and the Hicks Muse Private Equity Research Center at the University of Texas at Austin. Ms. McMullan holds an MBA with a concentration in Finance from the McCombs School of Business at the University of Texas at Austin and a BA (honors) in International Business from Sheffield Hallam University, Sheffield, UK.

Daniel Morissette became our Director upon consummation of the Transaction in April 2016. Mr. Morissette serves as Senior Executive Vice President and Chief Financial Officer for Common Spirit Health and served as Senior Executive Vice President/Chief Financial Officer for Dignity Health since February 2016. Previously, Mr. Morissette served as the Chief Financial Officer for Stanford Health Care. Mr. Morissette has over 25 years of experience in health care, consulting and international business development. During the past five years, Mr. Morissette served as a director for Optum360. Mr. Morissette received a B.S. from DePaul University and an M.B.A. from The University of Chicago, Booth School of Business.

Eric L. Press has been our Director since consummation of the Apollo/RegionalCare Acquisition in December 2015. Mr. Press is a senior partner of Apollo Global Management, Inc., where he has been employed since 1998 and has served as an officer of certain affiliates of Apollo. From 1992 to 1998, Mr. Press was associated with the law firm of Wachtell, Lipton, Rosen & Katz specializing in mergers, acquisitions, restructurings and related financing transactions. From 1987 to 1989, Mr. Press was a consultant with The Boston Consulting Group. Mr. Press serves on several boards of directors, including Apollo Commercial Real Estate Finance, Inc., PlayAGS, Inc., Princimar Chemical Holdings, LLC, ADT Inc. and Constellis Holdings, LLC. During the past five years, Mr. Press also served as a director of Affinion Group Holdings, Inc. (from October 2005 to September 2015), Athene Holding Ltd. (from July 2009 to February 2014), Metals USA Holdings Corp. (from May 2005 to April 2013), Noranda Aluminum Holding Corporation (from March 2007 to December 2015), Prestige Cruise Holdings, Inc. (from April 2007 to November 2014), Verso Corporation (from January 2009 to July 2016) and Caesars Entertainment Corporation (from January 2008 to October 2017). Mr. Press graduated magna cum laude from Harvard University with a A.B. in economics and received his JD from Yale Law School. Mr. Press has significant experience making and managing private equity investments on behalf of Apollo. Between his work at Apollo and his prior experience as an attorney and a management consultant, Mr. Press has approximately 28 years of experience in the process of financing, analyzing, and investing in public and private companies and serving on their board of directors.

Martin S. Rash has been our director since October 2015 following the Apollo/RegionalCare Acquisition and served as Executive Chairman following the consummation of the RegionalCare/Capella Merger in April 2016 until October 2016. Additionally, Mr. Rash served as Chief Executive Officer and Chairman of RegionalCare from October 2016 until the consummation of the LifePoint/RCCH Merger. Mr. Rash served as the Executive Chairman at RegionalCare Hospital Partners, Inc. from March 2013 to January 2014 and served as its Chief Executive Officer from 2009 until March 2013. From December 1996 to 2005, Mr. Rash was Chairman and Chief Executive Officer of Province Healthcare, a $1 billion NYSE company that owned 21 hospitals and managed more than 50 facilities. Prior to his tenure at Province Healthcare, Mr. Rash served as Executive Vice President and Chief Operating Officer for Community Health Systems where he led the growth of the company from 10 to 41 hospitals in 17 states. Earlier in his 40-year healthcare career, he worked at numerous community hospitals in various administrative and financial roles. Mr. Rash's experience and leadership includes Board of Directorships in the past at Healthspring, a NYSE company, and Odyssey Healthcare, a NASDAQ company. He is a past Chairman of the Federation of American Hospitals and of the Nashville Health Care Council. He holds both a B.A. and M.B.A. from Middle Tennessee State University. He currently serves as Chairman of American Pathology Partners.

Olivia Wassenaar became our Director in December 2018. Ms. Wassenaar is a Senior Partner at Apollo Global Management and is Co-Lead of Natural Resources, having joined in 2018. Prior to that time, Ms. Wassenaar was a Managing Director at Riverstone Holdings and was previously a member of the Investment Banking division of Goldman Sachs. Ms. Wassenaar also serves on the boards of directors of Talos Energy Inc., Jupiter Resources Ltd., and American Petroleum Partners, LLC. During the past five years, Ms. Wassenaar also served as a director of Northern Blizzard Resources Inc. (from June 2011 to May 2017), USA Compression Partners, LP (from June 2011 to April 2018), Admiral Permian Resources, LLC (from March 2017 to May 2018), Hammerhead Resources Inc. (from June 2017 to May 2018), Canadian Non-Operated Resources GP Inc. (from August 2014 to May 2018), Eagle Energy Exploration LLC (from December 2013 to May 2018), Vesta Energy Corp. (from May 2017 to May 2018), Canera III (from 2015 to 2017), Niska Gas Storage Partners LLC (from July 2014 to June 2016), Pegasus Optimization Partners, LLC (from May 2019 to October 2019), Apex Energy, LLC (from September 2019 to December 2019). She received her AB, magna cum laude, from Harvard College and an MBA from the Wharton School at the University of Pennsylvania.

G. Rodney Wolford became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Wolford has over 40 years of wide-ranging experience in the health care industry, having served in leadership roles with health care providers, suppliers, consulting firms, associations and insurers. Redirecting his professional time from active executive leadership, he now focuses his professional time on multiple boards of directors and rural community economic development. Among his many executive positions, Mr. Wolford served as chief executive officer of Alliant Healthcare (now Norton Healthcare), the leading hospital system in Louisville, KY, Sterling Diagnostic, a worldwide manufacturer of x-ray film, Forhealth Technologies, the inventor of the first robot dedicated to hospital IV production, and a senior executive of Blue Cross Tennessee. Mr. Wolford currently serves on the boards of Atlanta based D4C Brands, a pediatric dentistry company, and Liberate Medical, which develops electronic stimulation for ventilator patients, and as a fund manager of Bluegrass Angel Fund III. During the past five years, Mr. Wolford has also served as a director of Haven Behavioral, Laboratory Supply Company, VetCor and Essent Healthcare.

Code of Ethics

Our Board expects its members, as well as our officers and employees, to act ethically at all times and to acknowledge in writing their adherence to the policies comprising our Code of Conduct, which is known as "Common Ground," and, as applicable, our Code of Ethics for Senior Financial Officers and Chief Executive Officer.

Board Structure

The Board consists of 13 directors. The Board has the following standing committees: audit; compensation; nominating and governance; compliance; quality; and executive. In addition, the board of directors of our parent company, DSB Parent, also has a compensation committee that administers equity-based compensation plans in which our managers, officers, employees, consultants and directors participate. As a result of the LifePoint/RCCH Merger and the RegionalCare/Capella Merger, Apollo has the power to control us and our affairs and policies, including the designation of a majority of the members of our Board and the appointment of management.

Committees of our Board of Directors

The Board has adopted written charters for each of the following standing committees:

Audit Committee

The current members of our audit committee are Messrs. Morissette, Haley and Wolford. Mr. Morissette is the chairman of our audit committee. The principal duties and responsibilities of our audit committee are to assist the Board in overseeing:

- the integrity of our financial statements;
- the independent auditor's qualifications, independence and performance;
- the performance of our internal audit function; and
- our compliance with certain legal, ethical and regulatory requirements.

The audit committee has the authority to conduct or authorize investigations into or studies of matters within its scope of responsibilities. It also has the authority to retain and determine funding for independent legal, accounting or other advisors (without seeking Board approval) as it determines necessary or appropriate to carry out its duties and responsibilities.

Our Board has determined that each of Messrs. Morissette and Wolford is an "audit committee financial expert" within the meaning of applicable SEC regulations.

Compensation Committee

The current members of our compensation committee are Messrs. Nord and Press. Mr. Press is the chairman of our compensation committee. The principal duties and responsibilities of our compensation committee are as follows:

- approving the non-equity-based compensation of our officers, directors and employees;
- administering our non-equity-based compensation plans; and
- making recommendations to DSB Parent for the equity-based compensation of DSB Parent and its subsidiaries' officers, directors and employees.

Nominating and Governance Committee

The current members of our nominating and governance committee are Messrs. Christie, Press and Rash. Mr. Press is the chairman of our nominating and governance committee. The principal duties and responsibilities of our nominating and governance committee are as follows:

- to assist the Board in identifying individuals qualified to serve as members of the Board and/or its committees; and
- other duties and responsibilities that our Board may delegate to the nominating and governance committee.

Compliance Committee

The current members of our compliance committee are Messrs. Levin, Morissette, Wolford and Rash. Mr. Wolford is the chairman of our compliance committee. The compliance committee is responsible for overseeing our legal and regulatory compliance program, including certain healthcare and regulatory compliance matters that affect us and our business operations.

Quality Committee

The current members of our quality committee are Messrs. Brownstein, Carpenter, David, Haley and Ms. McMullan. Mr. Carpenter is the chairman of our quality committee. The quality committee is responsible for monitoring and evaluating the adequacy and effectiveness of our quality of care and patient safety programs and initiatives.

Executive Committee

The current members of our executive committee are Messrs. David, Nord and Press. Mr. Nord is the chairman of our executive committee. The principal duties and responsibilities of our executive committee are as follows:

- to advise and counsel the Chief Executive Officer regarding company matters; and
- to take such actions as are necessary due to their urgent or highly confidential nature, or where convening the Board is impracticable, subject to certain limitations.

Item 11. ***Executive Compensation.***

The information that would be required to be disclosed under Part III, Item 11 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

The information that would be required to be disclosed under Part III, Item 12 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

For a discussion of certain relationships and related party transactions, refer to the notes to our accompanying consolidated financial statements included elsewhere in this Report and disclosure regarding our relationships and related party transactions contained in the Offering Memorandum dated February 11, 2020 for the 4.375% Secured Notes.

Equity Repurchases

Since the closing of the LifePoint/RCCH Merger, through December 31, 2019, DSB Parent has repurchased 3,750,184 profit units and 380,000 capital units from various former employees of LifePoint. Repurchases completed in 2019 are reflected as "Distributions to parent" in our accompanying consolidated statements of cash flows for the year ended December 31, 2019 included elsewhere in this Report. The aggregate amount of repurchases not completed prior to the end of 2019 is included under the caption "Accrued salaries" in our accompanying consolidated balance sheet as of December 31, 2019 included elsewhere in this Report. Repurchases are ongoing in the first quarter of 2020 and are anticipated to continue to occur from time to time.

Item 14. ***Principal Accounting Fees and Services*****.**

The Audit Committee has appointed Ernst & Young LLP as our independent registered public accounting firm. Services provided to us by Ernst & Young LLP in fiscal 2018 are described below.

Audit Fees. The aggregate audit fees billed by Ernst & Young LLP for professional services rendered for the audit of our annual consolidated financial statements and services that are normally provided by the independent registered public accounting firm in connection with statutory and regulatory filings totaled approximately $4.3 million for 2019 and approximately $6.0 million for 2018.

Audit-Related Fees. The aggregate fees billed by Ernst & Young LLP for assurance and related services other than those described under "Audit Fees" were approximately $2.4 million for 2019 and $0.2 million for 2018.

Tax Fees. The aggregate fees billed by Ernst & Young LLP for professional services rendered for tax compliance, tax advice and tax planning were approximately $0.3 million for both 2019 and 2018.

All Other Fees. There were no fees billed by Ernst & Young LLP for products or services other than those described above in 2019 or 2018.

PART IV

Item 15. ***Exhibits, Financial Statement Schedules.***

(a) The following documents are filed as part of this Report:

1. *Consolidated Financial Statements*:

2. *Financial Statement Schedule*: All schedules for which provision is made in the applicable accounting regulations of the SEC are omitted because they either are not required under the related instructions, are inapplicable, or the required information is shown in the consolidated financial statements or notes thereto.

3. *Exhibits*: The exhibits required by Item 601 of Regulation S-K that would be disclosed under Part IV, Item 15 of an annual report on Form 10-K filed with the SEC have been omitted as permitted pursuant to Section 4.02(a) of the Indentures.

Ernst & Young LLP
222 2nd Avenue South
Suite 2100
Nashville, TN 37201

Tel: (615) 252 2000
Fax: (615) 242-9128
ey.com

Building a better working world

Report of Independent Auditors

Board of Directors and Shareholders of
LifePoint Health, Inc.

We have audited the accompanying consolidated financial statements of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.), which comprise the consolidated balance sheets as of December 31, 2019 and 2018, and the related consolidated statements of operations, comprehensive loss, equity and cash flows for each of the three years in the period ended December 31, 2019, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.) at December 31, 2019 and 2018, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2019 in conformity with U.S. generally accepted accounting principles.

March 12, 2020

LifePoint Health, Inc.

Consolidated Statements of Operations
For the Years Ended December 31, 2019, 2018 and 2017
(In millions)

	2019	2018	2017
Revenues	$ 8,752.8	$ 2,778.1	$ 1,872.8
Salaries and benefits	4,044.0	1,329.4	874.3
Supplies	1,471.7	484.5	323.2
Other operating expenses, net	2,140.6	709.2	469.4
Depreciation and amortization	378.7	129.0	80.6
Interest expense, net	577.6	186.1	126.1
Merger, acquisition and other transaction-related costs	76.9	141.5	7.8
Impairments of goodwill and long-lived assets	3.3	78.4	14.1
Other non-operating losses, net	5.5	7.8	16.7
	8,698.3	3,065.9	1,912.2
Income (loss) before income taxes	54.5	(287.8)	(39.4)
Provision for (benefit from) income taxes	77.9	0.2	(1.3)
Net loss	(23.4)	(288.0)	(38.1)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(19.3)	(5.7)	(7.3)
Net loss attributable to LifePoint Health, Inc.	$ (42.7)	$ (293.7)	$ (45.4)

LifePoint Health, Inc.

Consolidated Statements of Comprehensive Loss
For the Years Ended December 31, 2019, 2018 and 2017
(In millions)

	2019	2018	2017
Net loss	$ (23.4)	$ (288.0)	$ (38.1)
Other comprehensive (loss) income:			
Unrealized losses on changes in funded status of pension benefit obligations	(4.4)	(3.1)	-
Other	-	-	0.3
Other comprehensive (loss) income	(4.4)	(3.1)	0.3
Comprehensive loss	(27.8)	(291.1)	(37.8)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(19.3)	(5.7)	(7.3)
Comprehensive loss attributable to LifePoint Health, Inc.	$ (47.1)	$ (296.8)	$ (45.1)

LifePoint Health, Inc.

Consolidated Balance Sheets
As of December 31, 2019 and 2018
(In millions, except for share and per share amounts)

	2019	2018
ASSETS		
Current assets:		
Cash and cash equivalents	$ 748.1	$ 58.9
Accounts receivable	1,167.9	1,108.9
Inventories	225.9	224.4
Prepaid expenses	92.7	92.7
Other current assets	172.2	227.8
	2,406.8	1,712.7
Property and equipment:		
Land	236.1	265.7
Buildings and improvements	2,709.9	2,784.5
Equipment	1,383.6	1,079.2
Construction in progress	148.6	436.5
	4,478.2	4,565.9
Accumulated depreciation	(618.8)	(248.8)
	3,859.4	4,317.1
Intangible assets, net	73.5	74.5
Other long-term assets	380.0	319.8
Goodwill	2,961.2	2,567.6
Total assets	$ 9,680.9	$ 8,991.7
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 340.6	$ 318.3
Accrued salaries	319.3	343.5
Other current liabilities	446.0	422.2
Current maturities of long-term debt	69.9	58.4
	1,175.8	1,142.4
Long-term debt, net	7,106.2	6,419.4
Long-term portion of reserves for self-insurance claims	196.5	194.0
Other long-term liabilities	164.9	146.5
Total liabilities	8,643.4	7,902.3
Redeemable noncontrolling interests	147.8	136.1
Equity:		
LifePoint Health, Inc. stockholders' equity:		
Common stock, $0.01 par value; 30,000 shares authorized; 100 shares issued and outstanding at December 31, 2019 and 2018	-	-
Capital in excess of par value	1,295.8	1,308.3
Accumulated other comprehensive loss	(7.5)	(3.1)
Accumulated deficit	(424.5)	(381.8)
Total LifePoint Health, Inc. equity	863.8	923.4
Noncontrolling interests	25.9	29.9
Total equity	889.7	953.3
Total liabilities and equity	$ 9,680.9	$ 8,991.7

LifePoint Health, Inc.

Consolidated Statements of Cash Flows
For the Years Ended December 31, 2019, 2018 and 2017
(In millions)

	2019	2018	2017
Cash flows from operating activities:			
Net loss	$ (23.4)	$ (288.0)	$ (38.1)
Adjustments to reconcile net loss to net cash provided by (used in) operating activities:			
Depreciation and amortization	378.7	129.0	80.6
Other non-cash amortization	39.5	9.9	5.8
Non-cash interest expense	27.1	5.8	-
Stock-based compensation	4.8	7.0	0.7
Impairments of goodwill and long-lived assets	3.3	78.4	14.1
Other non-operating losses, net	5.5	7.8	16.7
Deferred income taxes	2.2	(0.6)	(1.7)
Reserve for self-insurance claims, net of payments	(5.4)	2.3	(3.2)
Changes in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:			
Accounts receivable	(57.4)	(48.1)	17.8
Inventories, prepaid expenses and other current assets	(36.7)	(0.2)	(15.5)
Accounts payable, accrued salaries and other current liabilities	(53.6)	(9.6)	37.7
Income taxes payable/receivable	134.2	53.0	(2.9)
Other	(5.2)	(19.7)	(6.4)
Net cash provided by (used in) operating activities	413.6	(73.0)	105.6
Cash flows from investing activities:			
Acquisitions, net of cash acquired	(4.4)	(5,345.9)	(112.9)
Purchases of property and equipment	(336.7)	(319.7)	(145.1)
Proceeds from sales of hospitals and other ancillary businesses	6.4	-	93.5
Other	24.6	19.9	13.4
Net cash used in investing activities	(310.1)	(5,645.7)	(151.1)
Cash flows from financing activities:			
Proceeds from borrowings	-	5,125.0	37.6
Payments of borrowings	(28.3)	(189.3)	(1.7)
Net change in ABL Facility and Prior ABL Facility	(20.0)	10.0	10.0
Proceeds from lease financing	700.0	38.0	100.5
Repayment of MPT lease obligation in connection with hospital sale	-	-	(64.3)
Payments of debt financing costs	(18.1)	(207.0)	(0.9)
Cash (distributed to) contributed by parent	(10.9)	1,000.0	(37.6)
Distributions and other cash transactions associated with noncontrolling interests and redeemable noncontrolling interests	(18.0)	(6.0)	(3.9)
Capital and financing lease payments and other	(19.0)	(10.0)	(7.7)
Net cash provided by financing activities	585.7	5,760.7	32.0
Change in cash and cash equivalents	689.2	42.0	(13.5)
Cash and cash equivalents at beginning of period	58.9	16.9	30.4
Cash and cash equivalents at end of period	$ 748.1	$ 58.9	$ 16.9
Supplemental disclosure of cash flow information:			
Interest payments	$ 515.8	$ 138.1	$ 127.3
Capitalized interest	$ 11.1	$ 17.4	$ 6.1
Property and equipment acquired under capital and financing leases	$ 22.4	$ 3.1	$ 1.6
Income tax (refunds) payments, net	$ (58.5)	$ (53.7)	$ 0.8

LifePoint Health, Inc.

Consolidated Statements of Equity
For the Years Ended December 31, 2019, 2018 and 2017
(Dollars in millions)

	Common Stock		Capital in Excess of	Accumulated Other Comprehensive	Accumulated	Noncontrolling	
	Shares	Amount	Par Value	Income (Loss)	Deficit	Interests	Total
Balance at January 1, 2017	100	$ -	$ 348.1	$ (0.3)	$ (42.7)	$ -	$ 305.1
Net loss	-	-	-	-	(45.4)	-	(45.4)
Other comprehensive income	-	-	-	0.3	-	-	0.3
Stock-based compensation	-	-	0.7	-	-	-	0.7
Capital distribution to parent	-	-	(37.6)	-	-	-	(37.6)
Fair value adjustments related to redeemable noncontrolling interests	-	-	(3.1)	-	-	-	(3.1)
Balance at December 31, 2017	100	-	308.1	-	(88.1)	-	220.0
Net (loss) income	-	-	-	-	(293.7)	0.2	(293.5)
Other comprehensive loss	-	-	-	(3.1)	-	-	(3.1)
Stock-based compensation	-	-	7.0	-	-	-	7.0
Reclassification of vested stock-based compensation units to a liability	-	-	(6.8)	-	-	-	(6.8)
Capital contribution from parent	-	-	1,000.0	-	-	-	1,000.0
Noncontrolling interests assumed in LifePoint/RCCH Merger	-	-	-	-	-	29.9	29.9
Distributions to noncontrolling interests	-	-	-	-	-	(0.2)	(0.2)
Balance at December 31, 2018	100	-	1,308.3	(3.1)	(381.8)	29.9	953.3
Net (loss) income	-	-	-	-	(42.7)	4.4	(38.3)
Other comprehensive loss	-	-	-	(4.4)	-	-	(4.4)
Stock-based compensation	-	-	4.8	-	-	-	4.8
Reclassification of vested stock-based compensation units to a liability	-	-	(2.9)	-	-	-	(2.9)
Distributions to parent	-	-	(3.2)	-	-	-	(3.2)
Fair value adjustments related to redeemable noncontrolling interests	-	-	(11.2)	-	-	-	(11.2)
Finalization of accounting for the LifePoint/RCCH Merger	-	-	-	-	-	(0.2)	(0.2)
Distributions to noncontrolling interests	-	-	-	-	-	(8.2)	(8.2)
Balance at December 31, 2019	100	$ -	$ 1,295.8	$ (7.5)	$ (424.5)	$ 25.9	$ 889.7

Note 1. Organization and Summary of Significant Accounting Policies

Organization

LifePoint Health, Inc., a Delaware corporation, acting through its subsidiaries, owns or leases and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. At December 31, 2019, on a consolidated basis, LifePoint Health, Inc. operated 88 hospital campuses in 29 states throughout the United States ("U.S.").

Unless otherwise indicated or the context otherwise requires, references throughout these notes to the consolidated financial statements to the "Company" or "LifePoint" refer to LifePoint Health, Inc., and each of its consolidated subsidiaries after giving effect to the LifePoint/RCCH Merger (defined below) and (ii) "RCCH" refer to RegionalCare Hospital Partners Holdings, Inc. and each of its consolidated subsidiaries before giving effect to the LifePoint/RCCH Merger. References in this Report to the "Sponsor" refer to certain funds that are affiliates of the Company (the "Apollo Funds") that are ultimately controlled and/or managed by Apollo Management VIII, L.P. ("Apollo Management" and, when acting on behalf of the Apollo Funds, "Apollo"), which is an affiliate of Apollo Global Management LLC.

Additionally, references throughout these notes to the consolidated financial statements to the "LifePoint/RCCH Merger" refer to the merger, which was effective on November 16, 2018, of Legend Merger Sub, Inc., a Delaware corporation and wholly owned subsidiary of RCCH ("Legend Merger Sub"), with and into LifePoint Health, Inc., a Delaware corporation ("Legacy LifePoint"), with Legacy LifePoint surviving the LifePoint/RCCH Merger as a subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners, Inc." to "LifePoint Health, Inc."

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through majority voting control, and variable interest entities which the Company controls. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation. Noncontrolling interests in non-wholly-owned consolidated subsidiaries of the Company are presented as noncontrolling interests and redeemable noncontrolling interests and distinguish between the interests of the Company and the interests of the noncontrolling owners. Net income attributable to noncontrolling interests and redeemable noncontrolling interests represents the amounts attributable to the noncontrolling interests for each of the applicable periods presented. Investments in entities the Company does not control but does have a substantial ownership interest and can exercise significant influence are accounted for using the equity method.

The Company's financial statements have been presented on the basis of push down accounting in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") No. 805-50-S99. Under the push down basis of accounting, certain transactions incurred by the parent company which would otherwise be accounted for in the accounts of the parent are "pushed down" and recorded on the financial statements of the subsidiary. Accordingly, certain items resulting from the acquisition by Apollo have been recorded on the financial statements of the Company.

Use of Estimates

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

Revenue Recognition and Accounts Receivable

Overview

The Company recognizes revenues in the period in which performance obligations are satisfied. Generally, the Company bills patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. Amounts the Company receives for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in the Company's financial statements are recorded at the net consideration to which the Company expects to be entitled to receive in exchange for providing patient care.

The majority of the Company's performance obligations are satisfied over time for the delivery of patient care in both outpatient and inpatient settings. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected charges for services anticipated to be provided. The Company believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the remaining services needed to satisfy the obligation. Generally, unsatisfied or partially unsatisfied performance obligations at the end of the reporting period are related to patients admitted to the Company's hospitals that have not yet been discharged. The performance obligations for these patients are typically satisfied when the patients are discharged, which generally occurs within a matter of days of admission. Patients are generally billed when discharged, though they may be billed on an interim basis for longer stays. Accordingly, because all of the Company's performance obligations are part of a contract that is expected to have a duration of one year or less, the Company has elected to apply the exemption provided by ASC 606, "Revenue from Contracts with Customers" ("ASC 606") to not disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied as of period end.

Subsequent adjustments that are determined to be the result of an adverse change in the patient's or the payer's ability to pay are recognized as bad debt expense. With the adoption of ASC 606, bad debt expense is included under the caption "Other operating expenses, net" in the accompanying consolidated statements of operations, instead of separately as a deduction to arrive at revenue. Bad debt expense for the years ended December 31, 2019, 2018 and 2017 was not material for the Company.

Change in Accounting Estimate

During the year ended December 31, 2018, the Company recorded a decrease to revenues of $17.0 million as a result of a change in its accounting estimate of the collectability of accounts receivable. During the year ended December 31, 2018, the Company identified additional information which indicated that its current collection estimates might be different from its historical collection estimates. Management utilized this new information to further refine its estimation procedures to more precisely estimate the collectability of accounts receivable. The Company's change in its estimation procedures of the collectability of its accounts receivable is considered a change in accounting estimate in accordance with ASC 250, "Accounting Changes and Error Corrections."

Contractual Discounts

The Company derives a significant portion of its revenues from Medicare, Medicaid and other payers that receive discounts from the Company's established billing rates. The Company must estimate the total amount of these discounts to prepare its financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Company estimates contractual discounts on a payer-specific basis given its interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Subsequent changes in estimates for contractual discounts are reflected as an adjustment to revenues in the period of the change. Medicare, Medicaid and other discounted payer accounts receivables are written off after they have been final settled with the payer.

Cost Report Settlements

Cost report settlements under reimbursement agreements with Medicare, Medicaid and certain other payers for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the payment terms of the reimbursement agreement with the payer, correspondence from the payer, and the Company's historical experience. Estimated settlements are adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. For the years ended December 31, 2019, 2018 and 2017, the net adjustments to estimated cost report settlements and other government reimbursements resulted in an increase to revenues of $17.2 million, a decrease to revenues of $4.0 million, and an increase to revenues of $3.6 million, respectively.

The net cost report settlements due from the Company at December 31, 2019 and 2018 were $6.6 million and $0.5 million, respectively. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs consistent with the constraints that are required by ASC 606.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. The Company evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. The Company estimates the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that the Company utilizes include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that the Company expects to collect. Because the Company provides care to patients regardless of their ability to pay, the Company has determined that the differences between the amounts it bills based on gross or discounted charges and the amounts the Company expects to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and the Company accounts for this variable consideration in accordance with the provisions of ASC 606. Self-pay accounts receivable are written off after collection efforts have been followed in accordance with the Company's policies.

Charity Care

The Company provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the years ended December 31, 2019, 2018 and 2017, the Company estimates that its costs of care provided under its charity care programs approximated $34.1 million, $16.8 million and $11.7 million, respectively. The Company does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Company's policy not to pursue collection of amounts related to these patients, and therefore contracts with these patients do not exist.

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

Financing Component

The Company has elected to apply the practical expedient permitted under ASC 606 and does not adjust the estimated amount of consideration from patients and third-party payers for the effects of a significant financing component due to the Company's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payer pays for that service will be one year or less.

Rental Income

The Company leases certain real estate assets it owns to unrelated third parties, primarily medical office buildings to non-employed physicians. The Company recognizes rental income for these operating lease arrangements in which the Company is the lessor on a straight-line basis over the lease term in accordance with ASC 840, "Leases" ("ASC 840").

Concentration of Revenues

The Company's revenues by payer and approximate percentages of revenues were as follows for the years ended December 31, 2019, 2018 and 2017 (dollars in millions):

	2019		2018		2017	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,338.1	38.1 %	$ 1,105.3	39.8 %	$ 760.6	40.6 %
Medicaid	1,495.3	17.1	486.3	17.5	346.2	18.5
HMOs, PPOs and other private insurers	3,698.6	42.3	1,113.8	40.1	723.8	38.7
Self-pay	59.2	0.7	17.2	0.6	11.4	0.6
Other	143.6	1.6	49.4	1.8	26.7	1.4
Revenue from contracts with customers	8,734.8	99.8	2,772.0	99.8	1,868.7	99.8
Rental income	18.0	0.2	6.1	0.2	4.1	0.2
Revenues	$ 8,752.8	100.0 %	$ 2,778.1	100.0 %	$ 1,872.8	100.0 %

During the years ended December 31, 2019, 2018 and 2017, approximately 55.2%, 57.3% and 59.1%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs, collectively. The Company's management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies.

Any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs could have an adverse effect on the Company's revenues or results of operations. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payer or geographic area that would subject the Company to any significant credit risks in the collection of its accounts receivable.

The Company's revenues by primary service type and approximate percentages of revenues were as follows for the years ended December 31, 2019, 2018 and 2017 (dollars in millions):

	2019		2018		2017	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Inpatient services	$ 3,524.0	40.3 %	$ 1,188.3	42.8 %	$ 828.9	44.3 %
Outpatient services	5,067.2	57.9	1,534.3	55.2	1,013.1	54.1
Non-patient (a)	161.6	1.8	55.5	2.0	30.8	1.6
Revenues	$ 8,752.8	100.0 %	$ 2,778.1	100.0 %	$ 1,872.8	100.0 %

(a) Represents revenues from ancillary goods, services and rental income.

General and Administrative Costs

The majority of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as "general and administrative" by the Company would include its corporate overhead costs, excluding depreciation and amortization and merger, acquisition and other transaction-related costs, which were $179.5 million, $72.4 million and $42.8 million for the years ended December 31, 2019, 2018 and 2017, respectively.

Cash and Cash Equivalents

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

Inventories

Inventories of supplies are stated at the lower of cost (first-in, first-out) or market and consist of purchased items. Inventories acquired in connection with business combinations are recorded at fair value which approximates replacement cost. Inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

Investments

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, under the equity method of accounting in accordance with ASC 323, "Investments – Equity Method and Joint Ventures" ("ASC 323"). The Company does not consolidate its equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period. Refer to Note 9 for further discussion of the Company's equity method investments.

Property and Equipment

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

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

	Years		
Buildings and improvements (including those under capital leases and financing obligations)	3	-	40
Equipment	2	-	15
Equipment under capital leases	3	-	6

Depreciation expense (including capital and financing lease amortization) totaled $376.9 million, $128.5 million and $80.1 million for the years ended December 31, 2019, 2018 and 2017, respectively.

Whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

For the year ended December 31, 2018, the Company recognized an impairment charge of $24.5 million to reduce the carrying amounts of certain long-lived assets at one of its facilities to their estimated fair values, which is included under the caption "Impairments of goodwill and long-lived assets" in the accompanying consolidated statements of operations for the year ended December 31, 2018. There were no long-lived asset impairments recorded for the year ended December 31, 2019 or 2017.

Goodwill and Intangible Assets

The Company accounts for its acquisitions in accordance with ASC 805 using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350, Intangibles – Goodwill and Other ("ASC 350"), goodwill and intangible assets with indefinite lives are reviewed by the Company annually for impairment on October 1. Prior to the LifePoint/RCCH Merger, the Company historically determined that each of its hospitals represented a reporting unit in accordance with ASC 280, "Segment Reporting" ("ASC 280") and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that the consolidated business comprises a single reporting unit for goodwill impairment testing purposes. For the annual impairment evaluation, the Company determines fair value using a discounted cash flow ("DCF") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates, profitability and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing the Company's assumptions. The cash flows employed in the DCF analysis are based on the Company's most recent financial budgets and business plans and, when applicable, various growth rates and profitability for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the reporting unit.

The Company's intangible assets relate to contract-based physician minimum revenue guarantees; non-competition agreements; certificates of need and certificates of need exemptions; and licenses, provider numbers, accreditations and other. Contract-based physician minimum revenue guarantees and non-competition agreements are amortized over the terms of the agreements. The certificates of need, certificates of need exemptions, licenses, provider numbers, accreditations and other have been determined to have indefinite lives and, accordingly, are not amortized. Refer to Note 5 for further discussion of the Company's goodwill and intangible assets.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the income tax provision in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is not likely, a valuation allowance is established. The establishment or increase in a valuation allowance is included as an expense within the provision for income taxes in the consolidated statements of operations. The Company classifies interest and penalties related to its tax positions as a component of income tax expense. Refer to Note 6 for further discussion of the Company's accounting for income taxes.

Reserves for Self-Insurance Claims

Given the nature of the Company's operating environment, it is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("SIR") and deductible levels. At December 31, 2019, the Company's SIR for professional liability claims is $5.0 million per claim, with a $5.0 million inner aggregate, at the majority of its facilities. Additionally, the Company participates in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2019, the Company's deductible for workers' compensation claims was $1.0 million per claim in all states in which it operates except for Montana, Oklahoma, Ohio, Washington and Wyoming. The Company participates in state-specific programs for its workers' compensation claims arising in these states. The Company's SIR and deductible levels are evaluated annually as a part of its insurance program's renewal process.

The Company's reserves for self-insurance and deductible claims reflect the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The Company's expense for self-insurance and deductible claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's self-insured retention and deductible levels; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance and deductible claims was approximately $75.6 million, $20.7 million and $7.7 million for the years ended December 31, 2019, 2018 and 2017, respectively.

The Company's reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. These reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. The Company's reserves for self-insured claims have been discounted to their present value using a discount rate of 1.9% at December 31, 2019, 1.8% at December 31, 2018 and in a range of 1.4% to 2.4% at December 31, 2017. The Company's management selects a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

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

The following table provides information regarding the classification of the Company's reserves for self-insured claims at December 31, 2019 and 2018 (in millions):

	2019	2018
Current portion	$ 64.5	$ 70.7
Long-term portion	196.5	194.0
	$ 261.0	$ 264.7

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2019 and 2018 (in millions):

	2019	2018
Reserve at the beginning of the period	$ 264.7	$ 65.0
Liabilities assumed in LifePoint/RCCH Merger	-	194.7
Increase for the provision of current year claims	69.2	23.0
Increase (decrease) for the provision of prior year claims	6.7	(3.9)
Payments related to current year claims	(5.2)	(1.0)
Payments related to prior year claims	(75.9)	(14.8)
Provision for the change in discount rate	(0.3)	1.6
Noncash change in reserve for claims in excess of self-insured retention levels	1.8	0.1
Reserve at the end of the period	$ 261.0	$ 264.7

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of the Company's quarterly and semi-annual actuarial calculations resulted in changes to its reserves for self-insured claims for prior years. As a result, the Company's related self-insured claims expense increased by $6.7 million for the year ended December 31, 2019 and decreased by $3.9 million and $12.1 million for the years ended December 31, 2018 and 2017, respectively.

Point of Life Indemnity, Ltd.

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

Self-Insured Medical Benefits

The Company is self-insured for substantially all of the medical expenses and benefits of its employees. The reserve for medical benefits primarily reflects the current estimate of incurred but not reported losses based upon an annual actuarial calculation as of the balance sheet date. The undiscounted reserve for self-insured medical benefits was $53.8 million and $46.1 million at December 31, 2019 and 2018, respectively, and is included in the Company's accompanying consolidated balance sheets under the caption "Other current liabilities".

Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to the Company. The Company's accompanying consolidated financial statements include all assets, liabilities, revenues, and expenses at their consolidated amounts, which include the amounts attributable to the Company and the noncontrolling interest. The Company recognizes as a separate component of earnings that portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company. Refer to Note 10 for further discussion of the Company's noncontrolling interests and redeemable noncontrolling interests.

Variable Interest Entities

The Company's consolidated financial statements at December 31, 2019 include eight facilities that qualify as a variable interest entity in which the Company is the primary beneficiary under the provisions of ASC 810, "Consolidation," and in which the Company owns a controlling economic interest.

Stock-Based Compensation

The Company's indirect parent, DSB Parent L.P., a Delaware limited partnership ("DSB Parent"), has issued profits units (the "Units") to certain employees, directors and consultants under the terms and conditions of the Amended and Restated Limited Partnership Agreement of DSB Parent dated of December 3, 2015 (the "DSB Parent Partnership Agreement") and forms of award agreements. The Company accounted for these stock-based awards in accordance with the provisions of ASC 718, "Compensation – Stock Compensation" ("ASC 718"). In accordance with ASC 718, the Company recognized compensation expense based on the estimated grant date fair value of each stock-based award. The Company recognizes forfeitures of Units as they occur. Refer to Note 13 for further discussion of the Company's accounting for the Units.

Defined Benefit Pension Plans

In connection with the LifePoint/RCCH Merger, the Company acquired certain assets and assumed certain liabilities associated with two separate defined benefit pension plans covering certain employees at two of Legacy LifePoint's facilities. The Company accounts for its defined benefit pension plans in accordance with ASC 715, "Compensation – Defined Benefit Plans", ("ASC 715"). In accordance with ASC 715, the Company recognizes the unfunded liability of its defined benefit pension plans in the Company's consolidated balance sheets and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the defined benefit pension plans' assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligations are measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality. Refer to Note 12 for further discussion of the Company's defined benefit pension plans.

Defined Contribution Plans

The Company maintains three separate defined contribution retirement plans covering a majority of the Company's employees, including Legacy LifePoint employees, RCCH employees and employees at Community Medical Center. These defined contribution retirement plans contain discretionary matching contribution formulas and definite non-elective contribution formulas for employees at certain facilities. Effective as of the end of the day on December 31, 2019, the plan covering RCCH employees was merged into the plan covering Legacy LifePoint employees. Refer to Note 12 for further discussion of the Company's defined contribution plans.

Reclassifications

Certain reclassifications have been made to the prior years to conform to current year presentation. These reclassifications had no effect on net loss or cash flows as previously reported.

Adoption of Recently Issued Accounting Standards

ASC 606, "Revenue from Contracts with Customers"

Effective January 1, 2019, the Company adopted the provisions of ASC 606, which supersedes most existing revenue recognition guidance, including industry-specific healthcare guidance, by applying the full retrospective method for all periods presented. ASC 606 provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

Step 1: Identify the contract(s) with a customer.
Step 2: Identify the performance obligations in the contract.
Step 3: Determine the transaction price.
Step 4: Allocate the transaction price to the performance obligations in the contract.
Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

The adoption of the provisions of ASC 606 had no impact on the Company's current or historical financial position, results of operations or cash flows. Additionally, management does not anticipate that the provisions of ASC 606 will have an impact on the amount or timing of when the Company recognizes revenue prospectively. However, in accordance with ASC 606, the Company now recognizes the majority of its previously reported provision for doubtful accounts, primarily related to its self-pay patient population, as a direct reduction to revenues as an implicit pricing concession, instead of separately as a discrete deduction to arrive at revenue, and the related presentation of the allowance for doubtful accounts has been eliminated for all periods presented.

Accounting Standard Not Yet Adopted - Accounting Standards Update ("ASU") 2016-02, "Leases" ("ASU 2016-2")

In February 2016, the FASB issued ASU 2016-2, along with subsequent amendments, updates and an extension of the effective date (collectively, the "New Lease Standard"). The New Lease Standard requires the rights and obligations arising from lease contracts, including existing and new arrangements, to be recognized as assets and liabilities on the balance sheet. The New Lease Standard is effective for annual reporting periods beginning after December 15, 2020. As permitted, the Company plans to adopt the New Lease Standard early effective January 1, 2020 by applying a modified retrospective approach with a cumulative effect of the retrospective application of the provisions as an adjustment through retained earnings and without any adjustments to the comparable prior period information. Additionally, the Company expects to apply a number of available practical expedients to facilitate the adoption of the New Lease Standard, including the package of practical expedients to not reassess whether a contract is or contains a lease, the lease classification and the initial direct costs.

In preparation for the adoption of the New Lease Standard, the Company has implemented a new information technology application as well as new processes, policies, procedures and controls. The Company continues to evaluate and refine its estimates of the anticipated impacts the New Lease Standard will have on its financial position, results of operations and financial disclosures.

Note 2. LifePoint/RCCH Merger

Summary

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

Equity Contribution

In connection with the LifePoint/RCCH Merger, the Apollo Funds, together with certain other co-investors investing through a co-investment vehicle controlled by our Sponsor or its affiliates, indirectly contributed $1,000.0 million of newly invested capital to DSB Parent, which is the Company's indirect parent and is owned by the Apollo Funds, such co-investment vehicle and certain current or former directors, members of management, employees and consultants of the Company, and the $1,000.0 million of newly invested capital was further contributed to the Company to be used to partially fund the LifePoint/RCCH Merger.

Financing Transactions

Concurrently with the closing of the LifePoint/RCCH Merger, the Company (1) issued $1,425.0 million principal amount of 9.750% Senior Notes due 2026 (the "9.75% Unsecured Notes"), (2) entered into a new senior secured asset-based revolving credit facility (the "ABL Facility") in an aggregate principal amount of $800.0 million with a maturity of five years, (3) terminated its existing senior secured asset-based revolving credit facility, entered into on April 29, 2016 (the "Prior ABL Facility"), (4) entered into a senior secured term loan credit facility (the "Term Loan Facility") in an aggregate principal amount of $3,550.0 million with a maturity of seven years, and (4) repaid in full its $150.0 million term loan facility, entered into on April 25, 2018 (the "Prior Term Facility").

The Company has accounted for the LifePoint/RCCH Merger in accordance with ASC 805 under the acquisition method of accounting. The following table summarizes the fair values of assets acquired and liabilities assumed in connection with the LifePoint/RCCH Merger (in millions):

Cash	$	139.8
Accounts receivable		778.8
Other current assets		473.4
Property and equipment		2,711.4
Goodwill		2,331.2
Intangible assets		66.8
Other long-term assets		261.7
Accounts payable		(185.3)
Accrued salaries		(407.8)
Other current liabilities		(260.2)
Capital and financing leases, including current maturities		(141.4)
Other long-term liabilities		(238.0)
Noncontrolling interests and redeemable noncontrolling interests		(100.8)
Net assets acquired	$	5,429.6

The results of operations of Legacy LifePoint are included in the Company's results of operations beginning on November 17, 2018. Revenues from the operations acquired in the LifePoint/RCCH Merger included in the Company's consolidated statements of operations were $754.9 million for the year ended December 31, 2018. Income before income taxes from the operations acquired in the LifePoint/RCCH Merger was $50.9 million for the year ended December 31, 2018.

For the years ended December 31, 2019 and 2018, the Company recognized merger and integration-related costs of $47.1 and $134.7 million, respectively, primarily related to legal and transaction advisory services as well as employee severance and retention and other integration-related expenses in connection with the LifePoint/RCCH Merger. Included in the 2018 merger-related costs is a $55.0 million transaction fee paid by the Company to an affiliate of its Sponsor upon the closing of the LifePoint/RCCH Merger.

Note 3. Acquisitions, Divestitures and Joint Ventures

Acquisitions

Lourdes Health ("Lourdes")

At the close of business on August 31, 2018, the Company acquired Lourdes for $21.3 million, of which $17.5 million was financed from a sale-leaseback transaction with an affiliate of Medical Properties Trust ("MPT"), a Maryland corporation operating as a real estate investment trust. Lourdes is comprised of a 95 bed medical center and a 32 bed counseling center each located in Pasco, Washington. The results of operations of Lourdes are included in the Company's results of operations beginning on September 1, 2018.

Trios Health ("Trios")

At the close of business on August 3, 2018, the Company acquired Trios for $18.0 million. Trios is comprised of two hospital campuses with a total of 111 beds each located in Kennewick, Washington. In connection with the Trios acquisition, the Company entered into a sale-leaseback arrangement for a hospital building whose rent is contingent on the financial performance of the hospital and a sale-leaseback arrangement for a medical office building. The results of operations of Trios are included in the Company's results of operations beginning on August 4, 2018.

Pacific Medical Data Solutions ("PMDS")

Effective April 1, 2018, the Company acquired PMDS for $10.7 million. PMDS is a healthcare technology and software services company that provides revenue cycle, billing automation and software solutions to multi-specialty physician groups, ambulatory surgery centers and urgent care clinics.

St. Joseph Regional Medical Center ("St. Joseph")

At the close of business on April 30, 2017, the Company acquired St. Joseph, a 145 bed hospital in Lewiston, Idaho, for $112.2 million, of which $87.5 million was financed from a sale-leaseback transaction with MPT. The results of operations of St. Joseph are included in the Company's results of operations beginning on May 1, 2017.

Divestitures

Teche Regional Medical Center ("Teche")

In August 2018, the Company entered into a proposed settlement agreement with The Hospital Service District No. 2 of the Parish of St. Mary ("HSD"), a political subdivision of the state of Louisiana, outlining the terms of a definitive settlement agreement to terminate the Company's lease of Teche, located in Morgan City, Louisiana, and transfer the operations of Teche to a new operator designated by the HSD. In connection with the transfer of the operations of Teche to the new operator, in June 2019, the Company entered into a definitive agreement to sell substantially all of the owned assets of Teche to the HSD's designated new operator. In July 2019, the Company entered into a definitive settlement agreement with the HSD pursuant to which, among other things, at the effective time of the transfer of the owned assets of Teche to the HSD's designated new operator, the Company's lease of Teche terminated, the Company surrendered the leased assets of Teche to the HSD in accordance with the terms of the existing lease agreement, and the Company transferred operation of Teche to the HSD's designated new operator. The settlement and sale transactions were completed effective October 1, 2019. Included in the Company's consolidated results of operations for the years ended December 31, 2019 and 2018 are net operating losses before income taxes attributable to Teche of $1.4 million and $0.6 million, respectively.

Sharon Hospital ("Sharon")

The Company sold Sharon, located in Sharon, Connecticut on August 1, 2017 for $3.6 million. The Company recorded a loss on sale of $2.8 million during the year ended December 31, 2017 as a result of the divestiture. Included in the Company's consolidated results of operations for the year ended December 31, 2017 is a net operating loss before income taxes attributable to Sharon of $2.1 million.

EaStar Health System ("EaStar")

On March 31, 2017, the Company sold EaStar, located in Muskogee, Oklahoma. The total sales price was $89.3 million, plus certain working capital items and sales taxes. Of the proceeds, $68.5 million were paid to MPT to pay off the financing lease obligation and the related prepayment penalty. The remainder of the proceeds of $20.8 million were paid directly to the Company's parent. Included in the Company's consolidated results of operations for the year ended December 31, 2017 is a net operating loss before income taxes attributable to EaStar of $8.9 million.

Joint Ventures

Emory Healthcare Joint Venture

Effective January 1, 2020, the Company formed a new joint venture with Emory Healthcare, Inc. ("Emory") to operate St. Francis Hospital ("St. Francis") located in Columbus, Georgia. The Company holds a controlling interest in St. Francis such that it will continue to be included in the Company's consolidated financial statements.

In-Home Healthcare Partnership

The Company maintains a joint venture with a wholly-owned subsidiary of LHC Group, Inc. ("LHC"), In-Home Healthcare Partnership ("IHHP"), the purpose of which is to own and operate the Company's home health agencies and hospices and certain of LHC's home health agencies and hospices, leveraging the combined expertise of the Company and LHC to enhance home health and hospice services in the communities served by the Company's hospitals. The Company accounts for its ownership interest in IHHP as an equity method investment in accordance with ASC 323.

During the year ended December 31, 2019, the Company expanded its partnership with LHC by transferring ownership and management of one of the Company's home health agencies and two of the Company's hospices to IHHP effective December 1, 2019. As a result, the Company has transferred assets primarily comprised of accounts receivable and allocated goodwill in exchange for cash, and recognized aggregate gains of approximately $1.1 million, which is included under the caption "Other non-operating losses, net" in the accompanying consolidated statements of operations for the year ended December 31, 2019.

Additionally, effective January 1, 2020, the Company transferred the ownership of one additional home health agency and one additional hospice to IHHP and subsequently sold a portion of its ownership interest in IHHP to LHC for cash proceeds of approximately $23.6 million.

Note 4. Long-Term Debt

The Company's long-term debt, including current portions and capital and financing leases, consists of the following at December 31, 2019 and 2018 (in millions):

	2019	2018
Senior borrowings:		
ABL Facility	$ -	$ 20.0
Term Loan Facility	3,523.4	3,550.0
9.75% Unsecured Notes	1,425.0	1,425.0
8.25% Secured Notes	800.0	800.0
11.5% Unsecured Notes	350.0	350.0
Capital and financing lease obligations	1,267.9	557.2
Unamortized debt issuance costs	(191.8)	(227.4)
	7,174.5	6,474.8
Subordinated borrowings, net	1.6	3.0
Total debt	$ 7,176.1	$ 6,477.8

Maturities of the Company's long-term debt outstanding at December 31, 2019, including capital and financing leases, but excluding unamortized debt issuance costs and other obligations that do not require eventual settlement in cash, are as follows for the years indicated (in millions):

2020	$ 69.9
2021	61.3
2022	125.2
2023	854.4
2024	404.5
Thereafter	5,682.0
	$ 7,197.3

ABL Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Company and Legend Merger Sub (together, prior to the effective time of the LifePoint/RCCH Merger, the "Co-Borrowers") entered into the ABL Facility in an aggregate principal amount of $800.0 million and terminated its Prior ABL Facility. The ABL Facility has a maturity of five years; provided that if more than $200.0 million aggregate principal amount of the 8.25% Secured Notes remain outstanding 91 days before the stated maturity thereof (the "ABL Springing Maturity Date"), then the ABL Facility will mature and the commitments under the ABL Facility will terminate on the ABL Springing Maturity Date. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint assumed all of the rights and obligations of Legend Merger Sub under the ABL Facility. The ABL Facility also includes both a letter of credit sub-facility and a swingline loan sub-facility (including in its capacity as co-borrower under the Term Loan Facility). In addition, the Company may request one or more incremental revolving commitments in an aggregate principal amount up to the greater of (x) the greater of (i) $255.0 million and (ii) 0.23 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, and (y) the amount by which the borrowing base exceeds the aggregate commitments under the ABL Facility, subject to certain conditions and receipt of commitments by existing or additional lenders.

As of December 31, 2019, the Company had no borrowings outstanding under the ABL Facility and approximately $44.1 million in letters of credit outstanding primarily related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements. Amounts available for borrowing under the ABL Facility were approximately $547.3 million as of December 31, 2019.

Collateral and Guarantors

All obligations under the ABL Facility are unconditionally guaranteed by DSB Acquisition, LLC, a Delaware limited liability company ("Holdings"), on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Co-Borrowers, subject to certain exceptions.

The obligations under the ABL Facility are secured by a pledge of the capital stock of the Co-Borrowers and substantially all of their assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy LifePoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the ABL Priority Collateral and a second-priority lien with respect to the Non-ABL Priority Collateral. Additionally, certain of the Company's restricted subsidiaries that are not guarantors will pledge certain of their assets (the "Credit Support Party Collateral") on a first-priority basis, as further security of the obligations under the ABL Facility. The Credit Support Party Collateral will secure only the obligations under the ABL Facility.

All borrowings under the ABL Facility are subject to the satisfaction of customary conditions, including the absence of a default and the accuracy of representations and warranties.

Interest Rates and Fees

Borrowings under the ABL Facility will bear interest at a rate equal to, at the Company's option, either (a) a LIBOR rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an initial applicable margin of 1.75% for LIBOR loans and 0.75% for base rate loans. The applicable margin for borrowings will be subject to step-downs based on average availability thresholds.

In addition to paying interest on outstanding principal under the ABL Facility, the Co-Borrowers will be required to pay a commitment fee under the ABL Facility in respect of the unutilized commitments under the ABL Facility at an initial rate equal to 0.375% per annum. The commitment fee may be subject to one step-down based on the average daily utilization under the ABL Facility. The Co-Borrowers will also be required to pay customary agency fees as well as letter of credit participation fees.

Restrictive Covenants and Other Matters

The ABL Facility contains certain customary affirmative covenants and events of default. The negative covenants in the ABL Facility include, among other things, limitations (none of which are absolute) on the Co-Borrowers and their subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates, enter into sale-leaseback transactions, change their lines of business, restrict dividends from their subsidiaries or restrict liens, change their fiscal year; and modify the terms of certain debt.

The ABL Facility requires that the Co-Borrowers and its restricted subsidiaries maintain a minimum fixed charge coverage ratio at any time when availability is less than an agreed amount.

The ABL Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the ABL Facility are entitled to take various actions, including the acceleration of amounts due under the ABL Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the ABL Facility.

Term Loan Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, Co-Borrowers entered into the Term Loan Facility with an original aggregate principal amount of $3,550.0 million and repaid in full its Prior Term Facility. The Term Loan Facility has a maturity of seven years; provided that if more than $150.0 million aggregate principal amount of the 11.5% Unsecured Notes remain outstanding 91 days before the stated maturity thereof (the "Term Springing Maturity Date"), then the Term Loan Facility will mature and the commitments under the Term Loan Facility will terminate on the Term Springing Maturity Date. At the Effective Time, Legacy LifePoint assumed all of the rights and obligations of Merger Sub under the Term Loan Facility (including in its capacity as a Co-Borrower under the Term Loan Facility). In addition, the Company may request one or more incremental commitments in an aggregate principal amount up to the sum of (x) the greater of (i) $800.0 million and (ii) 0.75 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, plus additional amounts subject to certain agreed leverage requirements, certain other conditions and receipt of commitments by existing or additional lenders.

The Term Loan Facility required scheduled quarterly amortization payments on the term loans in an annual amount equal to 1.0% of the original principal amount of the term loans, with the balance to be paid at maturity. After giving effect to the refinancing activities further described in Note 15, there are no more quarterly amortization payments required on the Term Loan Facility prior to maturity.

Collateral and Guarantors

All obligations under the Term Loan Facility are unconditionally guaranteed by Holdings on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Co-Borrowers, subject to certain exceptions.

The obligations under the Term Loan Facility are secured by a pledge of the capital stock of the Company and substantially all of its assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy LifePoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the "Non-ABL Priority Collateral" (which generally includes most inventory and fixed assets, equity interests and intellectual property of the Co-Borrowers and the subsidiary guarantors) and a second-priority lien with respect to the "ABL Priority Collateral" (which generally includes most accounts receivable and certain related assets of the Co-Borrowers and the subsidiary guarantors).

Interest Rates

Borrowings under the Term Loan Facility bore interest at a rate equal to, at the Company's option, either (a) a LIBOR rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an applicable margin of 4.50% for LIBOR loans and 3.50% for base rate loans. In connection with a repricing of the Term Loan Facility on January 21, 2020 as further described in Note 15, the applicable margins were reduced to 3.75% for LIBOR loans and 2.75% for base rate loans.

Restrictive Covenants and Other Matters

The Term Loan Facility contains certain customary affirmative covenants and events of default. The negative covenants in the Term Loan Facility include, among other things, limitations (none of which are absolute) on the Co-Borrowers and their subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates enter into sale-leaseback transactions, change their lines of business, restrict dividends from subsidiaries or restrict liens, change their fiscal year and modify the terms of certain debt or organizational agreements.

The Term Loan Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the Term Loan Facility are entitled to take various actions, including the acceleration of amounts due under the Term Loan Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the Term Loan Facility.

Refer to Note 15 for further discussion of refinancing activities occurring subsequent to December 31, 2019 and the related impact to the Term Loan Facility.

9.75% Unsecured Notes

On November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Company issued $1,425.0 million aggregate principal amount of the 9.75% Unsecured Notes. The 9.75% Unsecured Notes will mature on December 1, 2026. Interest on the 9.75% Unsecured Notes will accrue at 9.750% per annum and will be paid semi-annually, in arrears, on June 1 and December 1 of each year, beginning June 1, 2019.

Prior to December 1, 2021, the Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 9.75% Unsecured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. Additionally, prior to December 1, 2021, the Company may redeem in the aggregate up to 40% of the aggregate principal amount of the 9.75% Unsecured Notes in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 109.750%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 9.75% Unsecured Notes must remain outstanding after each such redemption. On or after December 1, 2021, the Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in indenture governing the 9.75% Unsecured Notes (the "9.75% Unsecured Notes Indenture").

The Company's obligations under the 9.75% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 9.75% Unsecured Notes and the related guarantees are unsecured obligations of the Issuers and the subsidiary guarantors.

The 9.75% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 9.75% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 9.75% Unsecured Notes Indenture also provides for customary events of default.

8.25% Secured Notes

On April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, the Company issued $800.0 million aggregate principal amount of 8.25% Secured Notes. The 8.25% Secured Notes are senior obligations of the Company which mature on May 1, 2023 and bear interest at a rate of 8.25% per annum, payable semiannually on May 1 and November 1 of each year.

On or after May 1, 2019, the Company may redeem the 8.25% Secured Notes at its option, in whole at any time or in part from time to time, at redemption prices set forth in the indenture governing the 8.25% Secured Notes.

The Company's obligations under the 8.25% Secured Notes are fully and unconditionally guaranteed, jointly and severally, by the Company's present and future direct and indirect wholly-owned material domestic subsidiaries that guarantee the Term Loan Facility. The 8.25% Secured Notes are secured by first priority security interests in the Non-ABL Priority Collateral and a second priority security interests in the ABL Priority Collateral.

The indenture governing the 8.25% Secured Notes contains restrictive covenants that are substantially the same as those in the 9.75% Unsecured Notes Indenture.

Refer to Note 15 for further discussion of refinancing activities occurring subsequent to December 31, 2019 and the related impact to the 8.25% Secured Notes.

11.5% Senior Unsecured Notes

Effective April 29, 2016, concurrently with the closing of the RegionalCare/Capella Merger, the Company issued $350.0 million aggregate principal amount of 11.5% Unsecured Notes in a private offering. The 11.5% Unsecured Notes mature on May 1, 2024 and bear interest at a rate of 11.5% per annum, payable semi-annually on May 1 and November 1 of each year.

On or after May 1, 2019, the Company may redeem the 11.5% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the indenture governing the 11.5% Unsecured Notes.

The Company's obligations under the 11.5% Unsecured Notes are fully and unconditionally guaranteed, jointly and severally, by the Company's present and future direct and indirect wholly-owned material domestic subsidiaries that guarantee the Term Loan Facility.

The indenture governing the 11.5% Unsecured Notes contains restrictive covenants that are substantially the same as those in the 9.75% Unsecured Notes Indenture.

Refer to Note 15 for further discussion of refinancing activities occurring subsequent to December 31, 2019 and the related impact to the 11.5% Unsecured Notes.

Capital and Financing Leases

Refer to Note 8 for further discussion of the Company's capital and financing leases.

Interest Rate Swap Agreement

On December 21, 2018, the Company entered into an interest rate swap agreement with Citibank, N.A. as counterparty (the "Interest Rate Swap") whereby the Company pays a fixed rate of 2.63% on a notional amount of $1,100.0 million and receives one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. Refer to Note 11 for additional information regarding the Company's accounting for its Interest Rate Swap.

Debt Transaction Costs

In connection with the issuance of the Term Loan Facility, the ABL Facility and the 9.75% Unsecured Notes, the Company capitalized $201.8 million of new debt issuance costs associated with these new debt instruments, which are included as a reduction to "Long-term debt, net" on the Company's accompanying consolidated balance sheet. During the year ended December 31, 2018, the Company wrote off $8.2 million of previously capitalized debt issuance costs in connection with the extinguishment of the Prior ABL Facility and Prior Term Facility, which is included under the caption "Other non-operating losses, net" in the accompanying consolidated statement of operations for the year ended December 31, 2018. For the year ended December 31, 2017, the Company recorded a loss on debt refinancing of $4.3 million, which is included under the caption "Other non-operating losses, net" in the accompanying consolidated statement of operations for the year ended December 31, 2017.

Note 5. Goodwill and Intangible Assets

Goodwill

The following table presents the changes in the carrying amount of goodwill for the years ended December 31, 2019 and 2018 (in millions):

Balance at January 1, 2018	$	651.5
Goodwill acquired in the LifePoint/RCCH Merger		1,950.1
Acquisitions		19.9
Impairments		(53.9)
Balance at December 31, 2018		2,567.6
Finalization of purchase price allocations for the LifePoint/RCCH Merger		381.1
Adjustments related to current and prior year acquisitions		17.0
Impairments		(3.3)
Write-off allocation related to IHHP transactions		(1.2)
Balance at December 31, 2019	$	2,961.2

Prior to the LifePoint/RCCH Merger, the Company historically determined that each of its hospitals represented a reporting unit in accordance with ASC 280 and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that the consolidated business comprises a single reporting unit for goodwill impairment testing purposes. In accordance with ASC 350, the Company evaluated goodwill for impairment in 2019 under both the prior and current reporting unit methodologies. Under the prior reporting unit methodology, for which each of the Company's hospitals represented a reporting unit, the Company performed a goodwill impairment test as of October 1, 2019 and recorded a non-cash impairment charge of $3.3 million for the year ended December 31, 2019 related to one of its facilities. Additionally, under the current methodology, for which the consolidated Company comprises a single reporting unit, the Company performed a goodwill impairment test as of October 1, 2019 which did not yield an impairment charge. For the year ended December 31, 2018, the Company recorded non-cash impairment charges in the aggregate of $53.9 million related to three of its facilities. For the year ended December 31, 2017, the Company recorded a non-cash impairment charge of $14.1 million related to one of its facilities.

Intangible Assets

The following table provides information regarding the Company's intangible assets included in the accompanying consolidated balance sheets as of December 31, 2019 and 2018 (in millions):

	2019	2018
Amortizable intangible assets:		
Contract-based physician minimum revenue guarantees		
Gross carrying amount	$ 34.7	$ 34.0
Accumulated amortization	(12.7)	(7.1)
Net total	22.0	26.9
Other amortizable intangible assets		
Gross carrying amount	13.8	4.5
Accumulated amortization	(3.6)	(0.5)
Net total	10.2	4.0
Total amortizable intangible assets		
Gross carrying amount	48.5	38.5
Accumulated amortization	(16.3)	(7.6)
Net total	32.2	30.9
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	29.3	31.0
Licenses, provider numbers, accreditations and other	12.0	12.6
Net total	41.3	43.6
Total intangible assets:		
Gross carrying amount	89.8	82.1
Accumulated amortization	(16.3)	(7.6)
Net total	$ 73.5	$ 74.5

Contract-Based Physician Minimum Revenue Guarantees

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or "physician minimum revenue guarantees," with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460, "Guarantees" ("ASC 460"). In accordance with ASC 460, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized as a component of other operating expenses, in the accompanying consolidated statements of operations, over the period of the physician contract, which typically ranges from four to five years. As of December 31, 2019 and 2018, the Company's liability for contract-based physician minimum revenue guarantees was $9.3 million and $12.6 million, respectively. These amounts are included as a current liability under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheets.

Other Amortizable Intangible Assets

The Company has entered into non-competition agreements with certain physicians and other individuals which are amortized on a straight-line basis over the term of the agreements. Additionally, in connection with the LifePoint/RCCH Merger, the Company recognized favorable leasehold interest intangible assets related to certain real property leases. The favorable leasehold interest represents the asset in excess of the approximate fair market value of the lease liabilities assumed as of the date of the LifePoint/RCCH Merger, which are amortized through rent expense on a straight-line basis over the remaining life of the leases.

Certificates of Need and Certificates of Need Exemptions

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and certain equipment at the Company's facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. The Company has acquired facilities in certain states that have adopted certificate of need laws. The Company has determined that these intangible assets have an indefinite useful life.

Licenses, Provider Numbers, Accreditations and Other

To operate hospitals, the Company must obtain certain licenses, provider numbers and accreditations from federal, state and other accrediting agencies. The Company has acquired facilities in certain jurisdictions that require licenses, provider numbers and accreditations. The Company has determined that these intangible assets have an indefinite useful life.

Amortization Expense

Amortization expense for the Company's intangible assets during the years ended December 31, 2019, 2018 and 2017 was $14.1 million, $4.7 million and $3.6 million, respectively.

Total estimated amortization expense for the Company's intangible assets during the next five years are as follows (in millions):

2020	$	11.3
2021		7.8
2022		4.7
2023		2.1
2024		1.0
Thereafter		5.3
	$	32.2

Note 6. Income Taxes

The provision for (benefit from) income taxes for the years ended December 31, 2019, 2018 and 2017 consisted of the following (in millions):

	2019	2018	2017
Current:			
Federal	$ 67.5	$ -	$ -
State	8.2	1.3	0.4
	75.7	1.3	0.4
Deferred:			
Federal	(80.6)	(27.1)	37.7
State	(19.9)	(10.0)	(4.4)
	(100.5)	(37.1)	33.3
Change in valuation allowance	102.7	36.0	(35.0)
Total	$ 77.9	$ 0.2	$ (1.3)

The Tax Cuts and Jobs Act (the "Tax Act") was signed into law on December 22, 2017. The Tax Act significantly revised the U.S. corporate income tax laws. The Company is most notably impacted by the reduction of the U.S. corporate tax rate from 35% to 21% for tax years after December 31, 2017 and limiting certain deductions such as interest expense and net operating loss carryforwards. The Tax Act also enhanced and extended through 2026 the option to claim accelerated depreciation deductions on qualified property. Due to the timing of the enactment and the complexity involved with applying the provisions of the Tax Act, the Company had not completed its determination of the accounting implications of the Tax Act on its income tax accruals for the year ended December 31, 2017. However, the Company reasonably estimated the effects of the Tax Act on its existing deferred tax assets and liabilities and recognized a provisional expense for income taxes of $57.7 million for the year ended December 31, 2017. The Company completed its analysis during the year ended December 31, 2018 and determined that no additional adjustment was needed to the $57.7 million provisional expense recorded for the year ended December 31, 2017.

The following table reconciles the differences between the statutory federal income tax rate to the Company's effective tax rate on net income (loss) before income taxes and including net income attributable to noncontrolling interests and redeemable noncontrolling interests for the years ended December 31, 2019, 2018 and 2017 (in millions):

	2019	2018	2017
Federal statutory rate	21.0 %	21.0 %	35.0 %
State income taxes, net of federal income tax benefits	(26.3)	2.2	23.2
Change in valuation allowance	171.0	(12.5)	99.6
Provisional expense resulting from the Tax Act	-	-	(146.6)
Tax effect of impairments of goodwill	1.8	(2.3)	(12.5)
Noncontrolling interests and redeemable noncontrolling interests	(7.4)	0.4	6.4
Nondeductible acquisition costs	(25.4)	(6.6)	-
Nondeductible merger-related compensation costs	1.2	(1.6)	-
Other nondeductible expenses and other items	7.1	(0.7)	(1.9)
Effective income tax rate	143.0 %	(0.1) %	3.2 %

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects were as follows as of December 31, 2019 and 2018 (in millions):

	2019	2018
Deferred income tax liabilities:		
Depreciation and amortization	$ (36.2)	$ (137.7)
Deferred loan costs	-	(0.4)
Tax deductible goodwill	(18.3)	(11.2)
Debt discount	-	(0.1)
Equity investments	-	(32.6)
Other	(6.3)	(4.0)
Total deferred income tax liabilities	(60.8)	(186.0)
Deferred income tax assets:		
Provision for doubtful accounts	48.1	72.4
Employee compensation	45.9	50.5
Acquisition and start-up costs	15.6	10.2
Net operating loss carryforwards	220.6	195.8
Insurance reserves	67.5	64.4
Prepaid rent	16.4	18.5
Section 163(j) interest expense carryforward	81.8	31.7
Investments in partnerships	27.1	-
Other	27.1	12.9
Total deferred income tax assets	550.1	456.4
Valuation allowance	(495.5)	(274.4)
Net deferred income tax assets	54.6	182.0
Deferred income taxes	$ (6.2)	$ (4.0)

Noncurrent deferred income tax liabilities totaled $6.2 million and $4.0 million at December 31, 2019 and 2018, respectively. As of December 31, 2019, the Company had federal net operating loss carryforwards of $388.7 million and state and local net operating loss carryforwards of approximately $2.9 billion. As of December 31, 2018, the Company had federal net operating loss carryforwards of $342.4 million and state and local net operating loss carryforwards of approximately $2.5 billion. The federal net operating loss carryforwards generated prior to 2018 expire between 2028 and 2037. The federal net operating loss carryforwards generated in 2018 and forward have an indefinite carryforward period. The state net operating loss carryforwards will expire between 2020 and 2038. The Company has established a valuation allowance for deferred tax assets at December 31, 2019 and 2018, due to the uncertainty of realizing these assets in the future. The valuation allowance increased $221.1 million during 2019, of which $117.0 million was a result of the finalization of the purchase price allocations for the LifePoint/RCCH Merger. The valuation allowance increased $140.3 million during 2018, of which $103.2 million of the increase was a result of the LifePoint/RCCH Merger.

No federal income tax payments were made during the years ended December 31, 2019, 2018 or 2017. Net refunds of Federal income taxes paid by Legacy LifePoint for tax years ended December 31, 2017 and November 16, 2018 in the amount of $59.5 million and $54.1 million were received during the years ended December 31, 2019 and 2018. The tax year 2017 refund resulted from an automatic accounting method change, for tax purposes, relating to income recognition made by Legacy LifePoint. The November 16, 2018 tax year-end refund resulted from estimated tax payments made by Legacy LifePoint prior to the announced LifePoint/RCCH Merger that were not needed due to the taxable loss generated for the year. Net state and local income tax payments in the amount of $1.0 million, $0.4 million, and $0.8 million were made during the years ended December 31, 2019, 2018 and 2017, respectively.

The Company's policy is to accrue interest and penalties related to potential underpayment of income taxes within the provision for income taxes. Interest is computed on the difference between the Company's uncertain tax benefit positions and the amount deducted or expected to be deducted in our income tax returns.

The Company files a consolidated U.S. federal income tax return, as well as income tax returns in various state jurisdictions. All of the Company's tax years are subject to examination by the Internal Revenue Service and various state taxing authorities.

Note 7. Other Current Liabilities

The following table provides information regarding the Company's other current liabilities, which are included in the accompanying consolidated balance sheets at December 31, 2019 and 2018 (in millions):

	2019	2018
Accrued interest	$ 49.6	$ 68.9
Current portion of self-insurance reserves	64.5	70.7
Self-insured medical benefits liabilities	53.8	46.1
Income taxes payable	71.8	-
Accrued property taxes	18.6	19.1
Accrued expenses and other	187.7	217.4
	$ 446.0	$ 422.2

Note 8. Leases

The Company leases real estate property and equipment under cancelable and non-cancelable leases. The leases expire at various times and have various renewal options. Certain leases that meet the lease capitalization criteria in accordance with ASC 840 have been recorded as an asset and liability at the lower of the net present value of the minimum lease payments at the inception of the lease or the fair value of the asset at the inception date. Interest rates used in computing the net present value of the lease payments are based on the Company's incremental borrowing rate at the inception of the lease. All of the lease agreements generally require the Company to pay maintenance, repairs, taxes and insurance costs. Rental expense of operating leases totaled $118.6 million, $57.3 million and $44.0 million for the years ended December 31, 2019, 2018 and 2017, respectively.

Future minimum lease payments at December 31, 2019, for those leases having an initial or remaining noncancelable lease term in excess of one year, but excluding obligations that do not require eventual settlement in cash, are as follows for the years indicated (in millions):

	Operating Leases	Capital and Financing Leases	Total
2020	$ 46.4	$ 118.2	$ 164.6
2021	45.4	102.9	148.3
2022	33.5	180.7	214.2
2023	24.8	109.4	134.2
2024	18.8	109.4	128.2
Thereafter	82.7	2,443.2	2,525.9
	$ 251.6	$ 3,063.8	$ 3,315.4
Less: interest portion		(1,966.5)	
		$ 1,097.3	

Sale-Leaseback Transactions

The real estate associated with certain of the Company's facilities and its health support center are leased from various third party entities in connection with sale-leaseback transactions. Certain of these leasing arrangements contain various forms of continuing involvement and resultantly fail sale-leaseback accounting criteria in accordance with ASC 840. Those leases with continuing involvement are accounted for as financing transactions. Additionally, for certain properties which satisfied the sale-leaseback accounting criteria, the sales proceeds received were in excess of the fair value of the properties leased. Accordingly, financing obligations have been recorded for such excess. At December 31, 2019, the Company has recorded $1,135.0 million of total financing obligations, including current portions, associated with sale-leaseback transactions in its accompanying consolidated balance sheet.

Properties failed sale-leaseback criteria due to several reasons, including fully prepaid arrangements with government authorities, the ability to share in the appreciation rights of the property, involvement in an ongoing build to suit construction project financed by a third party and more than minor subleasing arrangements.

2019 Sale Leaseback Transaction

On November 4, 2019, certain subsidiaries of the Company (collectively, the "LifePoint Entities") entered into a Real Property Asset Purchase Agreement (the "Real Property APA") with certain subsidiaries of MPT. The sale-leaseback transaction (the "Sale Leaseback Transaction") was completed effective December 17, 2019. Pursuant to the Real Property APA, the LifePoint Entities sold the real estate of the following medical facilities (the "2019 Master Lease Facilities") to certain affiliates of MPT, and immediately thereafter certain LifePoint Entities and certain affiliates of MPT entered into an agreed upon Master Lease Agreement (the "2019 Master Lease") pursuant to which such LifePoint Entities now lease or sublease the land and the buildings associated with the 2019 Master Lease Facilities from certain affiliates of MPT:

- Conemaugh Memorial Medical Center located in Pennsylvania;
- Conemaugh Meyersdale Medical Center located in Pennsylvania;
- Conemaugh Miners Medical Center located in Pennsylvania;
- Nason Medical Center located in Pennsylvania;
- Ottumwa Regional Health Center located in Iowa;
- Palestine Regional Medical Center located in Texas;
- SageWest Health Care – Lander Campus located in Wyoming;
- SageWest Health Care – Riverton Campus located in Wyoming;
- Southwestern Medical Center (including the Southwestern Behavioral Health Center) located in Oklahoma; and
- Western Plains Medical Complex located in Kansas.

The 2019 Master Lease has an initial term of 20 years (the "Initial Term"). However, the LifePoint Entities who are parties to the 2019 Master Lease have the option to extend the Initial Term for two additional five-year periods.

In connection with the Sale Leaseback Transaction, the Company received an aggregate amount of sale proceeds of $700.0 million and incurred $18.1 million of transaction-related expenses, which is included under the caption "Merger, acquisition and other transaction-related expenses" for the year ended December 31, 2019.

The Company anticipates using the net proceeds to reinvest in the Company and its subsidiaries. To the extent not so reinvested, such net proceeds will be used to repay existing debt of the Company and its subsidiaries in accordance with the Company's debt agreements. Refer to Note 15 for further discussion of refinancing activities occurring subsequent to December 31, 2019.

Note 9. Investments

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, under the equity method of accounting in accordance with ASC 323. The Company does not consolidate its equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period. The Company's equity method investments totaled $274.3 million and $231.9 million at December 31, 2019 and 2018, respectively, and are included under the caption "Other long-term assets" in the accompanying consolidated balance sheets.

Note 10. Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling Interests

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

The following table presents the changes in the Company's noncontrolling interests during the years ended December 31, 2019 and 2018 (in millions):

Balance at January 1, 2018	$ -
Noncontrolling interests assumed in the LifePoint/RCCH Merger	29.9
Net income attributable to noncontrolling interests	0.2
Distributions	(0.2)
Balance at December 31, 2018	29.9
Finalization of purchase price allocations for the LifePoint/RCCH Merger	(0.2)
Net income attributable to noncontrolling interests	4.4
Distributions	(8.2)
Balance at December 31, 2019	$ 25.9

Redeemable Noncontrolling Interests

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

The following table presents the changes in the Company's redeemable noncontrolling interests during the years ended December 31, 2019 and 2018 (in millions):

Balance at January 1, 2018	$ 60.7
Redeemable noncontrolling interests assumed in the LifePoint/RCCH Merger	75.7
Net income attributable to redeemable noncontrolling interests	5.5
Distributions, net of proceeds	(5.8)
Balance at December 31, 2018	136.1
Finalization of purchase price allocations for the LifePoint/RCCH Merger	(4.6)
Net income attributable to redeemable noncontrolling interests	14.9
Fair value adjustments	11.2
Distributions and repurchases	(9.8)
Balance at December 31, 2019	$ 147.8

Note 11. Fair Value of Financial Instruments

Fair Value Hierarchy

Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the fair value hierarchy pursuant to ASC 820, "Fair Value Measurements and Disclosures" ("ASC 820") that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

Level 1: Quoted market prices in active markets for identical assets or liabilities.
Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.
Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability.

Cash and Cash Equivalents, Accounts Receivable, Accounts Payable and Other Current Liabilities

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

Long-Term Debt

The carrying amounts and fair values of the Company's ABL Facility, Term Loan Facility, 9.75% Unsecured Notes, 8.25% Secured Notes and 11.5% Unsecured Notes, excluding unamortized debt issuance costs, as of December 31, 2019 and December 31, 2018 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2019	December 31, 2018	December 31, 2019	December 31, 2018
ABL Facility	$ -	$ 20.0	$ -	$ 20.0
Term Loan Facility	$ 3,523.4	$ 3,550.0	$ 3,549.8	$ 3,487.9
9.75% Unsecured Notes	$ 1,425.0	$ 1,425.0	$ 1,610.3	$ 1,353.8
8.25% Secured Notes	$ 800.0	$ 800.0	$ 849.0	$ 808.0
11.5% Unsecured Notes	$ 350.0	$ 350.0	$ 376.3	$ 359.6

The fair values of the Company's long-term debt instruments were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820.

Interest Rate Swap

The Company measures its Interest Rate Swap at fair value on a recurring basis. The fair value of the Company's Interest Rate Swap is based on quotes from its counterparty. The Company considers those inputs to be Level 2 in the fair value hierarchy. At December 31, 2019 and 2018, the fair value of the Company's Interest Rate Swap was a total liability of $24.6 million and $5.8 million, respectively, of which $10.7 million and $0.7 million, respectively, is included under the caption "Other current liabilities" and $13.9 million and $5.1 million, respectively, is included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheets.

The Company has not designated its Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging." Accordingly, all changes in the fair value of the Company's Interest Rate Swap are recognized through interest expense in its statement of operations. For the years ended December 31, 2019 and 2018, the Company recognized additional interest expense of $18.8 million and $5.8 million, respectively, related to changes in the fair value of its Interest Rate Swap.

Changes in the fair value of the Company's Interest Rate Swap could result in a material effect on its consolidated results of operations and financial position; however, the Company does not anticipate that changes in the fair value of its Interest Rate Swap will have any impact on its cash flows. The counterparty to the Interest Rate Swap exposes the Company to credit risk in the event of nonperformance. However, the Company does not anticipate nonperformance by its counterparty. The Company does not hold or issue derivative financial instruments for trading purposes.

Financial Liabilities

The Company has a contingent consideration liability payable to the former owners of Canyon Vista that represents the Level 3 estimated fair value of the contingent consideration using unobservable inputs and assumptions available to the Company. The liability for Canyon Vista is recorded at an estimated fair value of approximately $13.6 million at both December 31, 2019 and 2018. The key assumptions used in estimating the fair value of the Canyon Vista liability are the range of probabilities that the payments will be earned by the seller and a discount rate adjusted for the Company's credit risk.

Note 12. Employee Benefit Plans

Defined Benefit Pension Plans

In connection with the LifePoint/RCCH Merger, the Company acquired certain assets and assumed certain liabilities associated with two separate defined benefit pension plans (i) associated with certain employees of Marquette General Hospital covered by a collective bargaining agreement (the "Marquette Pension Plan") and (ii) associated with certain non-union employees of Bell Hospital (the "Bell Pension Plan" and, collectively with the Marquette Pension Plan, the "Pension Plans"). Both Pension Plans are closed to new participants. Participants in the Marquette Pension Plan are required to make annual contributions totaling 6% of annual compensation to the Marquette Pension Plan to continue accruing benefits. Participants in the Bell Pension Plan no longer accrue benefits. The Company makes contributions to the Pension Plans sufficient to meet its minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended.

Status and Expense

The following table presents the changes in the benefit obligations and plan assets of the Pension Plans during the years ended December 31, 2019 and 2018 and the unfunded liability of the Pension Plans at December 31, 2019 and 2018 (in millions):

	2019	2018
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 58.6	$ -
Benefit obligations assumed in the LifePoint/RCCH Merger	-	56.5
Service costs	0.5	0.1
Interest costs	2.4	0.3
Participant contributions	0.3	0.1
Actuarial loss	10.2	1.8
Benefits paid	(1.9)	(0.2)
Benefit obligation at end of year	70.1	58.6
Change in plan assets:		
Fair value of plan assets at beginning of year	38.5	-
Plan assets acquired in the LifePoint/RCCH Merger	-	39.6
Actual return on plan assets	8.1	(1.0)
Employer contributions	2.1	-
Participant contributions	0.3	0.1
Benefits and expenses paid	(1.9)	(0.2)
Fair value of plan assets at end of year	47.1	38.5
Unfunded liability included in other long-term liabilities in the Company's accompanying consolidated balance sheet	$ 23.0	$ 20.1

The Company recognizes changes in the funded status of the Pension Plans as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). For the years ended December 31, 2019 and 2018, the Company recognized comprehensive losses of $4.4 million and $3.1 million, respectively, as decreases in stockholders' equity through accumulated other comprehensive loss. The adjustments were primarily related to changes in the Company's unfunded pension liability due to changes in the discount rates and mortality assumptions used to measure the projected benefit obligation.

The following table summarizes the projected benefit obligation, accumulated benefit obligation and fair value of plan assets related to the Pension Plans as of December 31, 2019 and 2018 (in millions):

	2019	2018
Projected benefit obligation	$ 70.1	$ 58.6
Accumulated benefit obligation	$ 65.4	$ 54.9
Fair value of plan assets	$ 47.1	$ 38.5

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligation as of December 31, 2019 and 2018 (in millions):

	2019	2018
Discount rate	3.1 %	4.1 %
Rate of compensation increases, when applicable	3.0 %	3.0 %

The following table summarizes the components of net periodic costs for the years ended December 31, 2019 and 2018 (in millions):

	2019	2018
Service cost	$ 0.5	$ 0.1
Interest cost	2.4	0.3
Expected return on plan assets	(2.2)	(0.3)
Total net periodic benefit cost	$ 0.7	$ 0.1

The following table summarizes the weighted-average assumptions used by the Company to determine its net periodic benefit costs during the years ended December 31, 2019 and 2018 (in millions):

	2019	2018
Discount rate	4.1 %	4.2 %
Rate of compensation increases, when applicable	3.0 %	3.0 %
Expected long-term return on plan assets	5.7 %	5.8 %

Plan Assets

The investment policy for the Pension Plans has been formulated to achieve a risk adjusted return that balances the need for asset growth against the risk of significant fluctuations in asset prices and the need for significant contributions from the Company. On a quarterly basis, or more frequently as necessary, the current risk levels, asset performance and expected return on assets are reviewed and evaluated against goals and targets by a committee appointed to oversee investment of the Pension Plans' assets (the "Investment Committee"). The Investment Committee strives to maintain a balance between risk and return through the use of modern portfolio theory methods, in conjunction with Monte Carlo modeling to evaluate the behavior of the portfolio under different scenarios. At December 31, 2019, the Pension Plans' investments include a balance of mutual funds and money market funds in order to achieve an overall rate of return that minimizes the need for additional employer contributions. The Company measures the fair value of its Pension Plans' assets in accordance with ASC 820.

The Pension Plans' investments in mutual funds are valued at the net asset value ("NAV") of shares reported in the active market in which the funds are traded. Because quoted prices are available for mutual funds and the markets in which they are traded are generally considered active, the Company has classified each of them as a Level 1 investment. The Pension Plans' investments in money market funds are valued at quoted prices in markets that are not active by a combination of inputs, including but not limited to dealer quotes who are market makers in the underlying funds and other directly and indirectly observable inputs. Because the inputs used to value money market funds are either directly or indirectly observable, but are not quoted prices in active markets, the Company has classified these assets as Level 2 investments.

The following table summarizes the assets of the Pension Plans, measured at fair value as of December 31, 2019 and 2018, by major asset category and aggregated by level within the fair value hierarchy (in millions):

	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
December 31, 2019:				
Mutual funds	$ 44.5	$ 44.5	$ -	$ -
Money market funds	2.6	-	2.6	-
Total	$ 47.1	$ 44.5	$ 2.6	$ -
December 31, 2018:				
Mutual funds	$ 34.6	$ 34.6	$ -	$ -
Money market funds	3.9	-	3.9	-
Total	$ 38.5	$ 34.6	$ 3.9	$ -

The Company expects to contribute approximately $2.9 million to the Pension Plans during the year ended December 31, 2020. Additionally, the Company expects to make future benefit payments from the Pension Plans as follows for the years indicated (in millions):

2020	2.3
2021	2.5
2022	2.7
2023	2.9
2024	3.1
Five years thereafter	17.5
	$ 31.0

Multiemployer Pension Plan

In connection with the LifePoint/RCCH Merger, the Company assumed the obligation to contribute to a multiemployer pension plan on behalf of certain employees covered by collective bargaining agreements, in accordance with the terms of such collective bargaining agreements. The Company's contributions to the multiemployer pension plan are determined based on the terms of the applicable collective bargaining agreements. Multiemployer plans are different from single-employer plans because assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers. Also, if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers. If the Company stops participating in the multiemployer plan, the Company may be required to pay a withdrawal liability based on its portion of the unfunded status of the plan. Currently, the Company does not anticipate ending its participation in this plan.

Defined Contribution Plans

The Company maintains three separate defined contribution retirement plans covering a majority of the Company's employees, including Legacy LifePoint employees, RCCH employees and employees at Community Medical Center. These defined contribution plans contain discretionary matching contribution formulas and definite non-elective contribution formulas for employees at certain facilities. Effective as of the end of the day on December 31, 2019, the plan covering RCCH employees was merged into the plan covering Legacy LifePoint employees. The Company's expense related to its defined contribution plans was $31.2 million, $5.6 million and $3.1 million for the years ended December 31, 2019, 2018 and 2017, respectively.

Deferred Compensation Plans

The Company maintains three separate supplemental deferred compensation plans with respect to certain of its employees and affiliated physicians. As of December 31, 2019 and 2018, the assets associated with these deferred compensation plans were $39.6 million and $34.5 million, respectively, and the liabilities were $48.1 million and $41.3 million, respectively. These amounts are included under the captions "Other long-term assets" and "Other long-term liabilities", respectively, on the accompanying consolidated balance sheets at December 31, 2019 and 2018.

Note 13. Stock-Based Compensation

DSB Parent is authorized to issue Units to employees, executives, consultants and directors of the Company, under the DSB Parent Partnership Agreement. The Company has determined that the Units are a substantive class of members' equity for accounting purposes because the Units are legal equity of DSB Parent, they have participation features, including distribution and liquidation rights which allow them to participate in the residual returns of the DSB Parent and vested interests are retained upon termination. As a result, these awards are accounted for under ASC 718.

There are 35,270,000 aggregate number of Units authorized for issuance. Service Units and Performance Units have been issued under the DSB Parent Partnership Agreement and forms of award agreements.

Service Units

Service Units have been granted to certain members of the board of directors and Tranche A Units to certain employees, executives and consultants. Units that have been granted to members of the board of directors vest on a time-basis only, either in three equal installments on each of the first three anniversaries of the grant date or on the date that is the earliest of (i) six months and one day following November 16, 2018 or (ii) the date of the applicable director's termination of service due to death, disability or as a result of the director's removal from the board of directors other than for cause. Tranche A Units granted to certain employees, executives and consultants vest in equal installments on the last day of each of the first twenty calendar quarters that commence on or after the grant date or, in some cases, November 16, 2018. Service Units will automatically vest upon the sale of the Company. In the event of an initial public offering, all unvested Service Units will remain outstanding and continue to vest based on the stated vesting pattern. Unvested Service Units are forfeited upon a holder's termination of service.

Service Units are accounted for as equity awards and related compensation expense is recognized ratably over the vesting period. For employees and executives granted Service Units prior to November 16, 2018 who are severed during the 18-month period following the LifePoint/RCCH Merger under certain circumstances, Tranche A Units vest in full upon the eligible employee's termination date. On November 16, 2018, Service Units originally issued to approximately 40 employees and executives were modified in connection with the LifePoint/RCCH Merger. The Company calculated the fair value of the service units before and after the modification and recorded expense of $2.4 million and $2.7 million for the years ended December 31, 2019 and 2018, respectively, related to the modification and acceleration of service units. As of December 31, 2019, Service Units had unrecognized compensation expense of $8.0 million. The expense is expected to be recognized over a weighted-average period of 2.0 years from December 31, 2019.

Performance Units

Performance Units, which have been granted as Tranche B Units and Tranche C Units, will vest based upon equity holders of DSB Parent realizing certain targeted multiples of invested capital ("MOIC thresholds"). Performance Units are accounted for as equity awards with expense recognition occurring upon the realization of the stated MOIC thresholds due to a liquidity event. For employees and executives granted Performance Units prior to November 16, 2018 who were severed in connection with the LifePoint/RCCH Merger, Tranche B units vest in full upon the eligible employee's termination date and Tranche C units are forfeited in accordance with the original terms and conditions of the applicable Profits Units award agreement. On November 16, 2018, Tranche B Units previously issued to approximately 40 employees and executives were modified in connection with the LifePoint/RCCH Merger. The Company calculated the fair value of the Tranche B Units before and after the modification and recorded expense of $2.7 million and $3.6 million for the years ended December 31, 2019 and 2018, respectively, related to the modification and acceleration of Tranche B Units. For Performance Units not modified in connection with the LifePoint/RCCH Merger, the Company determined that a liquidity event was not probable, therefore no compensation expense has been recognized related to the unmodified Performance Units. Performance Units had unrecognized compensation expense of $2.4 million as of December 31, 2019. Unvested Units that do not vest on termination are forfeited upon such termination, subject to certain conditions.

The following table summarizes the Company's total stock-based compensation expense for the years ended December 31, 2019, 2018 and 2017 (in millions):

	2019	2018	2017
Service Units	$ 3.5	$ 3.4	$ 0.7
Performance Units	1.3	3.6	-
	4.8	7.0	0.7
Modification expense for awards classified as a liability	2.8	-	-
Total stock-based compensation expense	$ 7.6	$ 7.0	$ 0.7

Valuation Assumptions

The fair value of all Units was determined using a Monte Carlo simulation framework. The following table shows the weighted average assumptions used by the Company to develop the fair value estimates and the resulting estimates of weighted-average fair value per Unit granted during the years ended December 31, 2019, 2018 and 2017:

	2019	2018	2017
Common equity value of the Company (in millions)	$ 1,671.9	$ 624.1	$ 513.8
Expected volatility	38.0 %	24.0 %	27.5 %
Risk-free interest rate	2.90 %	1.60 %	1.10 %
Expected dividends	-	-	-
Average expected term (years)	5.0	3.2	4.1

Units Activity

The following represents the activity of the Units for the years ended December 31, 2019, 2018 and 2017:

	Service Units		Performance Units			
	Tranche A and Units to the Board	Weighted Average Grant Date Fair Value per Unit	Tranche B	Weighted Average Grant Date Fair Value per Unit	Tranche C	Weighted Average Grant Date Fair Value per Unit
Unvested at January 1, 2017	4,522,133	$ 0.69	4,893,569	$ 0.41	2,446,785	$ 0.30
Granted	548,200	0.93	548,200	0.47	274,100	0.28
Vested	(1,104,234)	0.64	-	-	-	-
Forfeited	(165,070)	0.84	(179,600)	0.44	(89,800)	0.28
Unvested at December 31, 2017	3,801,029	0.71	5,262,169	0.41	2,631,085	0.30
Granted	1,229,200	1.43	1,229,200	0.68	614,600	0.37
Vested	(2,054,331)	0.82	(1,636,959)	0.46	-	-
Forfeited	(266,140)	0.70	(379,400)	0.41	(1,008,180)	0.31
Unvested at December 31, 2018	2,709,758	0.97	4,475,010	0.47	2,237,505	0.31
Granted	6,996,576	1.23	6,868,920	0.80	3,884,460	0.63
Vested	(2,893,910)	1.07	(891,400)	0.54	-	-
Forfeited	(85,044)	1.18	(136,640)	0.60	(514,020)	0.38
Unvested at December 31, 2019	6,727,380	$ 1.19	10,315,890	$ 0.68	5,607,945	$ 0.53

During the year ended December 31, 2019, there were no convertible or expired Units.

Note 14. Commitments and Contingencies

Capital Expenditure Commitments

The Company is reconfiguring some of its facilities to more effectively accommodate patient services and to provide for a greater variety of services. The Company has incurred approximately $148.6 million in costs related to uncompleted projects as of December 31, 2019, which is included under the caption "Construction in progress" in the Company's accompanying consolidated balance sheet. At December 31, 2019, these uncompleted projects had an estimated cost to complete of approximately $91.5 million. The estimated timeframe for completion of these projects generally ranges from less than one year up to two years. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities. At December 31, 2019, the Company estimated its total remaining capital expenditure commitments to be approximately $1,523.1 million, which generally have remaining terms of one to six years. Of this amount, more than one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time.

Legal Proceedings and General Liability Claims

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

In addition, the Company is subject to the regulation and oversight of various state and federal governmental agencies. Further, under the False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against healthcare facilities that submit false claims for payments to, or improperly retain identified overpayments from, governmental payers. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without the Company's knowledge. If a provider is found to be liable under the False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus substantial civil monetary penalties that are subject to annual adjustment for inflation for each separate false claim.

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

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

The Company accrues an estimate for a contingent liability when losses are both probable and reasonably estimable. The Company reviews its accruals each quarter and adjusts them to reflect the impact of developments, advice of legal counsel and other information pertaining to a particular matter.

Note 15. Subsequent Events

In accordance with the provisions of ASC 855, "Subsequent Events," the Company evaluated all material events subsequent to the balance sheet date through March 12, 2020, the date of issuance, for events requiring disclosure or recognition in the Company's consolidated financial statements. There were no subsequent events requiring disclosure or recognition in the Company's consolidated financial statements other than those noted below or included elsewhere in this Report.

Repricing of Term Loan Facility and Repayment of a Portion of Term Loan Facility

On January 21, 2020, the Company amended its Term Loan Facility to, among other things, reduce the applicable interest rate margin for the term loans by 0.75% to 3.75% with respect to London Interbank Offered Rate ("LIBOR")-based loans and 2.75% with respect to base rate loans.

On January 23, 2020, the Company made a mandatory prepayment of $400.0 million of term loans outstanding under the Term Loan Facility with a portion of the net proceeds from the Sale Leaseback Transaction. After giving effect to the mandatory prepayment, the Company had prepaid all remaining quarterly amortization payments in respect of the Term Loan Facility.

Tender Offer, Redemption and Discharge of 8.25% Secured Notes and 11.5% Unsecured Notes

On February 7, 2020, the Company commenced a tender offer and consent solicitation (the "tender offer") to purchase any and all of its outstanding (i) 8.25% Secured Notes issued pursuant to the indenture, dated as of April 29, 2016, among the Company, the guarantors party thereto and Wilmington Trust, National Association, as trustee (as amended, supplemented or otherwise modified, the "8.25% Secured Notes Indenture") and (ii) 11.5% Unsecured Notes issued pursuant to the indenture, dated as of April 29, 2016, among the Company, the guarantors party thereto and Wilmington Trust, National Association, as trustee (as amended, supplemented or otherwise modified, the "11.5% Unsecured Notes Indenture"). The early tender deadline for the tender offer was February 21, 2020 and the expiration date for the tender offer was March 6, 2020.

Upon expiration of the early tender deadline, on February 24, 2020, the Company accepted and purchased (i) $622.5 million of the aggregate principal amount of the 8.25% Secured Notes that were validly tendered for total consideration of $1,052.50 per $1,000 principal amount, plus accrued and unpaid interest thereon, and (ii) $84.1 million of the aggregate principal amount of the 11.5% Unsecured Notes that were validly tendered for a total consideration of $1,072.50 per $1,000 principal amount, plus accrued and unpaid interest thereon. Following the expiration of the tender offer, on March 9, 2020, the Company accepted and purchased an additional $0.2 million of the aggregate principal amount of the 8.25% Secured Notes that were validly tendered after the early tender deadline for a tender consideration of $1,022.50 per $1,000 principal amount, plus accrued and unpaid interest thereon. No additional 11.5% Unsecured Notes were tendered after the early tender deadline.

On March 9, 2020, (i) pursuant to the 8.25% Secured Notes Indenture, the Company provided notice to the holders that it had elected to redeem any and all of the 8.25% Secured Notes that remain outstanding after giving effect to the tender offer at a redemption price of 104.125%, plus accrued and unpaid interest thereon, on May 1, 2020 (the "8.25% Notes Redemption") and (ii) pursuant to the 11.5% Unsecured Notes Indenture, the Company provided notice to the holders that it had elected to redeem any and all of the 11.5% Unsecured Notes that remain outstanding after giving effect to the tender offer at a redemption price of 105.750%, plus accrued and unpaid interest thereon, on May 1, 2020 (the "11.5% Notes Redemption"). Concurrently with the delivery of the notices of redemption, on March 9, 2020, the Company (i) irrevocably deposited with the trustee for the 8.25% Secured Notes approximately $191.9 million, which is the amount sufficient to fund the 8.25% Notes Redemption and to satisfy and discharge the Company's obligations under the 8.25% Secured Notes and the 8.25% Secured Notes Indenture, and (ii) irrevocably deposited with the trustee for the 11.5% Unsecured Notes approximately $296.5 million, which is the amount sufficient to fund the 11.5% Notes Redemption and to satisfy and discharge the Company's obligations under the 11.5% Unsecured Notes and the 11.5% Unsecured Notes Indenture.

Offering of 4.375% Secured Notes

On February 13, 2020, the Company completed the offering of $600.0 million in aggregate principal amount of its 4.375% Senior Secured Notes due 2027 (the "4.375% Secured Notes"). The 4.375% Secured Notes were offered and sold to qualified institutional buyers pursuant to Rule 144A under the Securities Act of 1933, as amended (the "Securities Act"), to persons outside of the United States in compliance with Regulation S under the Securities Act and to certain accredited investors as defined under Regulation D under the Securities Act. The 4.375% Secured Notes have not been, and are not required to be, registered under the Securities Act or any state securities laws and may not be offered or sold in the United States absent an effective registration statement or an applicable exemption from registration requirements or a transaction not subject to the registration requirements of the Securities Act or any state securities laws. The 4.375% Secured Notes were issued pursuant to the Indenture, dated as of February 13, 2020 (the "4.375% Secured Notes Indenture") among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee and notes collateral agent.

The net proceeds from the offering, together with the net proceeds from the Incremental Term Loan and cash on hand, was used to fund the settlement of the tender offer, the 8.25% Notes Redemption and the 11.5% Notes Redemption and to pay certain fees in connection with the refinancing transactions described herein.

The 4.375% Secured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Company's Term Loan Facility. The 4.375% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 4.375% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority collateral.

The 4.375% Secured Notes will mature on February 15, 2027. Interest on the 4.375% Secured Notes will accrue at 4.375% per annum and will be paid semi-annually, in arrears, on February 15 and August 15 of each year, beginning August 15, 2020.

On or after February 15, 2022, the Company may redeem the 4.375% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the 4.375% Secured Notes Indenture. In addition, prior to February 15, 2022, the Company may redeem the 4.375% Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 4.375% Secured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. Prior to February 15, 2022, the Company may also redeem up to 40% of the original aggregate principal amount of the 4.375% Secured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 104.375%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 4.375% Secured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption.

The 4.375% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets.

These covenants are subject to a number of important qualifications and exceptions as described in the 4.375% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 4.375% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 4.375% Secured Notes Indenture also provides for customary events of default.

Issuance of Incremental Term Loan

On February 24, 2020, the Company closed the issuance of $600.0 million of incremental term loans (the "Incremental Term Loan") under the Term Loan Facility. The Incremental Term Loan bears interest at a rate equal to, at its option, (a) a LIBOR rate plus an applicable margin of 3.75% or (b) a base rate plus an applicable margin of 2.75%. There are no scheduled amortization payments required on the Incremental Term Loan prior to maturity. The net proceeds from the Incremental Term Loan, together with the net proceeds from the 4.375% Secured Notes and cash on hand, was used to fund the settlement of the tender offer, the 8.25% Notes Redemption and the 11.5% Notes Redemption and to pay certain fees in connection with the refinancing transactions described herein.

SIGNATURES

LifePoint Health, Inc. has caused this Report to be signed on its behalf by the undersigned thereunto duly authorized.

LIFEPOINT HEALTH, INC.

Date: March 12, 2020

By: /s/ Michael S. Coggin
Michael S. Coggin
Executive Vice President and Chief Financial Officer

ANNUAL REPORT

OF

LIFEPOINT HEALTH, INC.

FOR THE

FISCAL YEAR ENDED DECEMBER 31, 2020

PREPARED IN ACCORDANCE WITH

ANNUAL REPORT ON FORM 10-K
(AS MODIFIED UNDER DEBT AGREEMENTS)

LifePoint Health, Inc.
(Exact Name of Company as Specified in Its Charter)

Delaware	**27-0500485**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**
330 Seven Springs Way Brentwood, Tennessee	**37027**
(Address of Principal Executive Offices)	**(Zip Code)**

(615) 920-7000
(Company's Telephone Number, Including Area Code)

LifePoint Health, Inc.

Annual Report

For the Fiscal Year Ended December 31, 2020

TABLE OF CONTENTS

DISCLOSURE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report for the fiscal year ended December 31, 2020 (this "***Report***") contains forward-looking statements that involve risks and uncertainties. Forward-looking statements include any statements that address future results or occurrences. In some cases, you can identify forward-looking statements by terminology such as: "may," "might," "will," "would," "should," "could" or the negatives thereof. Generally, the words "anticipate," "believe," "continue," "expect," "intend," "estimate," "project," "plan" and similar expressions identify forward-looking statements. In particular, statements about our expectations, beliefs, plans, objectives, assumptions or future events or performance contained elsewhere in this Report are forward-looking statements. These forward-looking statements include statements that are not historical facts, including statements concerning our possible or assumed future actions and business strategies. We have based these forward-looking statements on our current expectations, assumptions, estimates and projections. While we believe these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks, uncertainties and other factors, many of which are outside of our control, which could cause our actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. Such factors include, among others, the following:

- the length and severity of the novel coronavirus ("***COVID-19***") pandemic, the measures we are taking to respond to the pandemic and the potential availability of a vaccine on a widespread basis;
- significantly reduced patient volumes and operating revenues for elective procedures and services provided to non-COVID-19 patients and the uncertainty of future patient volumes and related revenues, including shifts from in-person patient services to telehealth services;
- the impact of increases in the volume of COVID-19 patients cared for across our facilities;
- the impact of existing or future COVID-19 related government and administrative regulation and stimulus, including the Families First Coronavirus Response Act, the Coronavirus Aid, Relief, and Economic Security Act (the "***CARES Act***") and other COVID-19 relief or stimulus legislation, and uncertainty in how these programs may be administered, monitored and modified in the future;
- supply shortages, workforce disruptions or shortages, and increased costs of providing care to our patients, including increased equipment, staffing and supply expenses resulting from the COVID-19 pandemic;
- the emergence of and effects related to other pandemics, epidemics and highly contagious infectious diseases;
- payment changes, including policy considerations and changes resulting from federal and state budgetary restrictions;
- impact from or likelihood of the repeal of, or material modification to, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "***Affordable Care Act***"), as a result of court or legislative action;
- potential impact from the repeal of the penalties associated with the "***individual mandate***" to purchase health insurance under the Affordable Care Act, included in the Tax Cuts and Jobs Act of 2017 (the "***Tax Act***");
- impact from changes to Medicaid supplemental payment programs;
- our compliance with new and existing laws and regulations, including laws and regulations adopted in connection with the COVID-19 pandemic, as well as costs and benefits associated with compliance;
- any potential action brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the "qui tam" or "whistleblower" provisions of the federal False Claims Act (the "***False Claims Act***");
- impact from the changes in payer mix marked by a shift of patients from private insurance to Medicare and Medicaid programs;
- our acquisition strategy, including integration risks relating to future acquisitions;
- the potential for material obligations if we acquire facilities with unknown or contingent liabilities;
- claims and legal actions relating to professional liabilities and other litigation risks;
- delayed payments and repayments resulting from reviews of claims to Medicare and Medicaid for our services;
- impact of controls imposed by payers designed to reduce inpatient services;
- risks associated with outsourcing functions to third-parties;
- our relationships with our joint venture partners;
- changes in physician employment regulations;
- increases in the amount and risk of collectability of patient accounts receivable, particularly as the unemployment rate and number of underinsured and uninsured patients increases as a result of the COVID-19 pandemic;
- our need to make investments continually in our processes and information systems to protect the privacy of patients, employees and other persons and reduce the risk of successful cybersecurity attacks;
- damage to our reputation, regulatory penalties, legal claims and liability under state and federal laws that we could suffer upon any cybersecurity or privacy breaches;
- anticipated capital expenditures, including routine projects, investments in information systems and capital projects related to acquisitions, construction of new facilities and construction projects and the expectation that capital commitments could be a component of future acquisitions;
- effects of competition in a facility's market;
- changes in industry and general economic trends, including macroeconomic conditions negatively impacted by the COVID-19 pandemic;
- recruitment and retention of senior executives, providers and other healthcare employees;

- our ability to acquire facilities on favorable terms and successfully complete asset sales and divestitures;
- effects of union organizing activities;
- potential recoupment of previously recognized income from electronic health record ("***EHR***") incentive programs;
- timeframes for completion of capital projects;
- changes in depreciation and amortization expenses;
- costs of providing care to our patients, including increased equipment, staffing and supply expenses resulting from the COVID-19 pandemic;
- accounting estimates and the impact of accounting methodologies and new accounting pronouncements;
- changes in interpretations, assumptions and expectations regarding tax legislation, including provisions of the CARES Act, and additional guidance that may be issued by federal and state taxing authorities;
- consolidation of commercial insurance companies and patient shifts to lower cost healthcare plans, including association health plans and short-term limited duration health insurance plans, which generally provide lower payment for services provided;
- participation in the healthcare exchanges (the "***Exchanges***") and the impact of increasing enrollment by patients in insurance plans with narrow networks, tiered networks, high deductibles or high co-payments;
- governmental or third-party investigations, legal actions and voluntary self-disclosures relating to overpayments or other regulatory compliance matters;
- the ability of our local management teams to identify and meet the needs of our patients, medical staffs and their communities;
- the efforts of insurers, healthcare providers and others to contain healthcare costs;
- our ability to obtain adequate levels of general and professional liability insurance;
- our ability to implement initiatives promoting cost reductions and operational efficiencies;
- possible future indebtedness that may be incurred; and
- other factors referenced under the caption "Risk Factors" in this Report.

Given these uncertainties, readers are cautioned not to place undue reliance on such forward-looking statements. We disclaim any obligation to update any such factors or to announce the result of any revisions to any of the forward-looking statements contained herein to reflect future results, events or developments.

Statements in this Report are made as of the date hereof unless stated otherwise. New factors emerge from time to time, and it is not possible to predict all such factors.

EXPLANATORY INFORMATION REGARDING THIS REPORT

This Report has been prepared in accordance with the obligations of the Company under (i) Section 4.02 of the Indenture, dated as of December 4, 2020 (the "***5.375% Unsecured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 5.375% Senior Notes due 2029 (the "***5.375% Unsecured Notes***"), (ii) Section 4.02 of the Indenture, dated as of April 13, 2020 (as amended or supplemented from time to time, the "***6.75% Secured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee and notes collateral agent, relating to the Company's 6.750% Senior Secured Notes due 2025 (the "***6.75% Secured Notes***"), (iii) Section 4.02 of the Indenture, dated as of February 13, 2020 (as amended or supplemented from time to time, the "***4.375% Secured Notes Indenture***") among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee and notes collateral agent, relating to the Company's 4.375% Senior Secured Notes due 2027 (the "***4.375% Secured Notes***") and (iv) Section 4.02 of the Indenture, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***9.75% Unsecured Notes Indenture***" and, together with the 5.375% Unsecured Notes Indenture, the 6.75% Secured Notes Indenture and the 4.375% Secured Notes Indenture , the "***Indentures***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 9.750% Senior Notes due 2026 (the "***9.75% Unsecured Notes***" and, together with the 5.375% Unsecured Notes, 6.75% Secured Notes and the 4.375% Secured Notes, the "***Notes***"), (v) Section 5.04 of the Asset-Based Revolving Credit Agreement, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***ABL Agreement***"), among the Company, as Lead Borrower, DSB Acquisition, LLC, a Delaware limited liability company ("***Holdings***"), the lenders party thereto from time to time and Citibank, N.A., as administrative agent and collateral agent, and (vi) Section 5.04 of the First Lien Credit Agreement, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***Term Loan Agreement***" and, together with the ABL Agreement, the "***Credit Agreements***"), among the Company, as Lead Borrower, Holdings, the lenders party thereto and Citibank, N.A., as administrative agent and collateral agent. This Report has been prepared in all material respects in accordance with the rules and regulations of the Securities and Exchange Commission (the "***SEC***") applicable to an Annual Report on Form 10-K for the fiscal year ended December 31, 2020, except to the extent permitted to be excluded by the Indentures and the Credit Agreements.

USE OF NON-GAAP FINANCIAL INFORMATION

In this Report, we have provided EBITDA and Adjusted EBITDA (collectively, the "***Non-GAAP Measures***") because we believe they provide the holders of our Notes (the "***Holders***") and the lenders under our Credit Agreements ("***Lenders***") with additional information to measure our performance and evaluate our ability to service our indebtedness. We believe that the presentation of Non-GAAP Measures is appropriate to provide additional information to the Holders and Lenders about certain material non-cash items and about unusual items that we do not expect to continue or to continue at the same level in the future as well as other items. Further, we believe the Non-GAAP Measures provide a meaningful measure of operating profitability because we use them for evaluating our business performance and understanding certain significant items.

The Non-GAAP Measures are not presentations made in accordance with United States ("***U.S.***") generally accepted accounting principles ("***GAAP***"), and our use of these terms may vary from others in our industry. EBITDA and Adjusted EBITDA should not be considered as alternatives to operating income or any other performance measures derived in accordance with GAAP as measures of operating performance or cash flows as measures of liquidity. EBITDA and Adjusted EBITDA have important limitations as analytical tools, and you should not consider them in isolation or as substitutes for analysis of our results as reported under GAAP. Because of these limitations, we rely primarily on our GAAP results and use EBITDA and Adjusted EBITDA only as a supplement. Refer to "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" for a description of the calculation and limitations of these measures.

DOCUMENT SUMMARIES AND REQUESTS

This Report contains summaries believed to be accurate with respect to certain documents, but reference is made to the actual documents for complete information. All such summaries, which do not purport to be complete, are qualified in their entirety by such reference. Copies of the documents referred to herein will be made available without cost to Holders and Lenders by making a written or oral request to us. Any such request may be made to us at the following address and telephone number:

LifePoint Health
330 Seven Springs Way
Brentwood, Tennessee 37027
Attn: General Counsel
Tel. (615) 920-7000

FISCAL YEAR

All references to "fiscal year" are to the twelve months ended December 31 of the year referenced.

OTHER ITEMS

LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.), a Delaware corporation, along with each of its consolidated subsidiaries, is referred to herein as the "***Company***," "***LifePoint***," "***we***," "***our***," "***us***," and, before giving effect to the LifePoint/RCCH Merger (as defined below), "***RCCH***," in each case, unless the context otherwise requires.

References in this Report to the "***LifePoint/RCCH Merger***" refer to the merger, which was effective on November 16, 2018, of Legend Merger Sub, Inc., a Delaware corporation and wholly-owned subsidiary of RCCH ("***Legend Merger Sub***"), with and into LifePoint Health, Inc., a Delaware corporation ("***Legacy LifePoint***"), with Legacy LifePoint surviving the LifePoint/RCCH Merger as a subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

References in this Report to the "***RegionalCare/Capella Merger***" refer to the merger, effective for accounting purposes on May 1, 2016, of a wholly-owned subsidiary of RegionalCare Hospital Partners Inc. ("***Regional Care***"), with and into Capella Health Holdings, LLC ("***Capella***"), with Capella surviving the RegionalCare/Capella Merger as a wholly-owned subsidiary of RegionalCare, which began to do business as RCCH HealthCare Partners.

References in this Report to the "***Apollo/RegionalCare Acquisition***" refer to the merger, which was effective on December 3, 2015, of DSB Merger Sub Inc., a Delaware corporation and wholly-owned subsidiary of Holdings, with and into RegionalCare with RegionalCare surviving such merger as a direct wholly-owned subsidiary of Holdings, which is indirectly controlled by our Sponsor.

References in this Report to the "***Sponsor***" refer to certain funds that are affiliates of the Company (the "***Apollo Funds***") that are ultimately controlled and/or managed by Apollo Management VIII, L.P. ("***Apollo Management***" and, when acting on behalf of the Apollo Funds, "***Apollo***"), which is an affiliate of Apollo Global Management, Inc.

PART I

Item 1. *Business*.

Our Company

We own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities through our subsidiaries. As of December 31, 2020, we operated 88 hospital campuses in 29 states throughout the U.S., having a total of 11,512 licensed beds. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a network of hospitals and outpatient facilities.

We seek to fulfill our mission of Making Communities Healthier® by (1) delivering high quality patient care, (2) supporting our physicians, (3) creating excellent workplaces for our employees, (4) taking a leadership role in our communities and (5) ensuring fiscal responsibility. We strive to create places where people choose to come for healthcare, physicians want to practice and employees want to work.

Our Business Strategy

The key elements of our business strategy include:

- *Commitment to the Delivery of Exceptional Quality Patient Care*. Providing high quality patient care is essential to our mission and will always be our top priority. We believe our quality efforts are central to creating places where people choose to come for care, physicians want to practice and employees want to work. Our National Quality Program provides a structured, evidence approach to enhancing quality and patient safety and is nationally renowned. Several factors contribute to providing high quality patient care, including leadership and accountability at all levels of our organization, aligning ourselves with talented physicians and medical staff who share our commitment to quality, and providing a clinical environment that is satisfactory to our patients, physicians and employees. We continually strive to improve physician and employee satisfaction, which we believe is critical to delivering quality patient care. We also partner with academic medical centers and regional health systems to better serve the needs of our communities. In addition, providing high quality patient care is increasingly vital to achieving our operating and financial success, including with governmental and commercial payers.

- *Continue to Grow in Existing Markets by Expanding Services and Access Points to Care*. We regularly conduct in-depth strategic reviews of the major service lines offered at each of our facilities and evaluate additional services through which we could better serve our communities and grow in our markets. We leverage our market-specific knowledge together with input and guidance from our local physician and community leaders to prioritize the healthcare services our communities are seeking. Focus areas include expansion of specialty service lines to meet unserved patient needs, expansion of access points to care, including outpatient, ancillary, retail and virtual health services, as well as investment in technology and equipment. We invest strategically in our markets in order to increase the quality and scope of services we provide, meet the needs of our communities and maintain our strong reputation as the healthcare provider of choice. This in turn helps us to continue recruiting physicians and growing the revenue of our facilities. We are implementing a transfer center strategy across our portfolio to increase access to our healthcare system and enhance the continuum of care through the delivery of quality care close to home, which further supports volume growth.

- *Develop Digital Health Capabilities to Engage our Communities with Seamless, Personalized, Quality Experiences Across the Healthcare Continuum*. We are committed to providing high quality care close to home and identifying innovative ways to make it easier for patients to access the care they need when and where they need it. We are working to optimize the patient health journey by partnering with digital health technology providers and connecting our patients and physicians with enhanced digital capabilities that increase access, improve engagement and satisfaction, and result in a more complete and seamless patient experience. Some of our digital health initiatives include on-demand telehealth services, artificial intelligence functionality, online scheduling for in-person and telehealth visits, virtual check-in and waiting room options, remote patient monitoring, next best action campaigns, and computational linguistics designed to identify at-risk patients.

- *Continue to Recruit and Retain Leading Physicians*. Our physician engagement strategies drive our ability to enhance and expand our services to meet the healthcare needs of our communities. We have a comprehensive recruiting program that is directed by an experienced department at our Health Support Center ("***HSC***") and is supported at the local level by our hospital system chief executive officers ("***CEOs***") and Boards of Trustees. We supplement our local teams with experienced specialists at our HSC and several third-party recruiting firms to assist us in identifying candidates that match the profile of our physician needs. We maintain a flexible approach to aligning our goals with our physician partners, including our willingness to recruit physicians through multi-year employment and/or income guarantee arrangements. In addition, we believe our physicians are attracted to our facilities because of several factors, including our commitment to quality care, our focus on employing and developing high quality nurses and support staff and our integration into, and support of, the communities we serve.

- *Routinely Optimize Our Portfolio to Strengthen Our Position in Existing Markets and Expand into New Markets*. We evaluate and selectively pursue acquisitions of hospitals, outpatient and ancillary clinics and other healthcare facilities in new and existing markets, with the goal of improving our operating performance and better meeting the healthcare needs of our communities. We employ a rigorous and disciplined approach to new market acquisitions and focus on a range of criteria, including expected financial returns and strategic benefits, to evaluate a target's suitability and fit within our portfolio. We seek to operate health systems that are, or have the potential to become, market leaders in communities with favorable demographic trends. We often acquire underperforming and/or undermanaged facilities where we can drive operating efficiencies in order to realize significant upside potential following an acquisition to generate attractive effective purchase multiples and strong returns on our investment. The recent market trend toward health system consolidation, particularly among underperforming not-for-profit hospital operators without the scale and/or operating discipline to compete, has benefited us and we believe will continue to support our acquisition strategy. Furthermore, we routinely evaluate our existing portfolio to assess whether we are meeting our strategic and financial objectives in our markets. We evaluate and may seek to opportunistically divest assets that do not meet our strategic and/or financial objectives and which may deliver more value to our stakeholders and the respective communities through a sale.

- *Continue to Engage in Strategic Relationships with Local Partners*. We partner with several academic medical centers and regionally significant health systems to better serve our communities. We have established partnerships with Duke University Health System ("***Duke***"), Norton Healthcare, Inc. ("***Norton***"), LHC Group, Inc. ("***LHC***"), University of Washington Health, Billings Clinic and Emory Healthcare ("***Emory***").

- *Continue to Focus on Cost Reduction and Operational Efficiency*. We strive to improve our operating performance by making our revenue cycle processes more efficient, making an even higher level of purchases through our group purchasing organization, operating more efficiently and effectively, and working to appropriately standardize our policies, procedures and practices across all of our affiliated facilities. As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have partnered with various third parties to provide certain nonclinical business functions, including payroll processing, supply chain management and revenue cycle functions. We believe this model is the most cost effective and efficient approach to managing these nonclinical business functions across multi-facility enterprises. Additionally, in connection with our efforts to responsibly manage purchasing costs, we participate along with other healthcare companies in a group purchasing organization, HealthTrust Purchasing Group, which makes certain national supply and equipment contracts available to our facilities. We also implement this operating discipline when we enter a new market through acquisitions, where we focus on optimizing staffing levels to reduce labor costs, leveraging our national scale and group purchasing organizations to reduce supply costs and standardizing revenue cycle and information technology ("***IT***") systems. We have made substantial progress implementing these initiatives consistently across our network, and we believe that opportunity exists for continued improvement in the near term, particularly among our recently acquired facilities.

- *Experienced Executive Management and Leadership Teams.* Our executive management team has an average of more than 20 years of healthcare industry experience with a proven record of achieving strong operating results. The executive management team is highly respected in the hospital management industry and has significant experience in managing and acquiring hospitals. Our executive management team is led by David Dill, who serves as our President and Chief Executive Officer. Mr. Dill has more than 20 years of operational and financial leadership experience in the healthcare industry.

Our Background

LifePoint/RCCH Merger

Summary

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc." Subsequently, Legacy LifePoint converted from a corporation to a limited liability company.

Equity Contribution

In connection with the LifePoint/RCCH Merger, the Apollo Funds, together with certain other co-investors investing through a co-investment vehicle controlled by our Sponsor or its affiliates, indirectly contributed $1,000.0 million of newly invested capital to DSB Parent L.P., a Delaware limited partnership ("***DSB Parent***"), which is our indirect parent and is owned by the Apollo Funds, such co-investment vehicle and certain current or former directors, members of management, employees and consultants of the Company, and the $1,000.0 million of newly invested capital was further contributed to the Company to be used to partially fund the LifePoint/RCCH Merger.

Financing Transactions

Concurrently with the closing of the LifePoint/RCCH Merger, we (1) issued the 9.75% Unsecured Notes, (2) entered into the ABL Agreement, which provides a senior secured asset-based revolving credit facility (the "***ABL Facility***") in an aggregate principal amount of $800.0 million with a maturity of five years, (3) terminated our existing senior secured asset-based revolving credit facility, which we entered into on April 29, 2016 (the "***Prior ABL Facility***"), (4) entered into the Term Loan Agreement, which provides a senior secured term loan credit facility (the "***Term Loan Facility***") in an aggregate principal amount of $3,550.0 million with a maturity of seven years, and (5) repaid in full our $150.0 million term loan facility, which we entered into on April 25, 2018 (the "***Prior Term Facility***").

Our Operations

Services

We operate health systems that provide a range of medical, surgical and behavioral health services across inpatient and outpatient settings, including general surgery, internal medicine, cardiology, radiology, oncology, orthopedics, women's services, neurology, rehabilitation services, pediatric services, emergency services and, primarily through our joint venture with LHC, home health and hospice services. In some of our health systems, we offer specialized services such as open heart surgery, skilled nursing, psychiatric care and neurosurgery. In many markets, we also provide outpatient services such as same day surgery, clinical laboratory services, diagnostic imaging services, respiratory therapy services, sports medicine services, urgent care services and lithotripsy. The services provided in any specific health system depend on many factors, including the community need for the service, whether physicians necessary to safely operate the service line are members of the medical staff of that hospital and the existence of any contractual or certificate of need restrictions.

Impact of COVID-19

During March 2020, the global COVID-19 pandemic began to significantly affect our facilities, employees, patients, communities, business operations and financial performance, as well as the U.S. economy and financial markets, as a whole. Approximately one year into the pandemic, we continue to be deeply committed to protecting the health of our communities and are continuing to respond to the evolving COVID-19 situation across the country. Importantly, we are taking every precaution to ensure we can continue providing quality care and safeguard the health and well-being of patients, employees, providers, volunteers and visitors in each community we serve. The national footprint of our health system, along with our HSC, has enabled us to support our communities during this challenging time.

We established an internal COVID-19 taskforce during the early stages of the pandemic which continues to meet regularly today. Additionally, in November 2020, we established a COVID-19 vaccine team to help facilitate the successful distribution and administration of vaccines across our markets.

Our top priority continues to be ensuring the safety, health and well-being of those in our facilities and communities. We have put in place a number of protocols to protect our patients, providers, employees, volunteers and visitors, including:

- mandatory masking for all providers, employees, volunteers and visitors across our facilities;
- required eye protection for providers and employees during all clinical encounters across our facilities;
- required COVID-19 testing for all admissions in communities with the highest rates of COVID-19 spread;
- performing pre-operative COVID-19 testing for patients undergoing certain elective procedures; and
- social distancing practices and other protective measures throughout our facilities, including visitor restrictions, closing common areas, limiting entry points and screening providers, employees and visitors who enter our facilities based on criteria established by the Centers for Disease Control and Prevention (the "***CDC***").

Restrictive measures, such as travel bans, social distancing and quarantine guidelines, significantly reduced the volume of procedures performed at our facilities during 2020, as well as the volume of emergency room and physician office visits unrelated to COVID-19. Furthermore, broad economic factors resulting from the current COVID-19 pandemic, including increasing unemployment rates and reduced consumer spending, could negatively affect our payer mix, increase the relative proportion of lower margin services we provide and reduce patient volumes, as well as diminish our ability to collect outstanding receivables.

Our evaluation of the measures taken across our health system in response to COVID-19 is ongoing and additional updates to our policies, procedures and operations could occur as best practices continue to evolve. Furthermore, our facilities are located across a wide geographic range of communities, which may require us to modify measures we take at specific facilities based on local conditions, including the severity of COVID-19 in the community served by the facility and changes in state and local restrictive measures.

As a result of the adverse impact of the COVID-19 pandemic on our business, we have undertaken several additional measures intended to enhance our financial flexibility, including among other things:

- increasing our liquidity with proceeds from the offering of the 6.75% Secured Notes;
- instituting net working capital optimization initiatives along with the curtailment of non-critical capital expenditures;
- receiving Medicare accelerated payments under the Centers for Medicare and Medicaid Services *("**CMS**")* expanded Accelerated and Advance Payment Program;
- receiving direct grant aid payments from the Emergency Fund established under the CARES Act; and
- anticipating current year cash tax savings related to various tax provisions of the CARES Act.

Additionally, although we have received funds that are available to us and our facilities under the CARES Act and other stimulus legislation and may seek additional funds that may become available under existing or future stimulus legislation, we cannot predict the manner in which such funds will be allocated or administered and we cannot assure you that we will be able to access such funds in a timely manner or at all. Most of these programs require healthcare providers to meet certain requirements and/or otherwise agree to certain terms and conditions in order to receive payment. In many cases, only limited guidance has been provided on those requirements and terms and conditions, and we already have seen changes in the substance and interpretation of that guidance.

For additional information about the risks presented by the COVID-19 pandemic, our responses to the pandemic, and the resources available to healthcare providers, refer to "—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" below and "Part I, Item 1A. Risk Factors" and "Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Developments, Trends and Operating Environment—Impact of COVID-19" included in this Report.

Management and Oversight

Our executive management team has extensive experience in operating multi-facility hospital networks and plays a vital role in the strategic planning for our facilities. A hospital's local management team is typically comprised of a CEO, chief operating officer, chief financial officer and a chief nursing officer. Local management teams work with the hospital's Board of Trustees and our HSC management teams to develop annual operating plans setting forth growth strategies through the expansion of current services, implementation of new services and the recruitment and retention of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the needs of our patients, medical staffs and the community as a whole is critical to the success of our facilities. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including quality of care, patient satisfaction and financial measures.

The Board of Trustees at each facility, consisting of local community leaders, members of the medical staff and the facility CEO, advises the local management teams and helps develop the strategic operating plan for their facility. In addition, it plays a key role in providing the patient care excellence that we demand. Members of each Board of Trustees are identified and recommended by our local management teams. The Boards of Trustees oversee policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

The majority of our facilities have a physician engagement group ("***PEG***") or a physician leadership group ("***PLG***") comprised of key physicians and members of the facility's administrative team. The mission of the PEG or PLG is to provide ongoing dialogue between hospital facility administration and members of the medical staff and community physicians primarily in the areas of operations, quality patient care, employee satisfaction and community relations.

We also provide support to the local management teams through our HSC resources in areas such as revenue cycle, business office, legal, managed care, clinical efficiency, physician services and other administrative functions. These resources allow for sharing best practices and standardization of policies and processes among all of our facilities.

Cost Management

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

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

Attracting Patients

We believe that the most important factors influencing a patient's choice in where to receive healthcare services are the quality of care delivered by the facility, the overall reputation of the facility, the availability and expertise of physicians and nurses, and the location and convenience of the facility. Other factors that affect utilization include local demographics and population growth, local economic conditions and the facility's success in contracting with a wide range of local payers.

Outpatient Services

The healthcare industry has experienced an accelerated shift during recent years from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology also have supported the shift to outpatient utilization. However, we expect the decline in inpatient admission use rates to moderate over the long term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through expanding service offerings and increasing the throughput and convenience of our emergency departments, outpatient surgery facilities and other ancillary units in our facilities.

Sources of Revenues

General

Our facilities generate revenues by providing healthcare services to our patients. Depending upon the patient's medical insurance coverage, we are paid for these services by governmental Medicare and Medicaid programs, commercial insurance, including health maintenance organizations ("***HMOs***"), preferred provider organizations ("***PPOs***") and plans offered through the Exchanges, private insurers, and directly by the patient. The amounts we are paid for providing healthcare services to our patients vary depending upon the payer. Governmental payers generally pay significantly less than the hospital's customary charges for the services provided. Insured patients are generally not responsible for any difference between customary hospital charges and the amounts received from commercial insurance payers. However, insured patients are responsible for payments not covered by insurance, such as exclusions, deductibles and co-payments.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2020, 2019 and 2018 (dollars in millions):

	2020		2019		2018	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,134.0	38.6 %	$ 3,338.1	38.1 %	$ 1,105.3	39.8 %
Medicaid	1,392.4	17.1	1,495.3	17.1	486.3	17.5
HMOs, PPOs and other private insurers	3,381.9	41.6	3,698.6	42.3	1,113.8	40.1
Self-pay	54.5	0.7	59.2	0.7	17.2	0.6
Other	142.7	1.8	143.6	1.6	49.4	1.8
Revenue from contracts with customers	8,105.5	99.8	8,734.8	99.8	2,772.0	99.8
Rental income	16.4	0.2	18.0	0.2	6.1	0.2
Revenues	$ 8,121.9	100.0 %	$ 8,752.8	100.0 %	$ 2,778.1	100.0 %

Medicare

For the year ended December 31, 2020, approximately 38.6% of our revenues related to patients participating in Medicare programs. Medicare provides hospital and medical insurance benefits, regardless of income, to persons age 65 and over, some disabled persons and persons with end-stage renal or Lou Gehrig's disease. All of our hospitals are currently certified as providers of Medicare services.

Over the years, Congress and CMS have made several sweeping changes to the Medicare program and its reimbursement methodologies, including the numerous changes contained in the Affordable Care Act. Many of these changes have resulted in decreased reimbursement to healthcare providers. In addition, the Budget Control Act of 2011 ("***BCA***"), which is intended to reduce the federal deficit, imposed a 2% reduction in Medicare spending which began on April 1, 2013. Congress has extended the 2% reduction in Medicare spending on numerous occasions. Most recently, Congress adopted the CARES Act and the Consolidated Appropriations Act, 2021 (the "***CCA***"), which temporarily suspend Medicare sequestration from May 1, 2020 until March 31, 2021, but also extend the 2% reduction in Medicare spending through 2030. Additional reductions in Medicare reimbursement could result from changes to, or the repeal of, the Affordable Care Act, or as a result of the enactment of Medicare reform, deficit reduction or other legislation.

Medicare Inpatient Prospective Payment System

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

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor each federal fiscal year ("***FFY***"), which begin on October 1 (for example, FFY 2021 began on October 1, 2020). The index used to adjust the base MS-DRG payment rate, which is known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. For FFYs 2021, 2020, and 2019, the hospital market basket index increased 2.4%, 3.0%, and 2.9%, respectively. Generally, however, the percentage increase in the MS-DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the hospital market basket increase for FFY 2019 was reduced by CMS by 0.75%. As also mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the Bureau of Labor Statistics' 10-year moving average of changes in annual economy-wide productivity. For FFYs 2021, 2020, and 2019, the productivity adjustment equated to a 0.0%, 0.4%, and 0.8% reduction in the market basket increase, respectively. As a result of these reductions and other changes implemented by CMS, the MS-DRG-rate increased by 2.9% for FFY 2021.

On October 1, 2007, CMS replaced the previously existing 538 diagnosis related groups with 745 MS-DRGs. The MS-DRGs are intended to more accurately reflect the cost of providing inpatient services and eliminate any incentives that hospitals may have to only treat the healthiest and most profitable patients. The American Taxpayer Relief Act of 2012 ("***ATRA***") required CMS to recoup $11 billion from IPPS payments in FFYs 2014 through 2017 to offset an additional increase in aggregate payments to hospitals that Congress believes occurred from FFYs 2008 through 2013 solely as the result of the transition to the MS-DRG system. In FFYs 2014, 2015 and 2016, CMS applied negative 0.8% adjustments as part of the recovery process required by ATRA, and it applied a negative 1.5% adjustment in FFY 2017 to recover the remaining outstanding amount. CMS had previously indicated that the reductions required by ATRA would be fully restored in FFY 2018. However, under the Medicare Access and CHIP Reauthorization Act of 2015 ("***MACRA***"), those reductions were to be restored in 0.5% increments over a six-year period from FFYs 2018 through 2023, which would result in a cumulative 3.0% increase in rates, which would be less than the 3.9% reduction that was imposed by CMS in FFYs 2014 through 2017. In addition, some of that restoration has been subject to further limits, such as under the 21st Century Cures Act (the "***Cures Act***") which further reduced the restoration for FFY 2018 from 0.5% to 0.4588%.

CMS has implemented a number of programs and requirements that are intended to promote value-based purchasing and to link payments to quality and efficiency. For example, all acute care hospitals are required to participate in CMS' Hospital Inpatient Quality Reporting Program (the "***IQR Program***") in order to receive the full hospital market basket update. Hospitals that do not participate in the IQR Program receive a 25% reduction in their IPPS annual payment update for the applicable FFY. Our hospitals reported all quality measures required by CMS related to the IQR Program and nearly all will receive the full market basket update through FFY 2021. In addition, hospitals that are not meaningful EHR users are also subject to an additional 75% reduction of the hospital market basket increase.

In addition, the Affordable Care Act requires U.S. Department of Health and Human Services ("***HHS***") to implement a value-based purchasing program for inpatient hospital services. This program rewards hospitals based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period. As part of the program, the Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by 2.0% each FFY. HHS pools the amount collected from these reductions to fund payments to reward hospitals that meet and exceed certain quality performance standards established by HHS. Under the program, each hospital's performance is evaluated during a specified performance period, and hospitals receive points on each of a number of pre-determined measures based on the higher of (i) their level of achievement relative to an established standard or (ii) their improvement in performance from their performance during a prior baseline period. Each hospital's combined scores on all the measures are translated into value-based incentive payments. Hospitals that receive higher total performance scores receive higher incentive payments than those that receive lower total performance scores. Because the Affordable Care Act provides that the funds pooled and otherwise set aside for the value-based purchasing program will be fully distributed, hospitals with high scores may receive greater reimbursement under the value-based purchasing program than they would have otherwise, and hospitals with low scores may receive reduced Medicare inpatient hospital payments.

Medicare also does not allow an inpatient hospital discharge to be assigned to a higher paying MS-DRG if certain designated hospital acquired conditions ("***HACs***") were not present on admission and the identified HAC is the only condition resulting in the assignment of the higher paying MS-DRG. In those situations, the case is paid as though the secondary diagnosis was not present. In addition, hospitals that fall into the top 25.0% of national risk-adjusted HAC rates for all hospitals in the previous year receive a 1.0% reduction in their total Medicare payments.

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

Medicare Hospital Outpatient Prospective Payment System and Other Outpatient Services

CMS reimburses hospital outpatient services under the Medicare hospital outpatient prospective payment system ("***OPPS***"), and generally uses fee schedules to pay for durable medical equipment and physical, occupational and speech therapy, clinical diagnostic laboratory and independent diagnostic testing facility services. Under the OPPS, hospital outpatient services are classified into groups called ambulatory payment classifications ("***APCs***"). Services in each APC are clinically similar and are similar in terms of the resources they require. Depending on the services provided, a hospital may be paid for more than one APC for an encounter. CMS establishes a payment rate for each APC by multiplying the scaled relative weight for the APC by a conversion factor. The payment rate is further adjusted to reflect geographic wage differences. The APC conversion factors for calendar years ("***CYs***") 2021, 2020, and 2019 were $82.797, $80.793, and $79.490, respectively, after the inclusion of the productivity adjustments and other reductions that were required by the Affordable Care Act. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Reporting Program (the "***OQR Program***"). Hospitals that do not satisfy the reporting requirements of the OQR Program are subject to a reduction of 2.0% in their annual payment update under the OPPS. Our hospitals reported all quality measures required by CMS related to the OQR Program and will receive the full market basket update through CY 2021.

Section 603 of the Bipartisan Budget Act of 2015 limits reimbursement for items and services that are furnished by certain off-campus outpatient provider-based departments ("***off-campus PBDs***") of hospitals. CMS included several provisions implementing Section 603 in the OPPS final rule for CY 2017. Under the final rule, CMS continues to make OPPS payments to off-campus PBDs that were billing Medicare as hospital departments under the OPPS prior to November 2, 2015 ("***grandfathered PBDs***"). However, grandfathered PBDs generally are not be able to relocate, and CMS has indicated that it may adopt limitations on the expansion of the service lines provided at grandfathered PBDs in the future. In addition to grandfathered PBDs, CMS continues to reimburse all items and services that are furnished in a "dedicated emergency department" of a hospital, as such term is defined for the purposes of the Emergency Medical Treatment and Active Labor Act ("***EMTALA***"), regardless of whether the items and services are emergency items and services, and all items and services that are furnished in off-campus PBDs that are located within 250 yards of a remote location of a hospital, which is a facility that is either created or acquired by a hospital for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the hospital, under the OPPS. All items and services not provided at a grandfathered or otherwise excepted off-campus PBD are generally paid by CMS under Medicare physician fee schedule ("***PFS***") rates that are approximately 40% of the applicable OPPS rate (the "***PFS Adjusted Rate***"). In addition, in 2018, CMS issued a final rule that generally reimburses clinic visit services provided at all off-campus PBDs, including grandfathered PBDs, at a reduced Medicare PFS-equivalent payment rate. The payment reduction for clinic visit services provided at off-campus PBDs was to be phased in over a two year period beginning in FFY 2019.

In December 2018, a lawsuit was filed challenging the portion of CMS' final rule that reduced reimbursement for clinic visit services provided at grandfathered PBDs to the lower Medicare PFS-equivalent payment rate. On September 17, 2019, the U.S. District Court for the District of Columbia ruled that the reduction in reimbursement for clinic services provided at grandfathered PBDs exceeded CMS' statutory authority. As a result of the ruling, CMS paid claims for clinic visit services provided at grandfathered PBDs in CY 2019 at the full OPPS payment rate. However, in the OPPS final rule for CY 2020, CMS noted that the court's ruling only applied to clinic visit services provided in CY 2019, and, as a result, CMS moved forward with the planning phase-in of the second year of the clinic visit service payment reduction in CY 2020 while it appealed the court's decision. A new lawsuit was filed on January 13, 2020, challenging the continued phase-in of the reduction for CY 2020. On July 17, 2020, the U.S. Court of Appeals for the District of Columbia reversed the lower court's ruling regarding the CY 2019 reductions and upheld CMS' reimbursement reductions for clinic visit services provided at grandfathered PBDs. The ruling of the U.S. Court of Appeals for the District of Columbia has been appealed to the U.S. Supreme Court. However, we cannot predict whether the U.S. Supreme Court will agree to hear the appeal and, if so, whether the appeal will be successful. CMS has stated that it will reprocess claims for outpatient clinic visit services that were provided at grandfathered PBDs in CY 2019 at the lower Medicare PFS-equivalent payment rate. CMS has indicated that it expects the reprocessing of the affected claims to be completed by July 1, 2021.

In addition to those reimbursement reductions and in furtherance of its efforts to increase site neutrality in Medicare payments, CMS announced in the OPPS final rule for CY 2021 that it would eliminate the Medicare program's inpatient only procedure list over a three-year period, beginning with the removal of approximately 300 primarily musculoskeletal-related procedures, with the list being completely phased out by CY 2024. The elimination of the inpatient only procedure list will make those procedures eligible to be paid by Medicare in the hospital outpatient setting when outpatient care is appropriate, as well as maintain the ability of Medicare to pay for these services in the hospital inpatient setting when inpatient care is appropriate, as determined by the patient's physician.

As part of the OPPS final rule for CY 2018, CMS also finalized a change to the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B Drug Pricing Program (the "***340B Program***"). The 340B Program allows certain non-profit and governmental hospitals and other healthcare providers to obtain substantial discounts on covered outpatient drugs (prescription drugs and biologics other than vaccines) from drug manufacturers. Under the final rule, CMS pays for separately reimbursable, non-pass through drugs and biologicals (other than vaccines) purchased through the 340B Program at the average sales price ("***ASP***") minus 22.5% rather than ASP plus 6%. CMS estimated that this change reduced Medicare payments for drugs and biologicals by $1.6 billion in CY 2018. To maintain budget neutrality, CMS implemented an offsetting increase in the conversion factor. As a result, OPPS reimbursement rates for non-drug items and services provided by all hospitals, including those not eligible to participate in the 340B Program, were increased in connection with the reduction to 340B Program payments. In the OPPS final rule for CY 2019, CMS expanded the 340B Program payment reductions to drugs that are obtained through the 340B Program and furnished by non-excepted, off-campus PBDs.

In September 2018, a lawsuit was filed challenging the authority of CMS to make the 340B Program payment reductions set forth in the OPPS final rule for CY 2018. On December 27, 2018, the U.S. District Court for the District of Columbia held that the payment reductions exceeded CMS' statutory authority and entered a permanent injunction against the reductions. However, because the 340B Program payment reductions were made in a budget-neutral manner and the savings derived from the reductions were used to increase reimbursement for all of the other items and services provided under the OPPS, the court ordered the parties to submit briefs as to how the issue should be remedied. The lawsuit was subsequently expanded to include the 340B Program payment reductions that were made in CY 2019, and an additional lawsuit has been filed against the 340B Program payment reductions being made by CMS in CY 2020. CMS appealed the District Court's rulings, and, on July 31, 2020, the U.S. Court of Appeals for the District of Columbia reversed the lower court's ruling and upheld CMS' 340B Program payment reductions. The ruling of the U.S. Court of Appeals for the District of Columbia has been appealed to the U.S. Supreme Court, and we cannot predict whether the appeal will be successful or whether CMS will continue the 340B Program payment reductions under the new Presidential administration. If OPPS payments to hospitals are reduced (either retroactively or prospectively) in connection with the 340B Program, we would be materially adversely affected.

Medicare Disproportionate Share Hospital Payments

Hospitals may also qualify for Medicare disproportionate share hospital ("***DSH***") payments, if they treat a high percentage of low-income patients (as determined by a ratio involving Medicare and Medicaid patients eligible to receive Supplemental Security Income). DSH payments are determined annually based on certain statistical information specified by HHS and are paid as an addition to MS-DRG payments. The Affordable Care Act requires Medicare DSH payments to providers to be reduced by 75% beginning in FFY 2014, subject to adjustment if the Affordable Care Act does not decrease uncompensated care to the extent anticipated. The amount that is withheld is reduced by the percentage change in uninsured individuals under the age of 65, and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. The IPPS final rule for FFY 2021 established the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2021 at approximately $8.3 billion, a decrease of approximately $60 million from FFY 2020.

Medicare Dependent and Low Volume Hospital Programs

On April 16, 2015, MACRA was enacted. Among other things, MACRA extended the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by Medicare, and the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located a certain distance from another general acute care hospital and have less than a certain number of Medicare discharges each fiscal year, through September 30, 2017. The Bipartisan Budget Act of 2018 extended both of these programs through FFY 2022.

Cost Reports

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

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

Medicare Bad Debt Reimbursement

Under Medicare, the costs attributable to the deductible and coinsurance amounts that remain unpaid by Medicare beneficiaries after reasonable collection efforts can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the Medicare administrative contractor (*"**MAC**"*) from prior cost report filings.

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

Medicare Physician Fee Schedule

Professional medical services provided to Medicare beneficiaries by physicians and certain other healthcare practitioners, including physician assistants and nurse practitioners, are reimbursed under the PFS. Under the PFS, CMS has assigned a national relative value unit ("***RVU***") to most medical procedures and services that reflects the various resources required by a physician or practitioner to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service and the practice overhead and malpractice insurance expenses that are attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs and are then aggregated. The aggregated amount is multiplied by a conversion factor to determine the payment rate for the service. The conversion factor is updated by CMS on an annual basis.

MACRA, which was adopted in 2015, significantly changed how CMS determines the annual updates to the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased annually by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the Bipartisan Budget Act of 2018, were increased by 0.25% for CY 2019. PFS payment rates are scheduled to remain at their CY 2019 levels through CY 2025. To account for changes that have been made to the RVUs associated with certain procedures and services, particularly those associated with evaluation and management visits, the final PFS rule for CY 2021 reduced the PFS conversion factor to $32.41, an approximate reduction of 10.2%, in order to maintain budget neutrality as required by law. However, the CCA temporarily increases PFS payment rates by 3.75% (approximately $3 billion) for CY 2021 and partially offsets the reduction.

In addition to revising the methodology that is used to update payments that are made under the PFS, MACRA also established a Quality Payment Program ("***QPP***") for incentivizing physician and practitioner care that meets certain value, quality, cost, and performance criteria. Beginning in CY 2019, amounts paid to physicians and practitioners under the PFS are subject to adjustment through the QPP and participation in either the Merit-Based Incentive Payment System ("***MIPS***") or an Advanced Alternative Payment Model ("***APM***") program. Physicians and practitioners who participate in the MIPS program, which essentially consolidated the prior Physician Quality Reporting System, the Value-Based Modifier, and the Meaningful Use of EHR incentive programs, are subject to positive, zero, or negative performance adjustments depending on how the physician's or practitioner's performance compared to a performance threshold. The payment adjustments are based on the physician's or practitioner's performance in the year that is two years prior to the current payment period. As a result, PFS payments in CY 2021 will be based on CY 2019 performance scores, and so on for the following years. HHS and CMS revise the MIPS reporting measures on an annual basis and have indicated that they intend to routinely increase the performance thresholds in connection with those revisions. In addition, from CY 2019 through CY 2024, MACRA provides $500 million per year for an additional performance adjustment for physicians and practitioners who participate in MIPS and achieve exceptional performance. Physicians and practitioners who participate in a specified APM program, which, among other things, requires the physician or practitioner to receive a substantial amount of their revenue from an APM, will receive, from CYs 2019 through 2024, a lump-sum payment equal to 5% of their Medicare payments in the prior year for services paid under the PFS. Beginning in CY 2026, PFS payment rates for physicians and practitioners participating in an APM program would be increased by 0.75% a year. Payments for other physicians and practitioners would be increased by 0.25% per year.

Medicaid

For the year ended December 31, 2020, approximately 17.1% of our revenues related to patients participating in the various state Medicaid programs. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. Medicaid programs are funded by both the federal government and states to provide healthcare benefits to limited categories of low-income individuals under 65 years of age. These programs and the reimbursement methodologies are administered by the states under approved plans and vary from state to state and from year to year. Amounts received under the Medicaid programs are often significantly less than the hospital's customary charges for the services provided. Most state Medicaid payments are made under a prospective payment system, fee schedule, cost reimbursement program, or some combination of these three methods. All of our hospitals are currently certified to participate in their respective state Medicaid programs.

As enacted, the Affordable Care Act essentially required states to expand Medicaid coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level ("***FPL***"). However, that portion of the Affordable Care Act was held to be unconstitutional by the U.S. Supreme Court, and, as a result, states may opt out of the expansion without losing their existing Medicaid funding. Therefore, the income level required for individuals to qualify for Medicaid varies widely from state to state. To offset the cost of the Medicaid program's expansion, the Affordable Care Act authorized the federal government to provide states with "matching funds" (referred to as "***Enhanced FMAP***") to cover the costs of covering the newly eligible individuals. The Enhanced FMAP was 100% for CYs 2014 through 2016; 95% in CY 2017; 94% in CY 2018; 93% in CY 2019; and will be 90% in CYs 2020 and thereafter.

In recent years, we have benefited from the expansion of Medicaid under the Affordable Care Act, and effective as of January 1, 2020, Idaho and Utah, two additional states in which we operate, expanded their Medicaid programs. In addition, Oklahoma, an additional state in which we operate, is expected to expand its Medicaid program in 2021. However, a number of states in which we operate have not expanded their Medicaid programs or are seeking waivers that could reduce their Medicaid-eligible populations. Several states have adopted or are considering legislation designed to reduce or control their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs, and imposing additional taxes on hospitals to help finance such states' Medicaid systems. Given the reductions in the Enhanced FMAP and in light of the ongoing litigation regarding the constitutionality of, and potential further modification to, the Affordable Care Act, we are unable to predict how many, if any, additional states in which we operate will expand their Medicaid programs or how many, if any, of the states in which we operate that have expanded their Medicaid programs will keep their expansions in place in the future.

The Affordable Care Act also included a number of provisions that are intended to improve the quality of care that is provided to Medicaid beneficiaries. Among other things, the Affordable Care Act prohibits federal funds from being used to reimburse providers for services related to provider preventable conditions, such as HACs, wrong site surgeries and other provider preventable conditions that may be designated by each state Medicaid program.

Work Requirements

In addition to implementing value-based purchasing and quality-driven reimbursement requirements, CMS has also issued new guidance permitting states to impose work and/or community engagement requirements on certain Medicaid beneficiaries. In response to the guidance, a number of states, including several in which the Company has facilities, have requested demonstration waivers from CMS that would allow those states to impose work requirements on their Medicaid beneficiaries. CMS has approved the requests that have been made by Arizona, Arkansas, Georgia, Indiana, Michigan, Ohio, South Carolina, Utah and Wisconsin, and the remaining requests are still pending. However, a number of lawsuits have been filed challenging the authority of CMS to allow state Medicaid programs to impose work and/or community engagement requirements on their respective beneficiaries and, as a result, most of the demonstration waivers that have been approved by CMS have not yet been implemented. We cannot predict whether CMS will grant additional waivers that allow for the imposition of work and community engagement requirements on Medicaid beneficiaries or the impact that any such waivers will have on coverage for patients seeking care at our facilities. We also cannot predict whether the legal challenges that have been initiated against the demonstration waivers that have been approved by CMS will be successful or whether any legal challenges will be initiated against any other similar demonstration waivers that have been or may be granted by CMS in the future.

Medicaid Block Grants and Capped Federal Funding

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

On November 11, 2019, Tennessee, one of the states in which we operate, submitted an amendment to CMS for its Medicaid demonstration waiver that would convert federal funding for the Tennessee Medicaid program to a modified block grant program. CMS approved the amendment on January 8, 2021, and as required by state law, the Tennessee General Assembly approved the implementation of the amendment on January 15, 2021. Under the amendment, the Tennessee Medicaid program would receive federal matching funds for expenditures up to an aggregate annual cap. The aggregate cap would be based on the Tennessee Medicaid program's historical expenditures and would be increased to reflect a reasonable growth rate over time and for unexpected increases in enrollment. In exchange, the Tennessee Medicaid program would be given increased flexibility in how it operates and would be entitled to 55% of any savings that are achieved if spending is below the aggregate cap and the state meets certain quality targets. Any savings would generally be required to be re-invested in the Tennessee Medicaid or other health related programs. Despite being granted increased administrative flexibility, the Tennessee Medicaid program would be required to maintain the coverage and benefit levels that were in place as of December 31, 2020. We cannot predict whether the new Presidential administration will attempt to rescind CMS' approval of the amendment to the Tennessee Medicaid program, whether litigation will be filed against the conversion of federal funding for the Tennessee Medicaid program to a modified block grant program, whether the changes authorized by the amendment to the Tennessee Medicaid program will ever become effective, and, if so, the impact those changes will have on our operations and revenues.

Medicaid Supplemental Payments

Medicaid supplemental payments ("***MSPs***") are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and Upper Payment Limit ("***UPL***") payments.

Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating those patients. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. Although federal Medicaid law defines some level of hospitals that must receive Medicaid DSH funding, states have broad discretion to define additional hospitals that also may qualify for Medicaid DSH payments and the amount of such payments. However, the total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law.

Pursuant to the Affordable Care Act, as amended by subsequent legislation, funding for Medicaid DSH programs was to be reduced by $4 billion in FFY 2020 and $8 billion per year from FFY 2021 through FFY 2025. Congress has delayed the reduction in funding for Medicaid DSH programs on a number of occasions, most recently through the CCA, which eliminates the scheduled Medicaid DSH reductions for FFYs 2021 through 2023 but adds additional Medicaid DSH reductions for FFYs 2026 and 2027. We cannot predict whether Congress will further delay or otherwise modify the reductions in the future. Because many of the states in which we operate have not expanded Medicaid programs as intended under the Affordable Care Act, the reduction in Medicaid DSH payments may take place without a coupled increase in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars. UPL programs have expanded in recent years, and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs.

On November 18, 2019, CMS released a proposed rule, the Medicaid Fiscal Accountability Rule, that was intended to increase federal oversight of MSPs and state Medicaid financing policies. Among other things, the proposed rule would have added new reporting requirements on UPL payment arrangements, imposed limitations on UPL payments that are made to physicians and certain other practitioners, and imposed limits on the use of healthcare provider taxes, intergovernmental transfers and certified public expenditures. CMS withdrew the proposed rule in 2020. However, some of the reporting requirements contained in the Medicaid Fiscal Accountability Rule were included in the CCA, and, beginning in FFY 2022, each state will be required to provide CMS with, among other things, (i) a description of the stated purpose and intended effects of the state's MSPs, (ii) an explanation of how the state's MSPs will result in payments that are consistent with the requirements of the Medicaid program, including the program's standards with respect to efficiency, economy, quality of care, and access, (iii) the criteria used to determine provider eligibility for the state's MSPs, (iv) a comprehensive description of the methodology used to calculate the amount of, and distribute, MSPs to each eligible provider, and (v) an assurance that the total Medicaid payments made by the state to inpatient hospital providers, including any MSPs, will not exceed the UPL. The CCA also further clarifies how third-party payments are to be considered when determining Medicaid DSH hospital-specific limits. We cannot predict the impact, if any, that the reporting requirements and other Medicaid provisions in the CCA will have on MSPs and UPL payments that are made by state Medicaid programs or whether Congress or CMS will adopt any additional legislation or regulations that will eliminate or otherwise limit MSPs and/or UPL payments. In addition, we cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease.

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

Recovery Audit and Other Review Contractors

Recovery audit contractors ("***RACs***") are used by CMS and state agencies to detect Medicare and Medicaid overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare and Medicaid claims filed by healthcare providers. RACs perform post-discharge audits of medical records to identify overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services and are paid on a contingency basis. Any claims identified as overpayments are subject to a RAC program appeals process. In 2016, in connection with the procurement of the new recovery audit contracts, CMS made a number of enhancements to the RAC program, including the establishment of a RAC program Provider Relations Coordinator, requiring RACs to maintain an overturn rate of less than 10% at the first level of appeal, requiring RACs to maintain an accuracy rate of at least 95%, and establishing additional documentation request limits based on a provider's compliance with Medicare rules, that are intended to address provider and other stakeholder concerns. CMS has also limited the number of claims that RACs may audit by limiting the number of records that RACs may request from hospitals based on each hospital's claim denial rate for the previous year.

In addition to RACs, CMS employs Unified Program Integrity Contractors ("***UPICs***"), which integrate the functions of the former Zone Program Integrity Contractors, Program Safeguard Contractors, and Medicaid Integrity Contractors, to perform post-payment audits of Medicare and Medicaid claims and identify overpayments. A number of state Medicaid agencies and other contractors have also increased their review activities.

Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our hospitals have had Medicare claims audited by the RAC program. While our hospitals have successfully appealed many of the adverse determinations raised by Medicare RAC audits, we cannot predict if this trend will continue or the results of any future audits. We cannot predict the volume or outcome of any future audits conducted by the various RACs and other review programs to which our hospitals will be subject.

Utilization and Claim Review

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

In addition to utilization reviews, CMS has also adopted a nationwide claim review and provider education program known as the Targeted Probe and Educate ("***TPE***") program, which is intended to reduce errors in the claims submission process and focuses on items and services that pose the greatest risk to the Medicare program or that have a high national error rate, such as short inpatient stays. Under the TPE program, MACs use data analysis to identify providers who, for a particular item or service, have high claim denial rates or billing practices that vary significantly from their peers. Once a provider has been identified, the MAC reviews between 20 and 40 of the provider's claims for the item or service and, if issues are noted, offers the provider an individualized education session that is based on the results of the review. The provider is then generally given 45 days to improve its systems and processes, and, after that period has ended, the MAC conducts another review of the provider's claims. If additional issues are identified, the provider is given the opportunity for another education session. Providers are typically given three rounds of review and education before being referred to CMS for further action, potentially including pre-payment review, referral for RAC review, or in some cases revocation of billing privileges.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payers including HMOs, PPOs and other private insurers. Also included in this category are the patient responsibility portions for co-payment and deductible obligations under these programs. Our revenues from HMOs, PPOs and other private insurers were approximately 41.6% of our revenues for the year ended December 31, 2020. Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services or accept fixed, pre-determined fees for our services. These discounted contractual arrangements often limit our ability to increase charges or revenues in response to increasing costs. We actively negotiate with these payers in an effort to maintain or increase the pricing of our healthcare services. However, we have no control over patients switching their healthcare coverage to a payer with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. Additionally, plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when we are not a participating provider in the network, it can result in higher patient responsibility amounts that a patient may not have the ability to pay or may choose not to pay. We expect these trends to continue in the coming years.

Self-Pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Our revenues from self-pay patients were approximately 0.7% of our revenues for the year ended December 31, 2020. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities experienced in prior years, which included increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. We cannot predict how administrative or judicial interpretations, legislative actions or any other modifications to the Affordable Care Act that may be implemented or adopted, such as the cessation of cost sharing reduction payments or the repeal of the individual mandate, may impact our self-pay revenues. We also cannot predict whether the business closures and layoffs that are occurring as a result of the COVID-19 pandemic will increase the number of underinsured and uninsured patients that seek treatment at our facilities.

In addition, effective January 1, 2022, the No Surprises Act requires health care providers, including hospitals and other health care facilities, to provide uninsured patients with a good faith estimate of the provider's total expected charges for scheduled items or services, including any expected ancillary services, before providing the items or services to the patient. Uninsured patients will be able to utilize a patient-provider dispute resolution process to challenge the provider's charges if they receive a bill that is substantially higher than the good faith estimate that was provided by the health care provider. We cannot predict how the uninsured patient good faith estimate and dispute resolution provisions of the No Surprises Act will impact the amounts collected by the Company's facilities for self-pay patients.

Surprise Medical Billing

On December 21, 2020, Congress adopted legislation that is intended to limit the "surprise" medical bills that are often received by individuals receiving emergency and certain other services (such as anesthesia services) from out-of-network providers. Effective as of January 1, 2022, the No Surprises Act prohibits out-of-network providers from balance billing patients for (i) emergency care services that are provided by out-of-network facilities or at in-network facilities by out-of-network providers and (ii) transportation and related services that are provided by out-of-network air ambulance providers. The No Surprises Act also generally prohibits out-of-network providers from billing patients for non-emergency medical treatment unless the provider first notifies the patient of the provider's network status and estimated charges and the patient agrees to be financially liable for the additional amounts. Violations of the No Surprises Act are punishable by civil monetary penalties of up to $10,000, and the No Surprises Act may be enforced by both the state and federal governments.

When the prohibitions of the No Surprises Act apply, a patient's financial liability will generally be limited to his or her in-network amount, which will be determined in accordance with a process that will be set forth in regulations that are required to be promulgated by the Secretary of HHS prior to the effective date of the legislation. In addition, the patient's third-party payer must either pay the out-of-network provider an initial payment amount or issue a notice of denial to the provider for the services that were rendered within 30 days of the payer's receipt of the provider's claim. If the provider is not satisfied with the payer's initial payment amount, the provider and the payer will begin a 30-day negotiation period. If the provider and the payer cannot agree on a payment amount during the negotiation period, the parties may elect to initiate an independent dispute resolution ("***IDR***") process. The IDR process will be conducted by a neutral arbitrator that has been approved by the federal government. As part of the IDR process, the provider and the payer will each submit a final payment offer for consideration by the arbitrator. The arbitrator may consider any relevant information regarding the claim, including the acuity of the patient and the training and experience of the provider. However, the arbitrator may not consider the provider's billed charges or the reimbursement rates paid by Medicare, Medicaid or any other government healthcare program. The arbitrator will be required to pick one of the two offers (i.e., the arbitrator will not be allowed to split the difference between the amounts that have been proposed by the payer and the provider or otherwise determine a different payment amount), and the losing party will be responsible for the costs of the arbitration.

We cannot predict how the No Surprises Act will be implemented by HHS or how it will ultimately be enforced by the federal and various state governments. We also cannot predict the amounts that will be received by our facilities and our employed providers for out-of-network services, whether the No Surprises Act will impact the in-network payment rates that are offered by third-party payers and the willingness of those payers to enter into participation agreements with us and our facilities in the future, or the costs we will incur in complying with the requirements of the No Surprises Act. In addition, a number of states are considering or have already adopted legislation to eliminate surprise medical billing. We cannot predict how state legislative actions to modify or pass these proposals may be implemented or adopted, or what impact, if any, those actions may have on our operations and revenues.

Price Transparency

Transparency in healthcare pricing has become a focal point for CMS, Congress, and many state legislatures. For example, effective as of January 1, 2021, hospitals generally are required to post their standard charges prominently on a publicly available website. Under CMS regulations, each hospital's standard charges must be posted in two ways: (1) a single machine-readable digital file containing the gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for all items and services provided by the hospital and (2) a public display in a consumer-friendly manner of cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for at least 300 "shoppable" services (70 CMS-specified and 230 hospital-selected). CMS has stated that it intends to audit and monitor hospital compliance with its reporting requirements and to take actions to address hospital noncompliance, including issuing a warning notice, requesting a corrective action plan, and imposing civil monetary penalties. In addition to the CMS hospital price transparency regulations, HHS and the Departments of the Treasury and Labor have issued regulations that require most private health plans, including group health plans and individual health insurance market plans, to disclose pricing and cost-sharing information to their beneficiaries. A number of states have also adopted their own healthcare price transparency and/or disclosure statutes.

In addition to addressing surprise billing, the No Surprises Act contains a number of provisions that are intended to promote provider and health plan price transparency. Among other things, effective as of January 1, 2022, under the No Surprises Act, healthcare providers will be required to provide "good faith estimates" of their total expected charges for scheduled items and services to the patient's health plan if the patient is insured prior to the item and/or service being provided. Health plans will be required to provide patients with an "advanced explanation of benefits" that includes: (1) information regarding the network status of the provider, (2) a copy of the provider's "good faith estimate," (3) an estimate of the amount that the patient will be expected to pay for the item or service, and (4) information on any applicable pre-authorization requirements. The Secretary of HHS is required to adopt regulations to implement the price transparency provisions of the No Surprises Act.

Although we continue to evaluate, and are taking proactive steps in response to, the legislative and regulatory developments regarding price transparency, we cannot predict how existing regulations will be implemented or interpreted or whether any other requirements will be imposed on providers and health plans. We also cannot predict what affect the public disclosure of hospitals' or insurance providers' negotiated rates will have on our future negotiations with payers or the effect that the disclosure of pricing information by healthcare providers and health plans will have on our patient volumes and revenues.

Healthcare Reform

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, requiring most Americans to obtain health insurance, also referred to as the "individual mandate," providing additional funding for Medicaid in states that choose to expand their programs, reducing IPPS, OPPS and Medicare and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and instituting certain private health insurance reforms. The Affordable Care Act has, however, been subject to a number of legislative and regulatory changes and court challenges, and its future is uncertain.

For example, during his term, President Trump issued various executive orders that were designed to delay or alter the implementation of various provisions of the Affordable Care Act. While President Biden has stated that he will take executive actions to increase the number of individuals covered under the Affordable Care Act, such as by opening a special enrollment period, we cannot predict the impact that the change in Presidential administrations may have on how the Affordable Care Act is interpreted and/or implemented in the future. In addition, a number of bills have been introduced in Congress that would repeal the Affordable Care Act and would replace it with varying health coverage plans, including plans that would allow insurers to sell health insurance across state lines, allow the use of health savings accounts ("***HSAs***") without a high-deductible plan, or give states the option to either keep the coverage framework created by the Affordable Care Act (e.g., expanded Medicaid, individual subsidies, and insurance exchanges) or utilize the increased federal funding that was intended for Medicaid expansion to be provided by the federal government under the Affordable Care Act to create HSAs that can be used by low-income individuals to purchase health insurance.

In addition to the administrative actions and legislative efforts to repeal, replace or modify the Affordable Care Act, there have been and may continue to be a number of legal challenges to various provisions of the Affordable Care Act and the regulations that have been promulgated thereunder. For example, in 2018, a number of states filed a lawsuit against the federal government alleging that, in light of the repeal of the penalties associated with the individual mandate, the entire Affordable Care Act was unconstitutional. On December 14, 2018, the U.S. District Court for the Northern District of Texas ruled in favor of those states and held that the Affordable Care Act was unconstitutional. The Court did not, however, issue an injunction against the continued enforcement of the Affordable Care Act. On appeal, the U.S. Fifth Circuit Court of Appeals held that the individual mandate was unconstitutional, but it remanded the case back to the U.S. District Court for the Northern District of Texas for further analysis as to whether the entire Affordable Care Act should be held to be unlawful. The case was appealed to the U.S. Supreme Court, which heard oral arguments on the matter in November 2020 and is expected to issue its ruling on the case in the spring or summer of 2021.

We cannot predict the outcome or impact of any legislative efforts to repeal, replace, or materially modify the Affordable Care Act or the litigation that has been filed in relation to the Affordable Care Act, including its constitutionality. Additionally, we also cannot predict the impact that the new Presidential administration and Congressional leadership will have on the implementation and enforcement of the provisions of the Affordable Care Act, on any current, pending or potential regulations adopted to implement the law, or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

Expanded Coverage

Based on original Congressional Budget Office ("***CBO***") and CMS estimates, by 2020, the Affordable Care Act was originally expected to expand coverage to 32 to 34 million people, resulting in coverage of an estimated 95% of the legal U.S. population and an uninsured population of approximately 27 million individuals. This increased coverage was expected to occur through a combination of public program expansion and private sector health insurance and other reforms. However, in September 2020, the CBO estimated that, due to a number of factors, between 31 and 32 million people were uninsured in 2020 and that the number of uninsured individuals would remain relatively consistent through 2030.

Public program expansion has been driven primarily by expanding the categories of individuals who are eligible for Medicaid coverage and allowing individuals with relatively higher incomes to qualify for Medicaid coverage. When the Affordable Care Act was adopted, it essentially made the expansion of the Medicaid program mandatory. However, in 2012, the U.S. Supreme Court held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that chose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. Based on the U.S. Supreme Court's ruling, a number of states, including several in which the Company has facilities, have opted not to expand their Medicaid programs. Additional public program expansion has occurred through provisions of the Affordable Care Act that authorize the federal government to subsidize states that create non-Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL and allow Medicaid participating hospitals to make presumptive determinations of Medicaid eligibility for certain categories of individuals, such as pregnant women, infants, children, and parents and other caretaker relatives and their spouses. If an individual is found to be presumptively eligible for Medicaid benefits, the hospital will get paid for the services it provides during the temporary presumptive eligibility period, just as though the patient were already enrolled in the Medicaid program.

The expansion of health coverage through the private sector as a result of the Affordable Care Act has occurred through new requirements on health insurers, employers and individuals. For example, commencing January 1, 2014, health insurance companies were prohibited from imposing annual coverage limits, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. In addition, since January 1, 2011, each health plan has been required to keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. Also, since September 23, 2010, health insurers have not been permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old. Larger employers are subject to new requirements and incentives to provide health insurance benefits to their full-time employees, and, effective January 1, 2016, all employers subject to the requirement were required to offer health insurance coverage to 95% of their full-time employees and their dependents in order to avoid penalties.

To facilitate the purchase of health insurance by individuals and small employers, each state was required to establish an Exchange by January 1, 2014. For individuals and families below 400% of the FPL, the cost of obtaining health insurance through the Exchanges is subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. Health insurers participating in the Exchanges must offer a set of minimum benefits to be defined by HHS and may offer more benefits. Any benefits to us from the expansion of private sector coverage depend in large part on our success in contracting with payers whose policies are listed on the Exchanges. We currently have contracts with Exchange payers in every state in which we operate, and the reimbursement rates paid under those contracts generally are comparable to that paid to us by other private payers.

Public Program Spending

The Affordable Care Act provides for a number of Medicare, Medicaid and other federal healthcare program spending reductions. The CBO previously estimated that between 2013 and 2023, these program spending reductions would include $415 billion in Medicare fee-for-service market basket and productivity reimbursement reductions for all providers, the majority of which ($260 billion) would come from hospitals. The CBO's estimate also included an additional $56 billion in reductions of Medicare and Medicaid DSH funding. CMS had originally estimated that the Affordable Care Act would result in $64 billion in reductions of Medicare and Medicaid DSH funding, with $50 billion of the reductions coming from Medicare. Some of those reductions, most notably the Medicaid DSH funding reductions, have been delayed by subsequent legislation, and we cannot predict whether the public program spending reductions required by the Affordable Care Act will be further delayed or modified in the future.

Accountable Care Organizations

The Affordable Care Act requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("***ACOs***"). ACOs are groups of hospitals, physicians and other designated professionals and suppliers who come together voluntarily to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS are eligible to share in a portion of the amounts saved by the Medicare program. There are several types of ACO programs, and as of January 1, 2021, 477 ACOs had been established to participate in the Medicare Shared Savings Program, and additional ACOs are being established by private payers. A few of our facilities currently participate in ACOs.

Bundled Payment Pilot Programs

The Affordable Care Act created the Center for Medicare & Medicaid Innovation ("***CMMI***") and made it responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs while improving quality of care. Under these projects and initiatives, participating providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care and accept accountability for costs and the quality of care that is provided. By financially rewarding providers for quality, cost-effective care and penalizing providers when costs exceed a certain amount, these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. In connection with these programs, CMMI has developed a voluntary Bundled Payment for Care Improvement Advanced Model ("***BPCI Advanced***") to test innovative payment and service delivery models that have the potential to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care for beneficiaries. Participation in bundled payments programs is generally voluntary, but CMS does currently require hospitals in certain geographic areas to participate in the Comprehensive Care for Joint Replacement model, which covers certain extremity joint replacement procedures and is scheduled to end in 2021. CMS has developed a radiation oncology bundled payment program that could become effective as soon as January 1, 2022, and CMS has indicated that it expects to develop additional voluntary and mandatory bundled payment models in the future. Several of our facilities currently participate in bundled payment programs.

Specialty Hospital Limitations

Over the last decade, we have faced competition from hospitals that have physician ownership. The Affordable Care Act prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand. As of December 31, 2020, we operated four hospitals through joint ventures with physicians in which we own a controlling interest.

Impact of the Affordable Care Act on the Company

The expansion of health insurance coverage under the Affordable Care Act has resulted in an increase in the number of patients using our facilities who have either private or public program coverage. It is difficult to predict with great precision the timing or size of positive or negative impacts on revenue as a result of the Affordable Care Act, because of uncertainty surrounding a number of material factors, including the following:

- the elimination of the penalties associated with the individual mandate;
- the cessation of cost sharing reduction payments to insurers;
- the outcome of continuing litigation relating to the constitutionality of the Affordable Care Act or the possibility that the Affordable Care Act will be further modified by Congress;
- how many previously uninsured individuals will ultimately obtain coverage as a result of the Affordable Care Act;
- what percentage of the future newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states impose work and community engagement and/or premium requirements on their Medicaid beneficiaries;
- the number of states that ultimately elect to expand their Medicaid programs and when that expansion occurs;
- whether any states that have expanded their Medicaid programs will scale back such expansion through the imposition of work or premium requirements or otherwise as the Enhanced FMAP is reduced;
- the extent to which states will enroll any new Medicaid participants in managed care programs;
- the rates charged by private payers for insurance purchased on the Exchanges;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the future rates paid to hospitals by private payers for newly covered individuals under different plans, including those covered through the Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- increasing self-pay amounts as a result of individuals in the Exchanges who select high deductible plans and risks presented by their ability to pay such deductibles;
- whether or not private insurers will participate in the Exchanges, and whether such participation is through the use of narrow networks that restrict the number of participating providers or tiered networks that impose significantly higher cost sharing obligations on patients that obtain services from providers in a disfavored tier; and
- whether the net effect of the Affordable Care Act, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business.

Additionally, since approximately 55.7% of our revenues in 2020 were related to patients participating in Medicare and Medicaid programs, collectively, the reductions in Medicare and Medicaid reimbursement and in the growth of spending by the Medicare and Medicaid programs that are contemplated by the Affordable Care Act will significantly impact us and could offset any positive effects of the Affordable Care Act. It is difficult to predict with great precision the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

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

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

Competition for Patients

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

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

In addition, tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, exemptions from sales, property and income taxes, and participation in the 340B Program. In certain states, some not-for-profit hospitals are permitted by law to directly employ physicians while for-profit hospitals are prohibited from doing so.

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

Human Capital Resources

Overview

At December 31, 2020, our subsidiaries collectively had approximately 52,000 employees, including approximately 12,000 part-time employees. The majority of these employees are hospital-based, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our facilities. We understand that, to fulfill our mission of Making Communities Healthier®, we must create places where people choose to come for healthcare, physicians want to practice, and employees want to work. To support this mission, talent development has been a longstanding strategic pillar for the organization.

Diversity, Equity and Inclusion

We are committed to creating an inclusive, community-based healthcare delivery system that provides equitable opportunities for all people, starting with our employees. We appointed a Chief Diversity and Patient Experience officer in early 2021 who is leading an enterprise-wide strategy focused on training and education of our workforce, targeted efforts to address health equity in our communities, and the recruitment and development of diverse talent. This includes the creation of new formal partnerships to recruit more diverse talent and match new recruits with carefully selected mentors and sponsors within our organization.

Recruitment and Retention

We believe that healthcare is best delivered close to home, and our facilities strive to recruit and retain qualified management and staff personnel. Our frontline caregivers, including nurses, are the heartbeat of our organization, and we have a robust strategy to enhance the recruitment and retention of clinical staff into the future. This strategy includes meaningful education and career advancement opportunities, and competitive compensation. The scarce availability of nurses and other medical support personnel in some markets has required us to enhance wages and benefits and/or hire more expensive temporary personnel in certain situations.

Our facilities also employ and have affiliations with physicians. Many physicians today prefer to be employed, rather than operating their own practices or joining existing medical groups. Our hospitals and affiliated entities employed more physicians during 2020 than 2019. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians and incur additional expenses as a result. We expect this trend to continue.

We seek to attract both employed and affiliated physicians by maintaining a sharp focus on quality, driven by our National Quality Program; employing high performing talent; equipping our facilities with technologically advanced equipment and an attractive, up-to-date physical plant; and otherwise creating an environment within which physicians choose to practice. While physicians may terminate their association with our facilities at any time, we believe that by striving to maintain and improve the quality of care at our facilities and by maintaining ethical and professional standards, our facilities will be better positioned to attract and retain qualified physicians with a variety of specialties.

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

Labor Costs and Union Activity

Approximately 3,000 of our employees across certain of our facilities are unionized. While some of our non-unionized facilities experience union organizing activity from time to time, currently we do not expect these efforts to affect our future operations materially. Our facilities, like most facilities, have experienced rising labor costs. Our labor costs also may increase at higher rates among unionized employees. Unionized employees also may have rights under their collective bargaining agreements that restrict the ability of a facility to take certain actions with respect to these employees.

Government Regulation

Overview

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

Acute care hospitals are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing, certification and accreditation. All of our hospitals are currently licensed under appropriate state laws and are qualified to participate in the Medicare and Medicaid programs. In addition, as of December 31, 2020, with the exception of Bluegrass Community Hospital and Saline Memorial Hospital, all of our hospitals were accredited by the Joint Commission.

Legislative and Regulatory Developments in Response to COVID-19

Numerous recent legislative and regulatory actions have been taken in an attempt to provide businesses, including healthcare providers, with relief from the negative impacts of the COVID-19 pandemic. The legislative and regulatory responses to COVID-19 generally impact many of the statutes, regulations and policies summarized or discussed throughout this Report. Unless otherwise noted, such summaries or discussions have not been updated to reflect the impact of the COVID-19 legislative and regulatory developments.

CARES Act and Related Stimulus Legislation

On March 27, 2020, the CARES Act was signed into law. The CARES Act is intended to provide over $2 trillion in stimulus funding for the U.S. economy. Among other things, the CARES Act contains a number of provisions that are intended to assist healthcare providers as they combat the effects of the COVID-19 pandemic. Those provisions include, among others:

- the temporary suspension of Medicare sequestration from March 1, 2020, to December 31, 2020;
- the delay of the planned reductions to the Medicaid DSH payments program until December 11, 2020;
- an appropriation of $180 million to Health Resources and Services Administration's Federal Office of Rural Health Policy that will be awarded to small rural hospitals by the states through the Small Rural Hospital Improvement Program;
- an appropriation of $250 million to the Hospital Preparedness Program; and
- an appropriation of $100 billion to the Emergency Fund for a new program to reimburse, through grants or other mechanisms, hospitals, healthcare providers and other approved entities for COVID-19-related expenses or lost revenues, represented as a negative change in year-over-year net patient care operating income.

The Paycheck Protection Program and Health Care Enhancement Act was enacted on April 24, 2020, which, among other things, provides an additional allocation of $75 billion to the Emergency Fund and an allocation of $25 billion for COVID-19 testing.

On December 21, 2020, Congress adopted the CCA, which provides an additional $900 billion in COVID-19 relief, including an additional $3 billion allocation to the Emergency Fund. The CCA also, among other things, further extends the temporary suspension of Medicare sequestration through March 31, 2021, delays the planned reductions to the Medicaid DSH payments program through FFY 2023, adds additional reductions to the Medicaid DSH payments program in FFYs 2026 and 2027, provides for a 3.75% increase in PFS rates in CY 2021 and allocates $30 billion for the purchase and administration of COVID-19 vaccines and related therapeutics.

Direct Grant Aid Payments

With respect to payments being made to providers from the Emergency Fund, beginning April 10, 2020, the Emergency Fund distributed $50 billion to hospitals based on their 2018 net patient revenue. Since that time, the Emergency Fund has distributed an additional $56 billion to a number of different types of healthcare providers, including participants in state Medicaid/CHIP programs, providers in areas particularly impacted by the COVID-19 outbreak, rural providers (including hospitals and rural health clinics), skilled nursing facilities, dentists, providers of services with lower shares of Medicare reimbursement or who predominantly serve Medicaid beneficiaries, and providers requesting reimbursement for the treatment of uninsured patients. In addition, on October 1, 2020, HHS announced that an additional $24.5 billion in relief payments would be made from the Emergency Fund, on an application basis, to certain healthcare providers. HHS has stated that these additional relief payments will be allocated in a way that is intended to achieve an equitable payment of two percent of annual revenue from patient care for all applicants and may also take into account a provider's change in operating revenues from patient care, minus their operating expenses from patient care. We recognized $646.3 million of direct grant aid payments as other income under the caption "Government stimulus income" in our accompanying consolidated statement of operations for the year ended December 31, 2020 included elsewhere in this Report.

Payments made by the Emergency Fund to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers are required to file attestations acknowledging receipt of the payments and must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients and not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse. HHS has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the OIG, will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, HHS temporarily expanded the CMS Accelerated and Advance Payment Program to a broad group of Medicare Part A and Part B providers. Under the expanded Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period. The repayment of these accelerated/advance payments does not begin until one year after the date of the provider's or supplier's receipt of the payment, which means repayment of these amounts will not commence until the second quarter of 2021. Once the repayment period starts, the amounts previously advanced to the provider or supplier will automatically be recouped from the provider's or supplier's new Medicare claims at a rate of 25% for a period of 11 months. After the end of that 11-month period, the amounts previously advanced to the provider or supplier will be automatically recouped from the provider's or supplier's new Medicare claims at a rate of 50% for a period of six months. At the end of the 17-month recoupment period, a letter requesting repayment of any remaining balance will be issued, and the provider or supplier will have 30 days from the date of the letter to repay the balance in full. If the remaining balance is not repaid after 30 days, the unpaid balance will accrue interest at a rate of 4% from the date of the demand letter until the balance has been repaid in full. Through December 31, 2020, we received a total of $991.0 million of Medicare advance payments under the Accelerated and Advance Payment Program, of which $369.8 million and $621.2 million are included under the captions "Current portion of Medicare advance payments" and "Long-term portion of Medicare advance payments", respectively, in our accompanying consolidated balance sheet at December 31, 2020 included elsewhere in this Report. We do not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program.

COVID-19 Waivers and Temporary Suspension of Certain Regulatory Requirements

In addition to the financial relief that has been provided by the federal government under the CARES Act and other legislation that has been passed by Congress, CMS and many state governments have also issued a number of waivers or temporarily suspended a number of healthcare facility licensure and reimbursement requirements in order to provide hospitals, skilled nursing facilities, and other types of healthcare providers with increased flexibility to meet the challenges that are being presented by the COVID-19 pandemic. For example, CMS has temporarily waived the enforcement of certain requirements of the Medicare hospital conditions of participation and the Stark law to enable hospitals to treat patients in temporary locations and to obtain services from physicians in a more efficient and timely manner. Likewise, many states have also suspended the enforcement of certain certificate of need and licensure requirements to ensure that hospitals and other healthcare providers have sufficient capacity to treat COVID-19 patients. Our facilities have utilized the waivers and regulatory flexibility that is being provided to the extent necessary to appropriately respond to the COVID-19 pandemic.

CARES Act Tax Provisions

The CARES Act also provides for certain federal income tax changes, including an increase in the interest expense tax deduction limitation, the deferral of the employer portion of Social Security payroll taxes, refundable payroll tax credits, employee retention tax credits, net operating loss carryback periods, alternative minimum tax credit refunds and bonus depreciation of qualified improvement property. The federal income tax changes brought about by the CARES Act are complex and further guidance is expected. For the year ended December 31, 2020, we have deferred cash payments of approximately $84 million related to Social Security payroll tax payments into 2021 and 2022. Additionally, we have generated 2020 cash tax savings of approximately $57 million related to corporate tax law changes which increased the limitation in the tax deductibility of interest expense from 30% to 50% of adjusted taxable income as well as the ability to carry back net operating losses to each of the five tax years preceding the tax year of such loss. However, we may change our provision for income taxes and our deferred income taxes as our understanding of the CARES Act tax provisions evolves due to additional U.S. Department of Treasury guidance. Any such adjustments could materially impact our provision for income taxes and, as a result, our financial results in the relevant periods.

Fraud and Abuse Laws

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

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

Anti-kickback Statute

The Anti-kickback Statute prohibits the payment, receipt, offer or solicitation of anything of value, whether in cash or in kind, with the intent of generating referrals or orders, or recommending or arranging for services or items covered by a federal or state healthcare program. Violations of the Anti-kickback Statute are punishable by, among other things, imprisonment, criminal fines, substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation, damages equal to three times the total remuneration associated with the unlawful referrals or services, and/or possible exclusion from participating in Medicare, Medicaid or other governmental healthcare programs. Violations of the Anti-kickback Statute can also result in liability under the False Claims Act.

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

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

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

Stark Law

The Stark law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship if those entities provide certain "designated health services" unless an exception applies. The Stark law also prohibits entities that provide designated health services reimbursable by Medicare and Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires entities to refund amounts received for items and services provided pursuant to a prohibited referral on a timely basis. "Designated health services" include, among other things, inpatient and outpatient hospital services, laboratory services and radiology services. A violation of the Stark law may result in (i) a denial of payment, (ii) substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation or circumvention scheme and (iii) exclusion from participation in the Medicare and Medicaid programs and other governmental healthcare programs. In addition, violations of the Stark law could also result in penalties under the False Claims Act.

There are ownership and compensation arrangement exceptions to the self-referral prohibition. There are also exceptions for many of the customary financial arrangements between physicians and facilities, including employment contracts, leases and recruitment agreements, and there is a "whole hospital exception," which allows a physician to make a referral to a hospital if, among other things, the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. The Affordable Care Act significantly modified the requirements of the whole hospital exception and placed a number of restrictions on the ownership structure, operations, and expansion of physician owned hospitals. Four of our facilities are subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations.

In recent years, CMS has issued a number of proposed and final rules modifying and/or clarifying the Stark law exceptions. For example, on November 20, 2020, HHS published two final rules related to the Anti-kickback Statute and the Stark law that are intended to reduce regulatory barriers to care coordination and ease unnecessary compliance burdens for physicians and other healthcare providers. Among other things, the rules create new Anti-kickback Statute safe harbors and Stark law exceptions for value-based and cyber-technology arrangements and provide new guidance and clarification as to how the Anti-kickback Statute and Stark law will be interpreted and enforced by the OIG and CMS, respectively. We cannot predict the impact that the final rules will have on our facilities and our operations or whether the recent trend toward reducing provider compliance burdens will continue in the future. We also anticipate that there will be further changes to the regulations that implement the Anti-kickback Statute and/or the Stark law, and those changes may require us to modify our activities.

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

False Claims Act

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

Changes in the Regulatory Environment

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

In addition to the changes mentioned above, the Affordable Care Act created False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. On February 11, 2016, CMS published a final rule that provides clarification around the meaning of overpayment identification and generally establishes a six-year lookback period for Medicare Part A and Part B providers and suppliers. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments, accurately prepare cost reports and timely resolve credit balances. In light of the provisions of FERA and the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law, including technical violations of certain fraud and abuse laws, and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

State Laws

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

Emergency Medical Treatment and Active Labor Act

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

Administrative Simplification Provisions and Privacy and Security Requirements

We are subject to the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***") which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. Additionally, we are subject to the privacy, security and breach notification regulations promulgated under HIPAA and the Health Information Technology for Economic and Clinical Health Act (the "***HITECH Act***"), which are designed to protect the confidentiality, availability and integrity of protected health information ("***PHI***") and establish an array of patient rights with respect to such information. The HIPAA privacy, security and breach notification regulations apply to covered entities, which include health plans, healthcare clearinghouses, and healthcare providers that conduct certain standard transactions (such as billing insurance) electronically. In addition, certain provisions of the privacy, security and breach notification regulations apply to business associates, which are entities that perform certain functions or activities on behalf of covered entities that require access to or the use or disclosure of protected health information. In certain circumstances, a covered entity may be held liable for the actions of its business associate if HHS determines an agency relationship exists between the covered entity and the business associate under federal agency law.

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

Violations of the HIPAA regulations may result in criminal penalties and substantial civil monetary penalties subject to a limit for violations of the same requirement in a calendar year, based on the level of culpability associated with the violation. The civil monetary penalties are also subject to annual inflation adjustments. In addition, state attorneys general are authorized to bring civil actions seeking either injunction or damages up to $25,000 for violations of the same requirement in a calendar year in response to HIPAA violations that affect their state residents. HHS has the discretion in many cases to resolve HIPAA violations through informal means without the imposition of penalties. However, the HIPAA privacy, security and breach notification regulations have and will continue to impose significant costs on our facilities in order to comply with these standards. We expect increased enforcement of the HIPAA regulations.

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

Corporate Practice of Medicine and Fee-Splitting

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

Certificates of Need

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

Not-for-Profit Hospital Conversion Legislation

Many states have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In states that do not have such legislation, the attorneys general have demonstrated an interest in reviewing these transactions under their general obligations to protect charitable assets. These legislative and administrative efforts primarily focus on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the not-for-profit seller. Reviews and approval processes adopted by state authorities can add additional time to the closing of a not-for-profit hospital acquisition, and can also impose on buyers ongoing requirements to provide certain levels of charity care, or limit buyers' ability to discontinue particular service lines or to sell or otherwise dispose of a converted hospital. Future actions by state legislators or attorneys general may seriously delay or even prevent our ability to acquire certain hospitals.

Environmental Regulation

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

Compliance Program

We maintain a company-wide ethics and compliance program designed to ensure that we maintain high standards of ethical conduct in the operation of our business and to meet or exceed applicable federal guidance and industry standards. We continually implement written policies and procedures for all of our employees to promote compliance with all applicable laws, regulations and Company policies and to encourage a "culture of compliance" within the Company and its facilities. The organizational structure of our ethics and compliance program includes oversight by our Board of Directors and compliance committees at the Company and facility levels. We have compliance officers and personnel at the Company level and at our facilities. Other features of our compliance program include initial and periodic ethics and compliance training, systems for identifying and tracking potential compliance issues (including databases and hotlines for employees to report, without fear of retaliation, any suspected legal or ethical violations), regular auditing and monitoring of activities that may give rise to potential compliance concerns, including coding audits and reviews of our financial relationships with physicians, and prompt review and resolution of any potential compliance issues that are identified.

Our compliance program also oversees the implementation and monitoring of the standards set forth by HIPAA for privacy. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and oversight at the Company level.

Risk Management and Insurance

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("***SIR***") and deductible levels. At December 31, 2020, our SIR for professional liability claims is $15.0 million per claim at the majority of our facilities. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2020, our deductible for workers' compensation claims was $1.0 million per claim in all states in which we operate except for Montana, Ohio, Oklahoma, Washington and Wyoming. We participate in state-specific programs for our workers' compensation claims arising in these states. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

We also maintain directors' and officers', property, some professional liability and other types of insurance coverage with unrelated commercial carriers. Our directors' and officers' liability insurance coverage for current officers and directors is a program that protects us as well as the individual director or officer. We maintain property insurance through unrelated commercial insurance companies.

We operate a captive insurance company under the name Point of Life Indemnity, Ltd. This captive insurance company, which is licensed by the Cayman Islands Monetary Authority and is a wholly-owned subsidiary of LifePoint, issues malpractice indemnity policies to some subsidiaries employing physicians and advanced practice providers.

Item 1A. ***Risk Factors.***

Any of the following risks could materially and adversely affect our business, financial condition or results of operations. In addition, the risks described below are not the only risks that we face. The following information should be read in conjunction with "Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Report. Additional risks and uncertainties not currently known to us or those that we currently view to be immaterial could also materially and adversely affect our business, financial condition or results of operations.

Risk Factor Summary

The following is a summary of the principal risks that could adversely affect our business, operations and financial results.

COVID-19 and Other Potential Pandemic Risks

- The COVID-19 global pandemic continues to affect our operations, business and financial condition, and our liquidity could be negatively impacted, particularly if the U.S. economy remains unstable for a significant amount of time.
- There is a high degree of uncertainty regarding the implementation and impact of the CARES Act and other stimulus legislation, as well as future stimulus legislation, if any, and lack of guidance regarding accounting treatment of funds received under such acts.
- The emergence and effects related to a pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations and financial condition.

Business and Operational Risks

- Our revenues will decline if federal or state programs reduce our Medicare or Medicaid payments.
- Uncertainty regarding the Affordable Care Act or future healthcare reform may adversely affect our business, financial condition and results of operations.
- Changes to Medicaid supplemental payment programs may materially and adversely affect our revenues and results of operations.
- Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may limit our revenues and profitability.
- We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations, or it could diminish the anticipated value of the acquired facility.
- If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.
- We are subject to risks associated with outsourcing functions to third parties.
- We conduct a significant portion of our operations through joint ventures.
- Deterioration in the collectability of "patient due" accounts could adversely affect our revenues and results of operations.
- Other hospitals and outpatient facilities provide services similar to those which we offer. In addition, healthcare providers provide services in their offices that could be provided in our facilities.
- We may have difficulty acquiring or divesting facilities on favorable terms.
- If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results could be negatively impacted.
- Under the A&R Capella Master Lease (as defined below) and the 2019 Master Lease, each of which separately governs certain of our facilities, a default with respect to one facility under either such lease, or in the case of the A&R Capella Master Lease, certain related separate leases, could cause a default under all of the facilities subject to the A&R Capella Master Lease or the 2019 Master Lease, as applicable, which would have a material adverse effect on our business, results of operations and financial condition.
- Because many of the facilities we operate are subject to long-term leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises.
- Many of the non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies intended to generate organic growth and improve operating results at our facilities.

Credit and Liquidity Risks

- Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments.
- We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.
- We may not be able to generate sufficient cash flow through operations or successfully access other capital resources to fund all of our capital expenditure programs and commitments.
- Our debt agreements contain restrictions that will limit our flexibility in operating our business.
- Repayment of our debt is dependent on cash flow generated by our subsidiaries.
- Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.
- Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.
- Our ability to utilize our net operating loss carryforwards ("***NOLs***") may be limited, and we may not be able to utilize our NOLs as a result of recent U.S. federal tax reform legislation.

Human Capital Risks

- Factors related to our employment of physicians could affect our financial performance.
- If we do not effectively attract, recruit and retain qualified physicians and other healthcare providers, our ability to deliver healthcare services efficiently will be adversely affected.
- Our facilities face competition for management and other non-physician staffing, which may increase labor costs and reduce profitability.
- Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and are subject to the terms of collective bargaining agreements.
- We are dependent on our executive management team and the loss of the services of one or more of our executive management team could have a material adverse effect on our business.

Regulatory and Legal Risks

- We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may reduce our revenues and profitability.
- We may be subjected to actions brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the False Claims Act's "qui tam" or "whistleblower" provisions.
- We will be subject to liabilities because of malpractice and related legal claims brought against our facilities or healthcare providers associated with, or employed by, our facilities or affiliated entities. If we become subject to these claims, we could be required to pay significant damages, which may not be covered by insurance.
- As a result of reviews of claims to Medicare and Medicaid for our services, we may experience delayed payments or incur additional costs and may be required to repay amounts already paid to us.
- Controls designed to reduce inpatient services may reduce our revenues.
- Certificate of need laws and regulations regarding licenses, ownership and operation may impair our future expansion in some states. In states without certificate of need laws, competing providers of healthcare services are able to expand and construct facilities without the need for significant regulatory approval.
- If we fail to implement and maintain certified electronic health record systems and other health information technology in an effective and timely manner, our operations could be adversely affected.
- The industry emphasis on value-based purchasing and bundled payment arrangements may negatively affect our revenues.

Data Security and Privacy Risks

- A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.
- If access to our information systems or those provided by our third-party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

COVID-19 and Other Potential Pandemic Risks

The COVID-19 global pandemic continues to affect our operations, business and financial condition, and our liquidity could be negatively impacted, particularly if the U.S. economy remains unstable for a significant amount of time.

The COVID-19 global pandemic continues to affect our facilities, employees, patients, communities, business operations and financial performance, as well as the U.S. economy and financial markets. Although vaccines have been developed and are being distributed in the U.S., the length and severity of the COVID-19 pandemic continues to evolve and much of its impact remains unknown and difficult to predict because many of the driving factors are beyond our control, including the timing and effectiveness of the distribution of the vaccines.

We are taking every precaution to ensure we can continue providing quality care and safeguard the health and well-being of patients, employees, providers, volunteers and visitors in each community we serve. For example, during 2020, we cancelled or postponed a substantial number of elective procedures scheduled at our hospitals and closed or reduced operating hours at certain of our physician clinics, ambulatory surgery centers and other outpatient centers that specialize in elective procedures, resulting in significantly reduced patient volumes and operating revenues. We cannot predict how quickly elective procedure volumes will return or if they will be further restricted in the future. In addition, we instituted social distancing practices and protective measures throughout our facilities, including visitor restrictions, closing common areas, limiting entry points and screening staff and visitors who enter our facilities based on the CDC's criteria.

Even with such steps, exposure to COVID-19 patients has led to increased risks to doctors and nurses, which has reduced and may further reduce our operating capacity and/or staffing levels, and may require us to continue utilizing temporary healthcare practitioners. If our hospitals were to continue to treat an increasing number of COVID-19 patients, they could experience staffing shortages or become overwhelmed by excessive demand, potentially preventing them from treating all patients who seek care. We also experienced supply chain disruptions during 2020, including shortages and delays, as well as price increases, in equipment, pharmaceuticals and medical supplies, particularly personal protective equipment (or PPE). Any staffing, equipment, and pharmaceutical and medical supplies shortages may impact our ability to see, admit and treat patients.

The willingness and ability of patients to seek healthcare services also has been impacted by restrictive measures, like travel bans, social distancing and quarantine guidelines, which have further reduced the volume of procedures performed at our facilities more generally, as well as the volume of emergency room and physician office visits unrelated to COVID-19. Furthermore, in response to the COVID-19 pandemic, regulatory barriers to telehealth services have been reduced to expand the availability of remote care. As patients become more comfortable with remote care, which generally receives a lower reimbursement for services, our revenues may be adversely impacted.

Broad economic factors resulting from the current COVID-19 pandemic, including increased unemployment rates and reduced consumer spending, could also negatively affect our payer mix, increase the relative proportion of lower margin services we provide and reduce patient volumes, as well as diminish our ability to collect outstanding receivables. See "—Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may limit our revenues and profitability." Business closings and layoffs in the areas in which we operate may lead to increases in the uninsured, underinsured and Medicaid populations and adversely affect demand for our services, as well as the ability of patients and other payers to pay for services as rendered. Any increase in the amount or deterioration in the collectability of patient accounts receivable will adversely affect our cash flows and results of operations, requiring an increased level of working capital. If general economic conditions continue to deteriorate or remain uncertain for an extended period of time, our liquidity and ability to repay our outstanding debt may be harmed.

In addition, our results and financial condition may be further adversely affected by future federal or state laws, regulations, orders, or other governmental or regulatory actions addressing the current COVID-19 pandemic or the U.S. healthcare system, which, if adopted, could result in direct or indirect restrictions to our business, financial condition, results of operations and cash flow. We may also be subject to lawsuits from patients, employees and others exposed to COVID-19 at our facilities, or from other third-parties or family members who are exposed due to contact with patients, employees, or others exposed at our facilities. Such actions may involve large demands, as well as substantial defense costs. Our professional and general liability insurance may not cover all claims against us.

The foregoing and other continued disruptions to our business as a result of the COVID-19 pandemic have had and are likely to continue to have a material adverse effect on our business and could have a material adverse effect on our results of operations, financial condition, cash flows and our ability to service our debt. Furthermore, the COVID-19 pandemic (including governmental responses, broad economic impacts and market disruptions) has heightened the materiality of certain other risk factors described herein.

There is a high degree of uncertainty regarding the implementation and impact of the CARES Act and other stimulus legislation, as well as future stimulus legislation, if any, and lack of guidance regarding accounting treatment of funds received under such acts. There can be no assurance as to the total amount of financial assistance or types of assistance we will receive, or that the terms of provider relief funding or other programs will not change in ways that affect our funding or eligibility to participate.

We received and may seek other funds that are made available to us and our facilities under the CARES Act and other existing or future stimulus legislation, if any; however, there is still a high degree of uncertainty surrounding the interpretation and implementation of the terms and conditions of these acts. There can be no assurance that the terms of provider relief funding or other programs under the CARES Act, and other existing stimulus legislation or future stimulus legislation, if any, will not change in ways that affect our funding or eligibility to participate, or that changes to the terms of such programs will not result in government recoupment of funds that were initially released to us as grants. Additionally, although the federal government may consider additional stimulus and relief efforts, such efforts may be drafted or implemented in ways that restrict, limit or otherwise negatively impact our ability to access these funds. As a result, we cannot predict the manner in which existing or future stimulus funds will be allocated or administered and we cannot assure you that we will be able to access future stimulus funds in a timely manner or at all. For additional information regarding the CARES Act, and related stimulus legislation and our participation in programs under the CARES Act and related stimulus legislation, if any, see "Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19."

In addition, there currently is limited and sometimes changing guidance available regarding the accounting treatment of funds that have been received by us and our facilities under the CARES Act and other COVID-19 stimulus legislation. This lack of guidance requires us to apply professional judgement and make certain estimates and assumptions with respect to the presentation, amount and timing of our recognition of direct grant aid received under the CARES Act. For additional information regarding the CARES Act and related financial impact, refer to Note 2 to the consolidated financial statements included elsewhere in this Report.

The emergence and effects related to a pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations and financial condition.

As evidenced by the COVID-19 pandemic, the occurrence of a pandemic, epidemic, outbreak of an infectious disease or other public health crisis in an area in which we operate could adversely affect our operations and financial condition. In reaction to such a crisis or the fear of exposure to infection, patients might cancel elective procedures or fail to seek needed care at our facilities, which could result in reduced patient volumes and operating revenues, potentially over an extended period of time. Furthermore, a pandemic, epidemic or outbreak might adversely affect our operations by causing a temporary shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. Additionally, such a crisis could diminish the public trust in healthcare facilities, especially hospitals that fail to accurately or timely diagnose, or are treating (or have treated) patients affected by infectious diseases, and negatively affect the reputation at our facilities.

Although we have disaster plans in place and operate pursuant to infectious disease protocols, the extent to which the potential emergence of a pandemic, epidemic or outbreak would impact our business and operations is difficult to predict and would depend on many factors beyond our control, including the speed of the contagion, the development and implementation of effective preventative measures and possible treatments, the scope of governmental and other restrictions on travel and other activities, and public reactions to these factors.

Business and Operational Risks

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

For the years ended December 31, 2020, 2019 and 2018, approximately 55.7%, 55.2% and 57.3% of our revenues, respectively, related to patients participating in Medicare and Medicaid programs, collectively. Numerous factors could materially decrease, or delay timing of, Medicare and Medicaid payments to our facilities. These factors include statutory and regulatory changes, administrative rulings and determinations concerning patient and provider eligibility and requirements for utilization review. Furthermore, the Affordable Care Act and related federal laws provide for material scheduled reductions in the growth rate of Medicare and Medicaid program spending, including reductions in market basket updates and Medicare and Medicaid DSH funding. Additionally, a number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs. States may also impose additional taxes on hospitals to help finance the state's Medicaid programs. Some states have also taken steps to implement work and/or community engagement requirements for Medicaid beneficiaries, which could have the effect of reducing the number of individuals eligible for Medicaid in those states.

Uncertainty regarding the Affordable Care Act or future healthcare reform may adversely affect our business, financial condition and results of operations.

The Affordable Care Act dramatically altered the U.S. healthcare system, and we have expended substantial cost and effort to prepare for and comply with the Affordable Care Act. The net effect of the Affordable Care Act on our business continues to be subject to a number of variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. Additionally, the Affordable Care Act has been challenged before the U.S. Supreme Court and several bills have been introduced in Congress to delay, defund or repeal implementation of or amend significant provisions of the Affordable Care Act.

For example, in 2017, the U.S. Department of Justice ("***DOJ***") announced that HHS was immediately ceasing its cost sharing reduction payments to insurance companies based on a determination that those payments had not been appropriated by Congress, and Congress enacted the Tax Act that, in addition to overhauling the federal tax system, repealed the penalties associated with the individual mandate effective as of January 1, 2019. In addition, in December 2019, the U.S. Fifth Circuit Court of Appeals found that the individual mandate set forth in the Affordable Care Act was unconstitutional and ordered the U.S. District Court for the Northern District of Texas to conduct further analysis as to whether the entire Affordable Care Act should be held to be unlawful. The U.S. Supreme Court heard the case during the fourth quarter of 2020, but it likely will not issue an opinion until 2021. We cannot predict the outcome of litigation challenging the constitutionality of the Affordable Care Act or whether the Affordable Care Act will be repealed, replaced, or modified. If the Affordable Care Act is found to be unconstitutional or if it is repealed, replaced or modified, we cannot predict what, if any, the replacement plan or modifications would be, when any such replacement plan or modifications would become effective, or whether any of the existing provisions of the Affordable Care Act would remain in place.

We also cannot predict the impact that the new Presidential administration and Congressional leadership will have on the implementation and enforcement of the provisions of the Affordable Care Act, on any current, pending or potential regulations adopted to implement the law, or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

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

MSPs are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and UPL payments. Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating these patients. The total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law. Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars.

The Affordable Care Act called for significant reductions in Medicaid DSH funding to account for decreases in uncompensated care anticipated under the health insurance coverage expansion. Subsequent changes in the law have delayed the implementation of these reductions, but they are scheduled to take effect in FFY 2021. Reductions in Medicaid DSH payments may take place without increases in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

UPL programs have expanded in recent years and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs. We cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease.

Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may limit our revenues and profitability.

The amounts we receive for services provided to patients are determined by a number of factors, including the payer mix of our patients and the reimbursement methodologies and rates utilized by our payers. We have seen shifts of patients from commercial and private insurance to Medicare and Medicaid programs and from "traditional" fee-for-service Medicare and Medicaid programs to "managed" Medicare and Medicaid programs. Additionally, we cannot predict whether the new Presidential administration or Congressional leadership will propose measures that would expand government-sponsored coverage, including "Medicare-for-all" or other single-payer proposals. Reimbursement rates generally are lower for (i) Medicare and Medicaid beneficiaries than they are for patients whose care is covered by commercial and private insurance and (ii) managed Medicare and Medicaid beneficiaries than they are for traditional Medicare and Medicaid beneficiaries. We also experience demographic pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs. Our revenues and results of operations may be adversely affected by these shifts.

In addition, our revenues from negotiated rates with HMOs, PPOs, insurance companies, employers and other private payers may decline based on renegotiations and the respective bargaining power of the parties. Also, consolidation among private payers may increase their bargaining power over fee structures. As a result, payers increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk related to paying for care provided. These changes include moving away from a percent of charge payment structure to a fixed payment for an episode of care, which typically reduces our payment rate and limits our ability to raise prices going forward. Furthermore, low-cost plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices, restrict or exclude our facilities or impose significantly higher cost sharing obligations for care provided by our facilities if they are classified in a disfavored tier. In addition, other healthcare providers, including some with greater financial resources, greater geographic coverage or a wider range of services, may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care plans to contract with us.

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

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

We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations or it could diminish the anticipated value of the acquired facility.

We may be unable to timely and effectively integrate facilities that we acquire with our ongoing operations. Many of the facilities we have acquired had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced delays in improving the operating margins or effectively integrating the operations of our acquired facilities, and we may experience such delays in implementing operating procedures and systems in newly or future acquired facilities. Integrating an acquired facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel. Additionally, we may experience delays in reimbursement from governmental and third-party payers as a result of the change of ownership of our acquired facilities.

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

Facilities we have acquired, including in connection with the LifePoint/RCCH Merger, or facilities we acquire in the future, may have unknown or contingent liabilities for historical activities or conditions, including liabilities for failure to comply with laws and regulations, retroactive payment adjustments or recoupments from payer audits, medical and general professional malpractice liabilities, unfunded pension liabilities, workers' compensation or other employee-related liabilities, previous tax or environmental liabilities, regulatory and compliance related liabilities, and unacceptable business or accounting practices. Although we endeavor to obtain contractual indemnification from sellers covering these matters in connection with some acquisitions, we have not obtained contractual indemnifications in connection with all of them, and any indemnification obtained from sellers may be insufficient to cover material claims or liabilities for past activities of acquired businesses and the sellers may have insufficient funds to satisfy any claims or liabilities for which we may otherwise be entitled to be reimbursed.

We typically retain and rely on existing local management teams at newly acquired facilities to implement changes to operating procedures and systems. Integrating local management teams can involve cultural and systems challenges that may demand a disproportionate share of our resources and senior management's attention, and we may experience turnover of providers and other key personnel. Our acquisitions have become, and may continue to become larger, and may occur in communities with competing facilities. As a result, the issues surrounding integration may become more complex, expensive and time-consuming and may have a greater impact on our financial performance when we experience delays or difficulties.

If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.

As of December 31, 2020, we had approximately $2,976.8 million of goodwill and other intangible assets and approximately $3,523.0 million of long-lived assets, net of accumulated depreciation. We expect to recover the carrying values of both our goodwill as well as our long-lived assets through our future cash flows. We evaluate the carrying value of our goodwill at least annually, based on our fair value, to determine whether it is impaired. We evaluate our long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows. If the carrying value of our goodwill or our long-lived assets is impaired, we may incur a material non-cash charge to earnings.

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

We outsource selected business functions to third parties, including revenue cycle management, patient access, billing, cash collections, payment compliance and support services, project implementation, supply chain management, payroll system services and parts of cybersecurity. We take steps to monitor and regulate the performance of the independent third parties to whom we delegate selected functions. Arrangements with third-party service providers may make our operations vulnerable if vendors fail to satisfy their obligations to us as a result of their performance, changes in their own operations, financial condition, or other matters outside of our control. We may also face legal, financial or reputational harm for the actions or omissions of such providers, including for violations of HIPAA and other privacy and security laws applicable to healthcare providers, and we may not have effective recourse against the providers for those harms. The expanding role of third-party providers may also require changes to our existing operations and the adoption of new procedures and processes for retaining and managing these providers, as well as redistributing responsibilities as needed. Effective management, development and implementation of our outsourcing strategies are important to our business and strategy. If there are delays or difficulties in enhancing business processes or our third-party providers do not perform as anticipated, we may not fully realize on a timely basis the anticipated economic and other benefits of the outsourcing projects or other relationships we enter into with key vendors, which could result in substantial costs, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us. Terminating, transitioning or renegotiating arrangements with key vendors or failure to renegotiate on favorable terms could result in additional costs and a risk of operational delays, potential errors and possible control issues as a result of the termination or during the transition or renegotiation phase.

We conduct a significant portion of our operations through joint ventures. We cannot provide assurances that relationships with our joint venture partners will remain strong, which could negatively affect our joint ventures, affiliations and other strategic alliances as well as our overall business.

We have completed a number of joint ventures, affiliations and other strategic alliances as part of our business strategy. We expect to enter into similar transactions in the future, including joint ventures where we may have a noncontrolling interest. Any changes in our relationships with our joint venture partners could disrupt ongoing business, negatively affect cash flow and distract management and other key personnel. In the event of a material disagreement with any of our joint venture partners or the breach of any of our joint venture agreements, a joint venture may be subject to dissolution, unwinding or purchase of either party's interest, which could have a material adverse effect on our revenues and results of operations or result in reputational harm.

As a general matter, our joint venture partners may have investment and operational goals that are not consistent with our company-wide objectives, including the timing, terms and strategies for future growth and development opportunities, and we could reach an impasse on certain decisions, which may hinder our ability to pursue preferred strategies for growth and development, could require significant resources and attention from management and key employees to resolve and could have an adverse effect on our operations, cash flow and revenue growth. In addition, our joint venture relationships with not-for-profit partners and the agreements that govern these relationships are structured based on current provisions of the Internal Revenue Code of 1986, as amended (the "***Code***") (and the Treasury Regulations thereunder), published rulings by the Internal Revenue Service ("***IRS***"), as well as case law relevant to joint ventures between for-profit and not-for-profit entities. Material changes in these legal authorities could adversely affect our relationships with not-for-profit partners and related joint venture arrangements.

Furthermore, joint ventures in which we have a noncontrolling equity interest and noncontrolling investments inherently involve a lesser degree of control over business operations, thereby potentially increasing the financial, legal, operational and compliance risks associated with the joint venture or minority investment. We may be dependent on joint venture partners or management who may have business interests, strategies or goals that are inconsistent with ours. Business decisions or other acts or omissions of the joint venture partner or management may adversely affect the value of our investment, result in litigation or regulatory action against us, result in reputational harm to us or adversely affect the value of our investment or partnership. To the extent another party makes decisions that negatively impact the joint venture or internal control issues arise within the joint venture, we may have to take responsive or other actions or we may be subject to penalties, fines or other related actions for these activities.

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

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

If we experience growth in self-pay volume and revenue, including increased acuity levels for uninsured patients and increases in co-payments and deductibles for insured patients, our revenues and results of operations could be adversely affected. Although we have experienced a reduction in uninsured patients since 2014 as a result of the Affordable Care Act and the expansion of state Medicaid programs, we are unable to predict whether that trend will continue in light of the repeal of the penalties associated with the individual mandate, the cessation of the cost sharing reduction payments to insurers, the decision by some states not to expand their Medicaid programs, and the business closings and layoffs that have and may continue to occur as a result of the COVID-19 pandemic. In addition, the risk of collection from insured patients (and the amounts due) has increased, and will likely continue to increase, as a result of more individuals being enrolled in insurance plans with high deductibles and high co-payments, including those purchased on the Exchanges. Furthermore, our ability to improve co-insurance collections and collections from self-pay patients may be limited by legislative developments, such as federal and state legislation designed to reduce "surprise billing," or by other regulatory or investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

An increase in the proportion of our accounts receivable being comprised of uninsured accounts and a deterioration in the collectability of these both insured and uninsured accounts could adversely affect our results of operations and revenues. Even if the Affordable Care Act remains implemented in its current form, we may continue to experience bad debts and be required to provide uninsured discounts and charity care for patients who choose not to purchase coverage, are undocumented immigrants who are not permitted to enroll in the Exchanges or government healthcare programs or live in states that do not expand or maintain the expansion of their Medicaid programs.

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

Competition among hospitals and other healthcare service providers, including outpatient facilities, has intensified in recent years. We also have acquired, and may continue to acquire, larger facilities in more concentrated population centers, which experience greater competition for healthcare services. We compete with other facilities, including larger tertiary and quaternary care centers located in metropolitan areas. Although the facilities with which we compete may be a significant distance away from our facilities, patients in our markets may migrate on their own to, may be referred by local providers to, or may be required by their health plan to travel to these facilities. Furthermore, some of the facilities with which we compete may offer more or different services than those available at our facilities, may have more advanced equipment or technology or may have a medical staff that is perceived to be better qualified. We also compete with facilities and health systems that are implementing physician and other provider alignment strategies, such as employing providers, acquiring physician practice groups and participating in ACOs or other clinical integration models, which may impact our competitive position. Also, many of the facilities that compete with our facilities are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions and are eligible to participate in the 340B Program. These facilities, in most instances, are also exempt from paying sales, property and income taxes and have the ability to issue tax-exempt bonds for financing.

Quality of care and value-based purchasing have also become significant trends and competitive factors in the healthcare industry. CMS makes public the performance data relating to multiple quality measures that facilities submit in connection with their Medicare payment. CMS also requires every Medicare participating hospital to establish and update annually a public online listing of the hospital's standard charges for items and services and recently issued new regulations that would significantly increase hospital charge reporting requirements. If the publicly-available performance and charge data become a primary factor in where patients choose to receive care, and if competing facilities have lower charges or better results than our facilities on those measures, our revenues and/or patient volumes could decline.

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

We may have difficulty acquiring or divesting facilities on favorable terms. Furthermore, our business could be negatively affected if acquisitions or divestitures are not successfully completed or if contingent liabilities materialize in connection with such transactions.

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

The cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired facility's results of operations, allocation of purchase price, effects of subsequent legislation and limitations on rate increases. As part of our acquisition strategy, we may commit to making significant capital improvements at acquired facilities. Such improvements may be difficult to achieve in the anticipated timeframe, if at all, due to a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions.

Our ability to engage in certain acquisitions in several states may be limited due to exclusivity, non-competition and non-solicitation provisions that we have agreed to in connection with our joint ventures and previous acquisitions and divestiture transactions. Additionally, certain acquisitions may require the consent of and collaboration with our joint venture partners based upon the applicable governing documents. If we cannot obtain the cooperation of our joint venture partners in certain instances, we may not be able to pursue these opportunities.

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

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

We regularly evaluate the potential disposition of assets and facilities that may no longer help us attain our objectives. When we decide to sell assets or facilities, we may encounter difficulties in finding buyers or alternative exit strategies on acceptable terms or in a timely manner, which could delay the achievement of our strategic objectives. Additionally, the terms of our Master Leases (as defined below) entered into pursuant to sale leaseback transactions may make it more difficult to dispose of certain facilities. We may also dispose of assets or a facility at a price, or on terms, less desirable than we anticipated. In addition, we may experience greater dis-synergies than expected. After reaching an agreement with a buyer for the disposition of assets or a facility, we will be subject to satisfaction of pre-closing conditions as well as to necessary regulatory and governmental approvals on acceptable terms, which, if not satisfied or obtained, may prevent us from completing the transaction. Dispositions may also involve continued financial involvement in the divested facilities, such as through continuing equity ownership, guarantees, indemnities, transition service agreements or other financial and commercial obligations, and inability to avoid retention of certain regulatory and compliance risks. There can be no assurance that the anticipated benefits of our future divestiture strategies will be realized. Furthermore, we may be exposed to contingent liabilities in connection with completed divestitures. Finally, certain acquisition agreements and joint venture arrangements contain covenants that restrict our ability to dispose of certain facilities without first seeking consent of a joint venture partner or other third parties, which may affect our ability to take advantage of business opportunities that may be in our interest. If we do not realize the anticipated benefits of such divestitures, if contingent liabilities related to such divestitures materialize or if we are unable to divest certain properties on favorable terms or at all, this could have a material adverse effect on our results of operations.

If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results could be negatively impacted.

We have initiated a multi-year business initiative to standardize certain processes, policies and systems throughout our facilities, including migrating our multiple IT platforms to a smaller number of enterprise-wide systems solutions. If we do not allocate and effectively manage the resources necessary to build and sustain the proper IT infrastructure and implement standardized systems, or if we fail to achieve the expected benefits from this initiative, it may impact our ability to operate profitably and efficiently, as well as comply in a timely manner with changing regulatory requirements and with the requests of patients, payers and business partners. The failure to transition to these systems on time, or anticipate necessary readiness and training needs, could lead to business disruption and loss of revenue. In addition, the operating results of newly acquired facilities could be impacted if such facilities are not integrated on a timely basis into our new systems. The actions we take to resolve compliance or regulatory issues within acquired facilities may affect our revenue or results of operations.

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

Under the A&R Capella Master Lease (as defined below) and the 2019 Master Lease, each of which separately governs certain of our facilities, a default with respect to one facility under either such lease, or in the case of the A&R Capella Master Lease, certain related separate leases, could cause a default under all of the facilities subject to the A&R Capella Master Lease or the 2019 Master Lease, as applicable, which would have a material adverse effect on our business, results of operations and financial condition.

If there is a default under that certain Amended and Restated Master Lease Agreement (the "***A&R Capella Master Lease***") with subsidiaries of MPT Camaro OpCo, LLC, a Delaware limited liability company and wholly-owned subsidiary of MPT, dated as of March 21, 2016, or the 2019 Master Lease (together with the A&R Capella Master Lease, the "***Master Leases***" and each a "***Master Lease***"), even if such default relates to one facility, the lessor(s) may terminate the applicable Master Lease in its entirety with respect to all of the facilities governed by such Master Lease. Additionally, we have entered into amended and restated separate leases with affiliates of MPT with respect to our joint ventures Capital Medical Center located in Olympia, Washington on October 31, 2016 (the "***Olympia Lease***") and National Park Medical Center in Hot Springs, Arkansas on March 21, 2016 (the "***Hot Springs Lease***").

Under each Master Lease, the Olympia Lease and the Hot Springs Lease, we are subject to financial covenants based on certain fixed charges. The failure to meet or obtain a waiver of such covenants or otherwise cure such non-compliance in each Master Lease, the Olympia Lease or the Hot Springs Lease in the future would result in an event of default under the applicable lease. We have received a waiver of compliance with respect to the Olympia Lease financial covenants through March 31, 2022. There can be no assurance that we will be able to obtain a similar waiver in the future if we are unable to meet such financial covenants. Additionally, on December 23, 2020, we entered into a definitive agreement with an unrelated third-party to sell our ownership interest in Capital Medical Center.

Other events that could trigger a default under each Master Lease, the Olympia Lease or the Hot Springs Lease if not cured within the time periods required by such lease include, without limitation, (i) failure to pay rent or other amounts due under the lease, (ii) failure to comply with the non-financial covenants under the lease, (iii) the bankruptcy of any facility lessee under such lease or the guarantor of the facility lessees under the applicable lease, (iv) termination of any licenses necessary for operation of a facility or required for certification under Medicare or Medicaid, (v) a change of control (as defined in the applicable lease) in violation of such lease and (vi) a default under any material documents between any lessee of the facilities and any lessor of any facility. Each Master Lease contains cross-default provisions so that certain defaults with respect to one of the facilities subject to such Master Lease may cause a default under the entire Master Lease. Accordingly, a default under a Master Lease that results in a termination of such Master Lease would cause us to lose the ability to operate all of the facilities subject to such Master Lease and to incur substantial costs in restoring the premises, which would have a material adverse effect on our business, results of operations and financial condition. Although the A&R Capella Master Lease and the 2019 Master Lease are not cross defaulted to one another, a default under the Olympia Lease or the Hot Springs Lease may trigger a cross default of the A&R Capella Master Lease.

If any of the Master Leases, the Olympia Lease or the Hot Springs Lease, is terminated prior to its expiration because of a default and the applicable affiliate of MPT, as lessor, exercises its rights thereunder, in addition to losing the ability to operate our facilities, we may be liable for (i) damages and incur charges such as continued lease payments through the end of the lease term (or such shorter period as proscribed in the applicable lease or by law) and (ii) maintenance costs for the leased property. Upon termination of either Master Lease, the Olympia Lease or the Hot Springs Lease, we will be obligated to restore the applicable premises to its original condition and repair all damage caused by the installation or removal of our applicable personal property, ordinary wear and tear excepted. We also have restoration obligations with respect to certain casualty and condemnation events. In addition, upon termination of a Master Lease, the Olympia Lease or the Hot Springs Lease, the lessor will have the option to purchase all of the applicable lessee's personal property at fair market value.

Because many of the facilities we operate are subject to long-term leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises.

The rights to use many of our facilities are based upon long-term leases, including the Master Leases. Pursuant to the terms of these leases, we are required to pay all rent due and comply with all other lessee obligations. As of December 31, 2020, the remaining term of these leases (including renewal options) generally ranged from less than one year up to 76 years. A pledge of our interest in some of these leases may also require the consent of the respective lessor and its lenders. As a result, we may not be able to sell, assign, transfer or convey our interest in certain facilities subject to such leases in the future absent consent of such third parties even if such transactions may be in our best interest. Most of the leases require that, upon the expiration or termination of the leases, we must surrender any improvements to the land to lessor. In addition, some of our leases include early termination provisions. We are typically responsible for all taxes, insurance, assessments and maintenance obligations under the leases. The leases also generally require the lessee to either reconstruct or restore the premises to its original condition following a casualty and to apply in a specified manner any proceeds received in connection therewith. In some leases the lessor has the option to purchase some or all of the assets owned by us and used in connection with the operation of the applicable facility. Accordingly, failure to comply with the terms of such leases, the invalidity of or default or termination under such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises, which could have a material adverse effect on our business, results of operations and financial condition.

Many of the non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies intended to generate organic growth and improve operating results at our facilities.

Many of the non-urban communities in which we operate continue to face challenging economic conditions, including high levels of unemployment and demographic trends. These challenging economic conditions have been further exacerbated by the impact of the COVID-19 pandemic. The economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of large employers, especially manufacturing or similar facilities. These employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our facilities for care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or similar facilities located in or near many of the non-urban communities in which our facilities primarily operate, could cause affected employees to move elsewhere for employment or lose insurance coverage that was otherwise available to them.

When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to:

- defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for facilities; or
- purchase a high-deductible insurance plan or no insurance at all, which increases a facility's dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms.

Additionally, non-urban communities are experiencing a much slower rate of growth, if any, as compared to more concentrated population centers. As a result, we may experience payer mix pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs.

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

Credit and Liquidity Risks

Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments.

We are a highly leveraged company. As of December 31, 2020, we had total outstanding debt of approximately $6,339.5 million, excluding finance leases and unamortized debt issuance costs and premium. Our substantial indebtedness could have important consequences for the Lenders and Holders of our indebtedness. For example, it could:

- limit our ability to borrow money for our working capital, capital expenditures, debt service requirements, strategic initiatives or other purposes;
- make it more difficult for us to satisfy our obligations with respect to our indebtedness and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the agreements governing our indebtedness;
- require us to dedicate a substantial portion of our cash flow from operations to the payment of interest and the repayment of our indebtedness, thereby reducing funds available to us for other purposes;
- limit our flexibility in planning for, or reacting to, changes in our operations or business;
- make us more highly leveraged than some of our competitors, which may place us at a competitive disadvantage;
- make us more vulnerable to downturns in our business, our industry or the economy;
- restrict us from making strategic acquisitions, engaging in development activities, introducing new technologies or developing business opportunities;
- cause us to make non-strategic divestitures;
- limit, along with the financial and other restrictive covenants in our indebtedness, among other things, our ability to borrow additional funds or dispose of assets;
- prevent us from raising the funds necessary to repurchase all notes tendered to us upon the occurrence of certain changes of control, which failure to repurchase would constitute an event of default under the Indentures governing the Notes; or
- expose us to the risk of increased interest rates, as certain of our borrowings, including borrowings under the ABL Facility and the Term Loan Facility, are at variable rates of interest.

In addition, the Indentures and the Credit Agreements contain restrictive covenants that limit or will limit our ability to engage in activities that may be in our long-term best interest. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of substantially all of our existing and future indebtedness.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.

Our ability to pay principal and interest and to satisfy our other debt obligations will depend upon, among other things:

- our future financial and operating performance (including the realization of any cost savings described herein), which will be affected by prevailing economic, industry and competitive conditions and financial, business, legislative, regulatory and other factors, many of which are beyond our control; and
- our future ability to borrow under the ABL Facility, the availability of which depends on, among other things, our complying with the covenants in the credit agreement governing the ABL Facility.

We cannot assure you that our business will generate cash flow from operations, or that we will be able to draw under the ABL Facility or otherwise, in an amount sufficient to fund our liquidity needs, including the payment of interest on the ABL Facility, the Term Loan Facility and the Notes.

If our cash flows and capital resources are insufficient to service our indebtedness, we may be forced to reduce or delay capital expenditures, sell assets, seek additional capital or restructure or refinance our indebtedness, including the Notes and any indebtedness under the Credit Agreements. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. In addition, the terms of existing or future debt agreements, including the ABL Facility, the Term Loan Facility, the Indentures, may restrict us from adopting some of these alternatives. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to dispose of material assets or operations to meet our debt service and other obligations. We may not be able to consummate those dispositions for fair market value or at all. Furthermore, any proceeds that we could realize from any such dispositions may not be adequate to meet our debt service obligations then due. The Sponsor and its affiliates have no continuing obligation to provide us with debt or equity financing. Our inability to generate sufficient cash flow to satisfy our debt obligations, or to refinance our indebtedness on commercially reasonable terms or at all, could result in a material adverse effect on our business, results of operations and financial condition and could negatively impact our ability to satisfy our obligations under our indebtedness.

If we cannot make scheduled payments on our indebtedness, we will be in default, and the Lenders under the Term Loan Facility and the Holders of the Notes could declare all outstanding principal and interest to be due and payable, the Lenders under the ABL Facility could terminate their commitments to loan money, our secured lenders (including the Lenders under the ABL Facility and the holders of the Notes) could foreclose against the assets securing their loans and the Notes and we could be forced into bankruptcy or liquidation.

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

We require substantial capital resources to fund our growth strategy and ongoing capital expenditure programs, including capital expenditure programs for renovation, expansion and construction at our facilities and the addition of equipment and technology at our facilities. We often commit to significant capital expenditures well in advance of the time these expenditures will be made. Our cash flows and available capital resources may be insufficient to fund our capital expenditure programs and commitments, and we may be forced to reduce or delay planned and required capital expenditures. Additionally, we may experience delays or impediments in satisfying the schedule for capital expenditure commitments because of a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions, adverse weather conditions, shortages of labor or materials or other unforeseen problems or delays. The failure to satisfy our capital expenditure commitment obligations could also damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities, lessors or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions.

At December 31, 2020, we estimated our total remaining capital expenditure commitments to be approximately $1,174.7 million, which generally have remaining terms of two to six years. Of this amount, more than one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time. The failure to satisfy our capital expenditure commitment obligations could damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities, lessors or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions. As a result, if our cash flows and available capital resources are not sufficient to fund all of our anticipated capital expenditures, it may be necessary for us to give priority to contractual capital expenditure commitment obligations over other elective capital expenditure programs.

Our debt agreements contain restrictions that will limit our flexibility in operating our business.

The Indentures and the Credit Agreements contain a number of covenants that will impose significant operating and financial restrictions on us, including restrictions on our and our subsidiaries ability to, among other things:

- incur additional debt, guarantee indebtedness or issue certain preferred shares;
- pay dividends on or make distributions in respect of, or repurchase or redeem, our capital stock or make other restricted payments;
- prepay, redeem or repurchase certain debt;
- make loans or certain investments;
- sell certain assets;
- create liens on certain assets;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates;
- alter the businesses we conduct;
- enter into agreements restricting our subsidiaries' ability to pay dividends; and
- designate our subsidiaries as unrestricted subsidiaries.

As a result of these covenants, we will be limited in the manner in which we conduct our business, and we may be unable to engage in favorable business activities or finance future operations or capital needs.

In addition, the ABL Facility requires us to maintain a minimum fixed charge coverage ratio at any time when the average availability is less than the greater of $65.0 million and 10% of the lesser of the aggregate amount of revolving facility commitments and the borrowing base at such time. In that event, we must satisfy a minimum fixed charge ratio of 1.0 to 1.0. At December 31, 2020, we were in compliance with this financial maintenance covenant.

A failure to comply with the covenants under the Indentures, the Credit Agreements or any of our other future indebtedness could result in an event of default, which, if not cured or waived, could have a material adverse effect on our business, financial condition and results of operations. In the event of any such default, the Lenders thereunder:

- will not be required to lend any additional amounts to us;
- could elect to declare all borrowings outstanding, together with accrued and unpaid interest and fees, to be due and payable and terminate all commitments to extend further credit;
- could require us to apply all of our available cash to repay these borrowings; or
- could effectively prevent us from making debt service payments on the Notes (due to a cash sweep feature under the ABL Facility).

Such actions by the Lenders could cause cross defaults under our other indebtedness. If we were unable to repay those amounts, the Lenders and Holders under the ABL Facility, the Term Loan Facility, the 6.75% Secured Notes and the 4.375% Secured Notes could proceed against the collateral granted to them to secure the ABL Facility, the Term Loan Facility, the 6.75% Secured Notes and the 4.375% Secured Notes, respectively. If any of our outstanding indebtedness under the ABL Facility, the Term Loan Facility, the Notes or any of our other existing or future indebtedness were to be accelerated, there can be no assurance that our assets would be sufficient to repay such indebtedness in full.

Repayment of our debt is dependent on cash flow generated by our subsidiaries.

Repayment of our indebtedness, including the ABL Facility, the Term Loan Facility and the Notes, is dependent on the generation of cash flow by our subsidiaries and their ability to make such cash available to us, by dividend, debt repayment or otherwise. Unless they are guarantors of the indebtedness, our subsidiaries do not have any obligation to pay amounts due on such indebtedness or to make funds available for that purpose. Our subsidiaries may not be able to, or may not be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each subsidiary is a distinct legal entity and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries. While our debt agreements will limit the ability of our restricted subsidiaries to incur consensual restrictions on their ability to pay dividends or make other intercompany payments to us, these limitations are subject to certain qualifications and exceptions. In the event that we do not receive distributions from our subsidiaries, we may be unable to make required principal and interest payments on our indebtedness. In the event we require restructuring or refinancing, we cannot assure you that we will be able to restructure or refinance any of our debt on commercially reasonable terms or at all.

Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.

We and our subsidiaries may be able to incur substantial indebtedness in the future. Although the terms of the Credit Agreements and the Indentures contain restrictions on our and our subsidiaries' ability to incur additional indebtedness, these restrictions are subject to a number of important qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. As of December 31, 2020, we had $538.8 million available for additional borrowing under the ABL Facility, after giving effect to any letters of credit issued thereunder, which were approximately $45.3 million as of December 31, 2020, all of which would be secured. In addition to the Notes and our borrowings under the Credit Agreements, the covenants under any other existing or future debt instruments could allow us to incur a significant amount of additional indebtedness and, subject to certain limitations, such additional indebtedness could be secured. The more leveraged we become, the more we, and in turn our security holders, will be exposed to certain risks described above under "—Our debt agreements contain restrictions that will limit our flexibility in operating our business."

Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. Assuming the revolving credit facility is fully drawn, each 1% change in assumed blended interest rates would result in an approximately $40 million change in aggregate annual interest expense on indebtedness under the ABL Facility and the Term Loan Facility. To manage this risk, we entered into an interest rate swap agreement on December 21, 2018 with Citibank, N.A. as counterparty (the "***Interest Rate Swap***"). The terms of the Interest Rate Swap require us to pay a fixed rate of 2.63% on a notional amount of $1,100.0 million and, in exchange, we receive one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. We have not designated our Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging" ("***ASC 815***"). Therefore, all changes in the fair value of our Interest Rate Swap will be recognized through interest expense in our results of operations. Changes in the fair value of our Interest Rate Swap could result in a material effect on our consolidated results of operations and financial position; however, we do not anticipate that changes in the fair value of our Interest Rate Swap will have any impact on our cash flows.

Our ability to utilize our NOLs may be limited, and we may not be able to utilize our NOLs as a result of recent U.S. federal tax reform legislation.

As of December 31, 2020, we had approximately $1.9 billion in state and local NOLs that expire at various dates between 2021 and 2039. To the extent available and not otherwise utilized, we intend to use any NOLs to reduce the applicable state corporate income tax liability associated with our operations. However, our ability to utilize our NOLs is based on the extent to which we generate future taxable income and on prevailing corporate income tax rates, and we cannot provide any assurance as to when and to what extent we will generate sufficient future taxable income to realize our deferred tax assets, whether in whole or in part. Furthermore, the utilization of our NOLs may become subject to an annual limitation under Section 382 of the Code (and similar state provisions) in the event of certain cumulative changes in the ownership interest of significant shareholders in excess of 50 percent over a three-year period. This could limit the amount of NOLs that can be utilized annually to offset taxable income. The amount of the annual limitation is determined based on the value of a company immediately prior to the ownership change. Subsequent ownership changes may further affect the limitation in future years. For these reasons, our ability to utilize our NOLs may be limited.

Human Capital Risks

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

Our subsidiaries employ a large number of physicians. Physician employment by health systems and acute care facilities, where permissible, is a trend in the industry and has become more common as a result of actual and potential reductions in payment amounts for physician services and increasing operating costs to physicians. Employed physicians generally present more direct risks to us than those presented by independent members of our hospitals' medical staffs, such as risks of unsuccessful physician integration, challenges associated with physician practice management and compliance risks arising from the increased billing and coding activities associated with the employment of physicians, the possibility of legal claims under federal and state employment law, and governmental scrutiny of physician employment arrangements. Employed physicians also require us to incur additional expenses, such as increased salary and benefit costs, medical malpractice expense and rent expense. Payments received by us for services provided by our employed physicians, the physicians to whom our facilities have provided recruitment assistance, and the physician members of our medical staffs could be adversely affected as physician payment methodologies move toward pay-for-performance as hospital payment models are doing. The combination of payment cuts, potential liabilities and increased expenses could have an adverse effect on our results of operations.

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

The success of our business operations depends on the number and quality of the physicians and other healthcare providers who perform services at our facilities. Our ability to recruit and retain quality providers in turn depends on several factors, including the actual and perceived quality of services furnished by our facilities, our ability to meet demands for new technology, our ability to identify and communicate with providers who want to practice in our communities and our ability to provide competitive financial compensation packages. Our ability to attract and retain providers is increasingly dependent on the ability of our facilities to offer and sustain employment arrangements. In particular, we face intense competition in the recruitment and retention of specialists and primary care providers. We may not be able to recruit all of the providers we target. In addition, we may incur increased malpractice, compliance or insurance expense depending on the quality of providers' clinical outcomes.

Additionally, our ability to recruit and employ providers is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the federal physician self-referral law (commonly referred to as the Stark law), the Anti-kickback Statute, state anti-kickback and self-referral statutes, and related regulations. The Stark law requires, among other things, that recruitment assistance can only be provided to physicians who meet certain geographic and practice requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit physicians currently in practice in the community beyond recruitment costs actually incurred by them. All arrangements with physicians must also be fair market value and commercially reasonable.

In addition to these legal requirements, there is competition from other communities and facilities for these providers, and this competition continues after the provider is practicing in one of our communities. For example, integrated ACOs and other kinds of "narrow" provider networks or organizations may exclude our providers from their plans' networks of healthcare providers. These contracting networks often organize hospitals, providers and ancillary healthcare providers into exclusive networks involving fewer healthcare providers. If our affiliated providers are excluded from such networks, we may have difficulty recruiting new providers or retaining existing providers.

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

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

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

In addition to depending on our physicians and other providers, the operations of our facilities are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians. We compete with other healthcare facilities in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our facilities, including physician assistants, nurses and other non-physician healthcare professionals. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue and the competition for experienced and talented hospital management personnel is intense. This may result in employee turnover, require us to enhance wages and benefits to recruit and retain management, nurses and other medical support personnel, recruit personnel from foreign countries (which may be limited by changes in immigration law, regulation and policy), and hire more expensive temporary or contract personnel. In addition, the states in which we operate could adopt mandatory nurse staffing ratios or could increase mandatory nurse-to-patient staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. Some of the employees at some of our facilities are represented by a union, and others may be in the future, which can also increase the cost of labor. If our labor costs increase, we may not be able to raise rates to offset these increased costs. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs could have a material adverse effect on our revenues or results of operations.

Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and subject to the terms of collective bargaining agreements.

Increased or ongoing labor union activity could adversely affect our labor costs or otherwise adversely impact us. Several of our facilities have unionized employees. When a new collective bargaining agreement with a union must be negotiated, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur, and our operations could be disrupted or our labor costs increased as a result of these disruptions. Our labor costs also could increase significantly if a substantial number of other employees at our facilities unionize. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained.

The terms of the collective bargaining agreements also set forth certain requirements related to the respective facility's employment practices, seniority, hours of work, overtime, holidays, use and redemption of paid time off, extended illness bank, vacation scheduling, compensation, pay practice, health and non-health benefits, leaves of absence, grievance procedures, disability accommodations and the facility's drug and alcohol policies. If these facilities fail to fulfill any of these requirements, it could result in discussions with union representatives or the filing of a grievance that could be costly and time-consuming for those facilities. Furthermore, the terms of the collective bargaining agreements constrain our flexibility with respect to these and other employee issues. The inability to negotiate future collective bargaining agreements on favorable terms with these employees or with other unionized employees could have a material adverse effect on our business, results of operations and financial condition.

We are dependent on our executive management team and the loss of the services of one or more of our executive management team could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our executive management team. In addition, we depend on the ability of our executive officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our executive management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our executive management team, we could experience a significant disruption in our operations and failure of the affected facilities to adhere to their respective business plans.

Regulatory and Legal Risks

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

All participants in the healthcare industry are required to comply with numerous overlapping laws and regulations at the federal, state and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to relationships with providers and other referral sources, the adequacy and quality of medical care, inpatient admission criteria, privacy and security of health information, standards for equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, compliance with building codes and environmental protection, among other matters. Many of the laws and regulations applicable to the healthcare industry are complex and may be violated inadvertently, and there are numerous enforcement authorities, including CMS, the Office of Inspector General (the "***OIG***"), the DOJ, state attorneys general, and contracted auditors, as well as private plaintiffs.

There are also heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. Recent enforcement actions have focused on, among other things, financial arrangements between hospitals and providers, billing for services without adequately documenting the medical necessity for such services and billing for services outside the coverage guidelines for such services. Hospitals continue to be one of the primary focal areas of the OIG and other governmental fraud and abuse programs, as described in the OIG Work Plan. Dealing with investigations can be time and resource consuming and can divert management's attention from the business. Any such investigation or settlement could increase our costs or otherwise have an adverse effect on our business. In addition, because of the potential for large monetary exposure under the False Claims Act, which provides for treble damages and substantial civil monetary penalties for each separate false claim or statement, healthcare providers often resolve allegations without admissions of liability for significant and material amounts to avoid the uncertainty of damages and penalties that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree, settlement agreement or corporate integrity agreement. These additional requirements can result in significant additional and ongoing expenditures. Given the significant size of actual and potential settlements, it is expected that the government will continue to devote substantial resources to investigating healthcare providers' compliance with the healthcare payment rules and fraud and abuse laws. Certain of our facilities have received inquiries and subpoenas from various governmental agencies regarding these matters, and we are also subject to various claims and lawsuits relating to these and other matters.

The laws and regulations with which we must comply continually change. In the future, different interpretations or enforcement of these laws and regulations could subject our business practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws and regulations, many of these laws and regulations are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable laws and regulations. If we fail to comply with applicable laws and regulations, we could suffer substantial civil or criminal penalties, including the loss of our licenses to operate our facilities or loss of our ability to participate in the Medicare, Medicaid and other governmental programs.

Additionally, we are subject to a variety of different federal, state and local employment and wage and hour laws. While we strive to comply with those laws, if we fail to do so, we may be subject to lawsuits by governmental authorities or private plaintiffs. In addition, the IRS and/or state taxing authorities may successfully challenge positions taken on our tax returns.

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

Finally, we send short message service ("***SMS***") text messages to patients. While we obtain consent from these individuals to send text messages, federal or state regulatory authorities or private litigants may claim that the notices and disclosures we provide, form of consents we obtain, or our SMS texting practices are not adequate or violate applicable law. In addition, we must ensure that our SMS texting practices comply with regulations and agency guidance under the Telephone Consumer Protection Act (the "***TCPA***"), a federal statute that protects consumers from unwanted telephone calls, faxes and text messages. While we strive to adhere to strict policies and procedures that comply with the TCPA, the Federal Communications Commission, as the agency that implements and enforces the TCPA, may disagree with our interpretation of the TCPA and impose penalties and other consequences for noncompliance. Determination by a court or regulatory agency that our SMS texting practices violate the TCPA could subject us to civil penalties and could require us to change some portions of our business. Even an unsuccessful challenge by patients or regulatory authorities of our activities could result in adverse publicity and could require a costly response from and defense by us.

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

The False Claims Act prohibits healthcare facilities and providers, as well as other entities or individuals from, among other things, knowingly submitting false claims for payment to the federal government, or knowingly causing the submission of such claims. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are generally entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. We are required to provide information to our employees and certain contractors about state and federal false claims laws and whistleblower provisions and protections. Defendants found to be liable under the False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus substantial civil monetary penalties, that are subject to annual inflation adjustments, for each separate false claim.

There are many potential bases for liability under the False Claims Act, including reckless or intentional acts or omissions. The government has used the False Claims Act to prosecute Medicare and other government healthcare program violations such as coding errors, billing for services not provided, submitting false cost reports, falsely certifying meaningful use of certified health information technology, and providing care that is not medically necessary or that is substandard in quality. The Affordable Care Act also (i) created potential False Claims Act liability for failing to report and repay identified overpayments within sixty (60) days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later, and (ii) provided that claims submitted in connection with patient referrals that result from violations of the Anti-kickback Statute constitute false claims for the purposes of the False Claims Act. Violations of the Stark law can result in False Claims Act liability, as well. In addition, a number of states have adopted their own false claims and whistleblower provisions whereby a private party may file a civil lawsuit in state court.

Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws, many of these laws are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable fraud and abuse laws.

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

We will be subject to medical malpractice lawsuits and other legal actions arising out of the operations of our facilities and the activities of our employed or affiliated providers. As a matter of policy, we typically notify patients of any potential harms they may have suffered at our facilities, regardless of whether such notifications are required by law and notwithstanding our uncertainty as to the severity of such harms or whether they even took place. This may lead to class actions or other multi-plaintiff lawsuits or whistleblower reports. These actions may involve large claims and significant defense costs and, if we or our facilities are found liable, any judgments against us may be material. Furthermore, some states in which we operate do not impose caps on non-economic malpractice damages and, even in the states that have imposed caps on such damages, litigants may seek recoveries under alternative theories of liability that might not be subject to such caps. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement whether or not we believe we are liable. Amounts we pay to settle any of these matters also may be material.

Although we maintain professional and general liability insurance with unrelated commercial insurance carriers, each individual plaintiff's claim is generally subject to an SIR insurance program administered in-house by our risk department with assistance from our insurance brokers. Any successful claim against us that is within our SIR amounts could have an adverse effect on our results of operations or liquidity. Some of these claims could exceed the scope of the excess coverage in effect, or coverage of particular claims could be denied, and any amounts not covered by insurance could be material.

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

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

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare and Medicaid for payment for our services. These post-payment reviews may increase as a result of government cost-containment initiatives, including enhanced medical necessity reviews for patients admitted as inpatients to general acute care hospitals for certain procedures and audits of claims under the RAC programs to detect overpayments not identified through existing claims review mechanisms. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those claims most likely to contain overpayments, such as incorrectly coded services, short stays, incorrect payment amounts, non-covered services and duplicate payments. The claims review strategies used by the RACs generally include a review of high dollar claims, including inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals.

In addition, CMS and the states use UPICs to perform post-payment audits of claims and identify Medicare and Medicaid overpayments. Third-party audits or investigations of Medicare or Medicaid claims could result in increases or decreases in operating revenues to be recognized in periods subsequent to when the related services were performed, which may have a material adverse effect on our results of operations.

Controls designed to reduce inpatient services may reduce our revenues.

Over the last several years, payers have instituted policies and procedures to reduce or limit the use of inpatient services. Controls imposed by Medicare, Medicaid, and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for payment are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by QIO, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of the MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. QIOs may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider that is in substantial noncompliance with quality standards be excluded from participation in the Medicare program.

Utilization review is also a requirement of most non-governmental managed care organizations and other third-party payers. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Additionally, in some states in which we operate, commercial third-party payers and Medicaid managed care plans have instituted policies that retroactively limit or deny patient coverage for emergency department and certain other services provided at hospitals if the payers believe the services could have been provided in less expensive settings. For example, such payers are increasingly seeking to pay relatively low "triage fees" for patients seen in emergency departments when the payers retrospectively determine the patients' treatment did not qualify as an emergency service. Significant limits on the scope of services reimbursed or on the amounts paid for such services could have a material adverse effect on our revenues and results of operations.

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

Some states require prior approval for the purchase, construction and expansion of healthcare facilities, based on the state's determination of need for additional or expanded healthcare facilities or services. Certain states in which we operate facilities require a certificate of need for the purchase, construction or expansion of hospital facilities, capital expenditures exceeding a prescribed amount, changes in bed capacity or services, or for other hospital-related activities. We may not be able to obtain certificates of need required for expansion activities or to effectively compete with competing healthcare providers in the future. In addition, all of the states in which we operate facilities require hospitals, other healthcare facilities, and most healthcare providers to maintain one or more licenses. If we fail to obtain any required certificate of need or license, our ability to operate or expand operations in those states could be impaired.

In the states in which we operate that do not require certificates of need for the purchase, construction and expansion of hospital facilities, competing healthcare facilities face lower regulatory barriers to entry and expansion. If competing healthcare entities are able to purchase, construct or expand healthcare facilities without the need for regulatory approval, we may face decreased market share and revenues in those markets.

If we fail to implement and maintain certified electronic health record systems and other health information technology in an effective and timely manner, our operations could be adversely affected.

The federal government has adopted laws and regulations intended to promote the adoption of health information technology, advance the interoperability of medical record systems, and support the access, exchange, and use of electronic health information. For example, under the Medicare Promoting Interoperability Programs (formerly the Medicare EHR Incentive Program), eligible hospitals, critical access hospitals and eligible professionals that do not successfully demonstrate meaningful use of certified electronic health record technologies every year (absent a hardship exception) are subject to a downward payment adjustment under Medicare. In addition, the 21st Century Cures Act and its implementing regulations impose new Medicare conditions of participation on hospitals and critical access hospitals related to the exchange of electronic health information and prohibit information blocking, which includes any practice that is unreasonable and likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information, by health care providers and certain other entities, unless required by law or otherwise permitted by an exception in the applicable regulations. Failure to comply with these requirements could subject us to financial penalties or other disincentives or reputational damage. In addition, complying with these and future initiatives related to health care technology and interoperability may require us to change our operations or incur additional costs related to investments in information technology and EHR system software upgrades, and our payers may not adequately reimburse us for these costs and investments.

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

There is a trend in the healthcare industry toward value-based purchasing of healthcare services and bundled payment arrangements. Value-based purchasing programs include both public reporting of quality data and payment limitations tied to the incidence of preventable adverse events or the quality and efficiency of care provided by facilities. For example, Medicare, Medicaid and many large commercial payers may require facilities to report certain quality data to receive full payment updates or avoid payment reductions. They may also impose payment reductions in connection with hospital acquired conditions ("***HACs***") and excessive readmissions for certain conditions designated by HHS. Our revenue may be negatively impacted by the application of one or more of these measures. Bundled payment arrangements generally set target payment amounts for all healthcare services provided to patients during particular episodes of care. They are intended to create incentives for physicians, hospitals and other providers to work together to provide higher quality and more coordinated care at a lower cost. We currently participate in a few ACOs as well as a number of bundled payment programs, and we expect value-based purchasing programs, including programs that condition payment on patient outcome measures, to become more common and to involve a higher percentage of payment amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively affect our revenues.

The implementation of participation and quality measurement requirements under the MACRA's Merit-Based Incentive Payment System may affect our revenues.

Under MACRA, CMS updates payment rates for physician and practitioner services on an annual basis, and implements the QPP that rewards value and outcomes through participation in MIPS or an APM program. Beginning in 2017, MIPS started measuring provider performance under four categories: quality, improvement activities, promoting interoperability and cost, and annually establishes a point threshold for each category and overall performance. In 2019, MIPS began rewarding or penalizing providers based on performance reported in CY 2017 and subsequent years. The MIPS adjustment has a more significant impact on payment for physician and practitioner services than the annual inflationary update to the Medicare PFS.

Physicians participate in MIPS unless they are participants of specific forms of APM, are newly enrolled in Medicare, or see a low volume of Medicare patients (i.e., no more than 200 patients in a calendar year, 200 covered professional services, or $90,000 in charges for professional services). Groups or eligible clinicians who choose not to participate and fall within specified circumstances may request an exception through a hardship application and incur no MIPS impact on Medicare payments. CMS permitted hardship applications in 2020 based on circumstances arising from COVID related operational issues. MIPS eligible clinicians or Group Practices were subject to a negative payment adjustment of up to minus 5% in CY 2020, or positive adjustment on a sliding scale (based on CY 2018 performance) and are subject to a negative payment adjustment of up to minus 7% in CY 2021, or positive adjustment on a sliding scale (based on CY 2019 performance) with the payment adjustment increasing each year until it reaches minus 9% in CY 2023 and up to beyond. In addition, MIPS eligible clinicians with exceptional performance may receive up to 10% bonus payment from $500 million that has been specifically allocated for this purpose. For CY 2020 reporting, CMS offered reporting flexibilities, including expanded hardship exceptions, in response to pandemic challenges. For CY 2021 payment adjustments, which are based on CY 2019 reporting, CMS reported that more than 97% of eligible clinicians participated, and projects that in light of the large number of hardship exceptions, negative adjustments were negligible and positive payment adjustments were much lower than expected. However, for the 84% of participating MIPS eligible clinicians whose score was exceptional (above 75 points), an additional positive adjustment of 1.79% will be received. MACRA requires MIPS to be operated in a budget neutral manner, and the number of providers receiving hardship exceptions and neutral treatment reduced the funding from negative adjustments which would have been available for positive adjustment payments. The impact of COVID-19 expanded hardship exceptions in 2020 was reported by CMS to have resulted in 29,136 providers receiving neutral scores in 2020. Providers participating in an APM may be eligible for more advantageous adjustments under MIPS (or avoid any negative adjustment) and receive a 5% bonus. At this time, we have limited participation in APMs.

If an eligible clinician has not been satisfactorily participating in MIPS (and is not qualified to participate in an APM), his or her claims for Medicare Part B services are likely to be subject to negative payment adjustments in CY 2021 (which will be based on CY 2019 performance) and CY 2022 (which will be based on CY 2020 performance). For participating eligible clinicians that meet or exceed the MIPS threshold or APM requirements, claims for payment are likely to be subject to positive adjustments as well as a share of an additional pool of bonus payments. At this time, and as CMS continues to modify MIPS payment policies, it is unclear how MIPS will impact our overall physician payments under the Medicare program. If we have not timely and effectively implemented policies and procedures, quality programs and appropriate clinician contracting to ensure compliance with MACRA and other QPP requirements, we would experience a negative effect on future revenues related to Medicare Part B claims.

MACRA requires that CMS publish each eligible clinician's MIPS score and performance category scores on its Physician Compare website. Publishing of MIPS scores could have an adverse reputational effect on us if our employed physicians have low scores or scores that are lower than those of the other clinicians in the relevant communities.

If current or future laws or regulations force us or cause us to restructure our arrangements with physicians and other providers, we may incur additional costs, lose contracts and suffer a reduction in net revenue under existing contracts, and we may need to refinance our debt or obtain consent from our lenders.

A number of laws bear on our relationships with our physicians and other providers. There is a risk that state authorities in some jurisdictions may find that our contractual relationships with our physicians violate laws prohibiting the corporate practice of medicine and fee-splitting. These laws generally prohibit the practice of medicine by lay entities or persons and are intended to prevent unlicensed persons or entities from interfering with or inappropriately influencing the physician's professional judgment. They may also prevent the sharing of professional services income with non-professional or business interests. In states that have enacted corporate practice of medicine and fee-splitting prohibitions, we believe that we have structured our physician contracts in an effort to remain compliant with such laws. A regulatory agency, however, could still make a determination that our arrangements constitute a corporate practice of medicine or fee splitting violation. A review or action by regulatory authorities or the courts could force us to terminate or modify our contractual relationships with physicians and affiliated medical groups or revise them in a manner that could be materially adverse to our business.

In addition, we have also entered into a number of joint venture arrangements with physicians and other providers (e.g., hospitals and hospital operators) that are subject to state and federal fraud and abuse laws, including the Anti-kickback Statute and False Claims Act. See "—We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may reduce our revenues and profitability." To the extent applicable, regulatory agencies may view these transactions as prohibited arrangements that must be restructured, or discontinued, or for which we could be subject to other significant penalties, including debarment, suspension or exclusion from state and federal government healthcare programs. Although compliance programs can mitigate the risk of investigation and prosecution for violations of these laws, the risks cannot be entirely eliminated. Any action against us for violation of these laws, even if we successfully defend against it, could cause us to incur significant legal expenses and loss of revenue from those joint ventures and divert our management's attention from the operation of our business.

Data Security and Privacy Risks

A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

We rely extensively on our information systems and certain systems operated by us and third-parties to manage clinical, financial and employee data, communicate with our patients, payers, vendors and other third parties and summarize and analyze operating results. These systems are at risk from cybersecurity attacks and other intrusions, including attempts to gain unauthorized access to and theft of our confidential data, misuse, corruption or destruction of confidential data and damage, disruptions or shutdowns of these systems due to viruses, malware, ransomware, employee error or malfeasance, and other electronic security breaches. Our systems, which transmit and store sensitive and confidential data, including personally identifiable information ("***PII***") and other PHI of our patients, employees and others, and our proprietary and confidential business performance and other data, will continue to be a target for attempts to gain unauthorized access and data theft due to the valuable nature of the information they contain, as well as at risk for accidental exposure. In addition, certain third-party medical devices and equipment are used at our facilities, and may be vulnerable to cybersecurity attacks or other breaches which could negatively impact our systems or our patients.

Cybersecurity breaches and other unauthorized access to our data can sometimes be difficult to discern, and any delays in detection may lead to increased harm. Such attacks or breaches are common in the healthcare sector and could result in the compromise of health information or other data subject to protection by HIPAA and other laws and regulations or disrupt our IT systems or business. While we are not aware of having experienced a material cybersecurity breach, there can be no assurance that we will not be subject to material cyber-attacks or security breaches in the future, or that the preventive actions we take to reduce the risk of such incidents and protect our IT and data will be sufficient. We continue to prioritize cybersecurity and the development of practices and controls to protect our systems. However, regardless of the nature, extent and timing of our actions, these measures may not prevent security breaches. If our services are subject to cyber-attacks that impair or deny the ability of patients to access our services, current and potential patients may become unwilling to provide us the information necessary for them to become users of our services or may curtail or stop using our services. As cyber-threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures and to investigate and remediate any information security vulnerabilities. As we are subjected to cyber-attacks and possible security breaches in the future, this could have an adverse impact on our business, reputation, financial condition and results of operations.

The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. If, in spite of our security and compliance efforts we or any of our business associates were to experience a breach, loss, or other compromise of PHI or PII, such event could disrupt our operations, result in increased data protection costs, damage our reputation, or result in regulatory penalties, legal claims and civil or criminal liability under HIPAA and other state and federal laws, which could have a material adverse effect on our results of operations.

If access to our information systems or those provided by our third-party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

Our business depends heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and to develop new systems in order to keep pace with continuing changes in information processing technology. In addition to our own systems, we rely on multiple third-party providers of financial, clinical, supply chain, patient accounting and network information services and, as a result, we face operational challenges in maintaining multiple provider platforms and facilitating the interface of such systems with one another. The third-party providers may not have appropriate controls to protect confidential information. We do not control the information systems of third-party providers, and in some cases we may have difficulty accessing information archived on third-party systems, which could subject us to liability for failure to respond to legal, regulatory or payer obligations or information requests. Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, flood, hurricane, telecommunications failure, terrorist attack or other catastrophic event. If these systems fail or are interrupted, if our access to these systems is limited in the future or if providers develop systems more appropriate for more urban healthcare markets and not suited for our facilities, our operations could suffer.

We intend to expand our operations, including by acquiring more facilities, which will require us to integrate and transition certain existing information systems. In addition, as new information systems are developed in the future, we will need to integrate them into our existing systems. Evolving industry and regulatory standards, such as the HITECH Act, HIPAA and EHR meaningful use/promoting interoperability regulations, also may require changes to our information systems in the future. System conversions are costly, time consuming and disruptive for providers, staff and, in some cases, patients. If such conversions occurred on a large scale or if we are unable to properly integrate other information systems or expand or update our current information systems, the costs and disruptions could have a material adverse effect on our revenues or results of operations.

Item 2. ***Properties.***

The table below presents certain information with respect to our hospital campuses as of December 31, 2020:

Facility Name	City	Licensed Beds	Ownership and Real Property Status
Alabama			
Andalusia Regional Hospital	Andalusia	88	Own
North Alabama Medical Center	Florence	263	Own
Shoals Hospital	Muscle Shoals	198	Own
Vaughan Regional Medical Center (a)	Selma	175	JV/Own
Arizona			
Canyon Vista Medical Center	Sierra Vista	100	Lease
Havasu Regional Medical Center (b)	Lake Havasu City	171	JV/Own
Valley View Medical Center	Fort Mohave	84	Own
Arkansas			
National Park Medical Center (c) (d)	Hot Springs	163	JV/Lease
Saline Memorial Hospital (a)	Benton	177	JV/Lease
St. Mary's Regional Medical Center	Russellville	170	Own
Colorado			
Colorado Plains Medical Center	Fort Morgan	50	Lease
Georgia			
St. Francis Hospital (e)	Columbus	376	Own
Idaho			
St. Joseph Regional Medical Center (d)	Lewiston	145	Lease
Indiana			
Clark Memorial Hospital (f)	Jeffersonville	236	JV/Own
Scott Memorial Hospital (f)	Scottsburg	25	JV/Own
Iowa			
Ottumwa Regional Health Center (d)	Ottumwa	217	Lease
Kansas			
Western Plains Medical Complex (d)	Dodge City	99	Lease
Kentucky			
Bluegrass Community Hospital	Versailles	25	Own
Bourbon Community Hospital	Paris	58	Own
Clark Regional Medical Center	Winchester	79	Own
Fleming County Hospital	Flemingsburg	25	Own
Georgetown Community Hospital	Georgetown	75	Own
Jackson Purchase Medical Center	Mayfield	107	Own
Lake Cumberland Regional Hospital	Somerset	295	Own
Logan Memorial Hospital	Russellville	75	Own
Meadowview Regional Medical Center	Maysville	100	Own
Spring View Hospital	Lebanon	75	Own
Michigan			
UP Health System - Bell	Ishpeming	25	Own
UP Health System - Marquette (g)	Marquette	222	JV/Own
UP Health System - Portage (a)	Hancock	96	JV/Own
Mississippi			
Bolivar Medical Center	Cleveland	199	Lease
Montana			
Community Medical Center (a)	Missoula	151	JV/Own
Nevada			
Northeastern Nevada Regional Hospital	Elko	75	Own
New Mexico			
Los Alamos Medical Center	Los Alamos	47	Own
Memorial Medical Center of Las Cruces	Las Cruces	199	Lease

Facility Name	City	Licensed Beds	Ownership and Real Property Status
North Carolina			
Central Carolina Hospital (g)	Sanford	137	JV/Own
Frye Regional Medical Center (g)	Hickory	355	JV/Lease
Harris Regional Hospital (g)	Sylva	86	JV/Own
Haywood Regional Medical Center (g)	Clyde	154	JV/Own
Maria Parham Medical Center (h)	Henderson	205	JV/Own
Person Memorial Hospital (g)	Roxboro	98	JV/Own
Rutherford Regional Medical Center (g)	Rutherfordton	143	JV/Own
Swain County Hospital (g)	Bryson City	48	JV/Own
Wilson Medical Center (h)	Wilson	384	JV/Own
Ohio			
Clinton Memorial Hospital	Wilmington	141	Own
Oklahoma			
Southwestern Medical Center (d)	Lawton	107	Lease
Southwestern Behavioral Health Center (d)	Lawton	92	Lease
Oregon			
Willamette Valley Medical Center (d)	McMinnville	60	Lease
Pennsylvania			
Conemaugh Memorial Medical Center (d) (g)	Johnstown	537	JV/Lease
Meyersdale Medical Center (d) (g)	Meyersdale	20	JV/Lease
Miners Medical Center (d) (g)	Hastings	25	JV/Lease
Nason Medical Center (d)	Roaring Spring	45	Lease
South Carolina			
Carolina Pines Regional Medical Center (c) (d)	Hartsville	116	JV/Lease
KershawHealth (d)	Camden	119	Lease
Providence Hospital - Downtown	Columbia	258	Own
Providence Hospital - Northeast	Columbia	74	Own
Tennessee			
Livingston Regional Hospital	Livingston	114	Own
Riverview Regional Medical Center	Carthage	35	Own
Southern Tennessee Regional Health System - Lawrenceburg	Lawrenceburg	99	Own
Southern Tennessee Regional Health System - Pulaski	Pulaski	95	Own
Southern Tennessee Regional Health System - Sewanee	Sewanee	41	Lease
Southern Tennessee Regional Health System - Winchester	Winchester	157	Own
Starr Regional Medical Center - Athens	Athens	118	Own
Starr Regional Medical Center - Etowah	Etowah	160	Own
Sumner Regional Medical Center	Gallatin	167	Own
Trousdale Medical Center	Hartsville	25	Own
Texas			
Ennis Regional Medical Center	Ennis	60	Lease
Palestine Regional Medical Center (d)	Palestine	160	Lease
Paris Regional Medical Center	Paris	154	Own
Parkview Regional Hospital	Mexia	58	Lease
Utah			
Ashley Regional Medical Center	Vernal	39	Own
Castleview Hospital	Price	39	Own
Virginia			
Clinch Valley Medical Center	Richlands	175	Own
Fauquier Health	Warrenton	210	Own
Sovah Health - Danville	Danville	250	Own
Sovah Health - Martinsville	Martinsville	220	Own
Twin County Regional Hospital (h)	Galax	141	JV/Own
Wythe County Community Hospital	Wytheville	100	Lease

Facility Name	City	Licensed Beds	Ownership and Real Property Status
Washington			
Capital Medical Center (d) (i)	Olympia	107	JV/Lease
Lourdes Health - Medical Center (d)	Pasco	95	Lease
Lourdes Health - Counseling Center (d)	Pasco	32	Lease
Trios Health - Southridge Hospital (j)	Kennewick	74	JV/Lease
Trios Health - Women's and Children's Hospital (j)	Kennewick	37	JV/Lease
West Virginia			
Logan Regional Medical Center	Logan	140	Own
Raleigh General Hospital	Beckley	300	Own
Wisconsin			
Watertown Regional Medical Center (a)	Watertown	95	JV/Own
Wyoming			
SageWest Healthcare - Lander (d)	Lander	76	Lease
SageWest Healthcare - Riverton (d)	Riverton	70	Lease
		11,512	

(a) This facility is owned and operated by a joint venture between us and an unrelated third-party. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(b) This facility is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest. The real property on which this facility is located is owned by the LifePoint member and leased to the joint venture.
(c) This facility is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest.
(d) This facility is subject to a sale-leaseback arrangement with affiliates of MPT.
(e) This facility is owned and operated by St. Francis Holding Company, LLC ("***SFHC***"), a joint venture between us and Emory. A wholly-owned LifePoint affiliate owns the real property of this facility and leases the real property to SFHC.
(f) This facility is owned and operated by the Regional Health Network of Kentucky and Southern Indiana ("***RHN***"), a joint venture between us and Norton. A wholly-owned LifePoint affiliate owns a controlling interest in RHN.
(g) This facility is owned and operated by Duke LifePoint Healthcare (or a joint venture between affiliates of the members of Duke LifePoint Healthcare). A wholly-owned LifePoint affiliate owns a controlling interest in Duke LifePoint Healthcare and such other joint venture.
(h) This facility is owned and operated by a joint venture between a local not-for-profit entity and Duke LifePoint Healthcare.
(i) This facility is owned and operated by a joint venture among us, physicians and a joint venture between us and University of Washington. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture. On December 23, 2020, certain LifePoint affiliates entered into an agreement with an unrelated third-party to sell LifePoint's majority ownership interest in this facility.
(j) This facility is owned and operated by a joint venture between us and University of Washington. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.

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

Item 3. ***Legal Proceedings.***

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

Except as discussed under "Legal Proceedings and General Liability Claims" in Note 14 to our accompanying consolidated financial statements included elsewhere in this Report, we are currently not a party to any pending proceedings, which, in management's opinion would have a material adverse effect on our business, financial condition or results of operations.

Item 4. ***Mine Safety Disclosures*****.**

Not applicable.

PART II

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

All of our equity securities are held by Holdings, whose indirect parent is DSB Parent. As of December 31, 2020, our Sponsor beneficially owned approximately 98.6% of the capital units of LifePoint with the remaining approximate 1.4% owned by our current or former directors, members of management, employees and consultants. Because our equity securities are privately held, there is no established public trading market for our equity securities.

Equity Compensation Plan Information

Refer to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by DSB Parent to our employees and directors.

Recent Sales of Unregistered Securities

There have been no recent sales of unregistered equity securities of the Company within the period covered by this Report.

Item 6. ***Selected Financial Data.***

Not applicable.

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

The following is management's discussion and analysis of our financial condition and results of operations for the three months and years ended December 31, 2020 and December 31, 2019. We recommend that you read this discussion together with our accompanying consolidated financial statements and related notes included elsewhere in this Report.

Management's discussion and analysis of our financial condition and results of operations as of and for the year ended December 31, 2018 has been omitted as permitted by Instruction 1 to Item 303(a) of Regulation S-K. Refer to "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations for the Years Ended December 31, 2019 and 2018" in our Annual Report for the year ended December 31, 2019 for management's discussion and analysis of changes in financial condition and results of operations as of and for the year ended December 31, 2018.

Overview

We, acting through our subsidiaries, own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. As of December 31, 2020, we operated 88 hospital campuses in 29 states throughout the U.S., having a total of 11,512 licensed beds. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a network of hospitals and outpatient facilities.

We seek to fulfill our mission of Making Communities Healthier® by (1) delivering high quality patient care, (2) supporting our physicians, (3) creating excellent workplaces for our employees, (4) taking a leadership role in our communities and (5) ensuring fiscal responsibility. We strive to create places where people choose to come for healthcare, physicians want to practice and employees want to work.

We generated revenues of $2,191.9 million and $2,218.6 million during the three months ended December 31, 2020 and 2019, respectively, and $8,121.9 million and $8,752.8 million for the years ended December 31, 2020 and 2019, respectively. For the years ended December 31, 2020 and 2019, approximately 55.7% and 55.2% of our revenues, respectively, related to patients participating in Medicare and Medicaid programs, collectively. Payments made to our facilities pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payers, together with certain limited services provided to Medicare recipients, to generate an operating profit. The healthcare industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payers. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our facilities.

Developments, Trends and Operating Environment

Entry into Agreement to Sell Capital Medical Center

On December 23, 2020, we entered into a definitive agreement with an unrelated third-party to sell our majority ownership interest in Capital Medical Center. We expect the transaction to close during the first half of 2021. We have excluded Capital Medical Center from the classification of "same-hospital" in the forthcoming discussion and analysis of our results of operations for the three months and years ended December 31, 2020 and 2019. For additional information regarding our planned and historical divestitures, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Entry into Services Agreement for Revenue Cycle Management

On October 28, 2020, we announced entry, through our subsidiary, LifePoint Corporate Services, into a services agreement with R1 RCM Inc. ("***R1***"), pursuant to which, commencing January 1, 2021, R1 began to manage revenue cycle operations in our hospitals that currently utilize independent revenue cycle management systems and those supported by our Business Services Center in Johnstown, Pennsylvania.

Impact of COVID-19

During March 2020, the global COVID-19 pandemic began to significantly affect our facilities, employees, patients, communities, business operations and financial performance, as well as the U.S. economy and financial markets, as a whole. Approximately one year into the pandemic, we continue to be deeply committed to protecting the health of our communities and are continuing to respond to the evolving COVID-19 situation across the country. Importantly, we are taking every precaution to ensure we can continue providing quality care and safeguard the health and well-being of patients, employees, providers, volunteers and visitors in each community we serve. The national footprint of our health system, along with our HSC, has enabled us to support our communities during this challenging time.

We established an internal COVID-19 taskforce during the early stages of the pandemic which continues to meet regularly today. Additionally, in November 2020, we established a COVID-19 vaccine team to help facilitate the successful distribution and administration of vaccines across our markets.

Our top priority continues to be ensuring the safety, health and well-being of those in our facilities and communities. We have put in place a number of protocols to protect our patients, providers, employees, volunteers and visitors, including:

- mandatory masking for all providers, employees, volunteers and visitors across our facilities;
- required eye protection for providers and employees during all clinical encounters across our facilities;
- required COVID-19 testing for all admissions in communities with the highest rates of COVID-19 spread;
- performing pre-operative COVID-19 testing for patients undergoing certain elective procedures; and
- social distancing practices and other protective measures throughout our facilities, including visitor restrictions, closing common areas, limiting entry points and screening providers, employees and visitors who enter our facilities based on criteria established by the CDC.

Restrictive measures, such as travel bans, social distancing and quarantine guidelines, significantly reduced the volume of procedures performed at our facilities during 2020, as well as the volume of emergency room and physician office visits unrelated to COVID-19. Furthermore, broad economic factors resulting from the current COVID-19 pandemic, including increasing unemployment rates and reduced consumer spending, could negatively affect our payer mix, increase the relative proportion of lower margin services we provide and reduce patient volumes, as well as diminish our ability to collect outstanding receivables.

Our evaluation of the measures taken across our health system in response to COVID-19 is ongoing and additional updates to our policies, procedures and operations could occur as best practices continue to evolve. Furthermore, our facilities are located across a wide geographic range of communities, which may require us to modify measures we take at specific facilities based on local conditions, including the severity of COVID-19 in the community served by the facility and changes in state and local restrictive measures.

As a result of the adverse impact of the COVID-19 pandemic on our business, we have undertaken several additional measures intended to enhance our financial flexibility, including among other things:

- increasing our liquidity with proceeds from the offering of the 6.75% Secured Notes;
- instituting net working capital optimization initiatives along with the curtailment of non-critical capital expenditures;
- receiving Medicare accelerated payments under the expanded Accelerated and Advance Payment Program (described in more detail below);
- receiving direct grant aid payments from the Emergency Fund established under the CARES Act (described in more detail below); and
- anticipating current year cash tax savings related to various tax provisions of the CARES Act (described in more detail below).

Additionally, although we have received funds that are available to us and our facilities under the CARES Act and related stimulus legislation and may seek additional funds that may become available under existing or future COVID-19 stimulus legislation, we cannot predict the manner in which such funds will be allocated or administered and we cannot assure you that we will be able to access such funds in a timely manner or at all. Most of these programs require healthcare providers to meet certain requirements and/or otherwise agree to certain terms and conditions in order to receive payment. In many cases, only limited guidance has been provided on those requirements and terms and conditions, and we already have seen changes in the substance and interpretation of that guidance.

For additional information about the risks presented by the COVID-19 pandemic, our responses to the pandemic and the resources available to healthcare providers, refer to "Part I, Item 1A. Risk Factors" included in this Report.

Legislative and Regulatory Developments in Response to COVID-19

CARES Act, Other Stimulus Legislation and Regulatory Developments

Numerous recent legislative and regulatory actions have been taken in an attempt to provide businesses, including healthcare providers, with relief from the negative impacts of the COVID-19 pandemic. For additional information about the CARES Act and other stimulus legislation and regulatory development related to the COVID-19 pandemic, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" included in this Report.

Direct Grant Aid Payments

With respect to payments being made to providers from the Emergency Fund, beginning April 10, 2020, the Emergency Fund distributed $50 billion to hospitals based on their 2018 net patient revenue. Since that time, the Emergency Fund has distributed an additional $74 billion to a number of different types of healthcare providers, including participants in state Medicaid/CHIP programs, providers in areas particularly impacted by the COVID-19 outbreak, rural providers (including hospitals and rural health clinics), skilled nursing facilities, dentists, providers of services with lower shares of Medicare reimbursement or who predominantly serve Medicaid beneficiaries, and providers requesting reimbursement for the treatment of uninsured patients. In addition, on October 1, 2020, HHS announced that an additional $24.5 billion in relief payments would be made from the Emergency Fund, on an application basis, to certain healthcare providers. HHS has stated that these additional relief payments will be allocated in a way that is intended to achieve an equitable payment of two percent of annual revenue from patient care for all applicants and may also take into account a provider's change in operating revenues from patient care, minus their operating expenses from patient care. For the year ended December 31, 2020, we recognized $646.3 million of direct grant aid payments as other income under the caption "Government stimulus income" in our accompanying consolidated statement of operations included elsewhere in this Report.

For additional information about direct grant aid payments, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" included in this Report.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, HHS had also expanded the CMS Accelerated and Advance Payment Program to a broader group of Medicare Part A and Part B providers. Under the expanded Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period. Through December 31, 2020, we received a total of $991.0 million of Medicare advance payments under the Accelerated and Advance Payment Program, of which $369.8 million and $621.2 million are included under the captions "Current portion of Medicare advance payments" and "Long-term portion of Medicare advance payments", respectively, in our accompanying consolidated balance sheet at December 31, 2020 included elsewhere in this Report. We do not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program.

For additional information about the repayment of these accelerated/advance payments refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" included in this Report.

CARES Act Tax Provisions

The CARES Act also provides for certain federal income tax changes, including an increase in the interest expense tax deduction limitation, the deferral of the employer portion of Social Security payroll taxes, refundable payroll tax credits, employee retention tax credits, net operating loss carryback periods, alternative minimum tax credit refunds and bonus depreciation of qualified improvement property. The federal income tax changes brought about by the CARES Act are complex and further guidance is expected. For the year ended December 31, 2020, we have deferred cash payments of approximately $84 million related to Social Security payroll tax payments into 2021 and 2022. Additionally, we have generated 2020 cash tax savings of approximately $57 million related to corporate tax law changes which increased the limitation in the tax deductibility of interest expense from 30% to 50% of adjusted taxable income as well as the ability to carry back net operating losses to each of the five tax years preceding the tax year of such loss. However, we may change our provision for income taxes and our deferred income taxes as our understanding of the CARES Act tax provisions evolves due to additional U.S. Department of Treasury guidance. Any such adjustments could materially impact our provision for income taxes and, as a result, our financial results in the relevant periods.

Healthcare Reform Efforts

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, requiring most Americans to obtain health insurance, also referred to as the "individual mandate," providing additional funding for Medicaid in states that choose to expand their programs, reducing Medicare inpatient prospective payment system, Medicare outpatient prospective payment system, and Medicare and Medicaid disproportionate share hospital payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and instituting certain private health insurance reforms. The Affordable Care Act has, however, been subject to a number of legislative and regulatory changes and court challenges, and its future is uncertain.

The net effect of the Affordable Care Act, as currently adopted, on our business continues to be subject to a number of variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. Additionally, the Affordable Care Act has been challenged before the U.S. Supreme Court. We cannot predict the outcome of litigation challenging the constitutionality of the Affordable Care Act or whether the Affordable Care Act will be repealed, replaced or modified. If the Affordable Care Act is found to be unconstitutional, we cannot predict what, if any, the replacement plan or modifications would be, when any such replacement plan or modifications would become effective, or whether any of the existing provisions of the Affordable Care Act would remain in place. We also cannot predict the impact that the new Presidential administration and Congressional leadership will have on the implementation and enforcement of the provisions of the Affordable Care Act, on any current, pending or potential regulations adopted to implement the law, or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

Refer to "Part I, Item 1. Business—Healthcare Reform" included in this Report for more information about the Affordable Care Act.

Competitive and Structural Environment

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

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

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

In addition to competitive concerns, many of our communities are experiencing slow growth, and in some cases, population losses. We believe this trend has occurred mainly as a result of recent challenging economic conditions because the economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves. In addition, other economic factors, including, potentially, self-rationing of healthcare services, have made it more difficult to increase the number of patients who seek care at many of our facilities.

Regulatory Environment

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

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

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

In light of the provisions of the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

Revenue Sources

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

Medicare and Medicaid Reimbursement

Revenues from governmental payers, such as Medicare and Medicaid, are controlled by complex rules and regulations that stipulate the amount a hospital is paid for providing healthcare services. We must comply with these rules and regulations to continue to be eligible to participate in the Medicare and Medicaid programs. These rules and regulations are subject to frequent changes as a result of legislative and administrative action and annual payment adjustments on both the federal and the state levels. In addition, Medicare payment methodologies have been, and are expected to continue to be, revised significantly based on cost containment and policy considerations.

For more information about Medicare and Medicaid reimbursement matters, refer to "Part I, Item 1. Business—Sources of Revenue" included in this Report.

Physician & Non-Physician Practitioner Services

We employ an increasing number of physicians and non-physician practitioners, such as physician assistants and nurse practitioners, in our hospital markets. Medicare pays us for services provided by our employed physicians and non-physician practitioners under the PFS system. MACRA, which was adopted in 2015, significantly changed how CMS determines the annual updates to the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased annually by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the Bipartisan Budget Act of 2018, were increased by 0.25% for CY 2019. PFS payment rates are scheduled to remain at their CY 2019 levels through CY 2025. In addition, MACRA also established the QPP for incentivizing physician and practitioner care that meets certain value, quality, cost, and performance criteria, and, beginning in CY 2019, amounts paid to physicians and practitioners under the PFS are subject to adjustment through the QPP and participation in either MIPS or an APM. For more information, refer to "Part I, Item 1. Business—Sources of Revenue—Medicare Physician Fee Schedule" included in this Report.

HMOs, PPOs and Other Private Insurers

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

Self-pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities have experienced in prior years, which included increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. We cannot predict how administrative or judicial interpretations, legislative actions or any other modifications to the Affordable Care Act that may be implemented or adopted, such as the cessation of cost sharing reduction payments or the repeal of the individual mandate, may impact our self-pay revenues.

Surprise Medical Billing

On December 21, 2020, Congress adopted legislation that is intended to limit the "surprise" medical bills that are often received by individuals receiving emergency and certain other services (such as anesthesia services) from out-of-network providers. Effective as of January 1, 2022, the No Surprises Act prohibits out-of-network providers from balance billing patients for (i) emergency care services that are provided by out-of-network facilities or at in-network facilities by out-of-network providers and (ii) transportation and related services that are provided by out-of-network air ambulance providers. The No Surprises Act also generally prohibits out-of-network providers from billing patients for non-emergency medical treatment unless the provider first notifies the patient of the provider's network status and estimated charges and the patient agrees to be financially liable for the additional amounts. Violations of the No Surprises Act are punishable by civil monetary penalties of up to $10,000, and the No Surprises Act may be enforced by both the state and federal governments.

We cannot predict how the No Surprises Act will be implemented by HHS or how it will ultimately be enforced by the federal and various state governments. We also cannot predict the amounts that will be received by our facilities and our employed providers for out-of-network services, whether the No Surprises Act will impact the in-network payment rates that are offered by third-party payers and the willingness of those payers to enter into participation agreements with us and our facilities in the future, or the costs we will incur in complying with the requirements of the No Surprises Act. In addition, a number of states are considering or have already adopted legislation to eliminate surprise medical billing. We cannot predict how state legislative actions to modify or pass these proposals may be implemented or adopted, or what impact, if any, those actions may have on our operations and revenues.

Price Transparency

Transparency in healthcare pricing has become a focal point for CMS, Congress, and many state legislatures. For example, effective as of January 1, 2021, hospitals generally are required to post their standard charges prominently on a publicly available website. CMS has stated that it intends to audit and monitor hospital compliance with its reporting requirements and to take actions to address hospital noncompliance, including issuing a warning notice, requesting a corrective action plan, and imposing civil monetary penalties. In addition to the CMS hospital price transparency regulations, HHS and the Departments of the Treasury and Labor have issued regulations that require most private health plans, including group health plans and individual health insurance market plans, to disclose pricing and cost-sharing information to their beneficiaries. A number of states have also adopted their own healthcare price transparency and/or disclosure statutes.

In addition to addressing surprise billing, the No Surprises Act also contains a number of provisions that are intended to promote provider and health plan price transparency. Among other things, effective as of January 1, 2022, under the No Surprises Act, healthcare providers will be required to provide "good faith estimates" of their total expected charges for scheduled items and services to the patient's health plan if the patient is insured prior to the item and/or service being provided. Health plans will be required to provide patients with an "advanced explanation of benefits" that includes (1) information regarding the network status of the provider, (2) a copy of the provider's "good faith estimate," (3) an estimate of the amount that the patient will be expected to pay for the item or service, and (4) information on any applicable pre-authorization requirements. The Secretary of HHS is required to adopt regulations to implement the price transparency provisions of the No Surprises Act.

Although we continue to evaluate, and are taking proactive steps in response to, the legislative and regulatory developments regarding price transparency, we cannot predict how existing regulations will be implemented or interpreted or whether any other requirements will be imposed on providers and health plans. We also cannot predict what affect the public disclosure of hospitals' or insurance providers' negotiated rates will have on our future negotiations with payers or the effect that the disclosure of pricing information by healthcare providers and health plans will have on our patient volumes and revenues.

Results of Operations

Certain Definitions

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

Adjusted EBITDA. EBITDA adjusted to exclude unusual items and other adjustments required or permitted in calculating debt covenant compliance under the Indentures governing the Notes and/or the Credit Agreements. We believe that this inclusion of supplementary adjustments to EBITDA applied in presenting Adjusted EBITDA are appropriate to provide additional information to investors about the impact of certain non-cash items, unusual items that we do not expect to continue or at the same level in the future and other items.

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

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

Consolidated. Consolidated information includes the results of all hospital operations and corporate overhead costs, including the results of our recent acquisitions and divestitures.

EBITDA. Earnings before interest, taxes, depreciation and amortization.

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

Outpatient factor. The sum of gross inpatient revenue and gross outpatient revenue divided by gross inpatient revenue.

Same-hospital. Same-hospital information includes the results of the same 87 hospital campuses operated during both the three and twelve months ended December 31, 2020 and 2019. Same-hospital information excludes the results of our previously divested hospitals, as well as Capital Medical Center, which is classified as held-for-sale as of December 31, 2020.

For the Three Months Ended December 31, 2020 and 2019

Summary

The following table summarizes our results of operations for the three months ended December 31, 2020 and 2019 (dollars in millions):

	Three Months Ended December 31,			
	2020		2019 [(a)]	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 2,191.9	100.0 %	$ 2,218.6	100.0 %
Salaries and benefits	1,018.0	46.4	1,023.4	46.1
Supplies	399.7	18.2	374.1	16.9
Other operating expenses, net	574.5	26.3	545.1	24.6
Government stimulus income	(232.2)	(10.6)	-	-
Depreciation and amortization	90.7	4.1	100.9	4.5
Interest expense, net	119.5	5.5	132.5	6.0
Debt transaction costs	13.4	0.6	-	-
Merger, integration and other transaction-related costs	-	-	39.1	1.8
Impairments of goodwill and long-lived assets	-	-	3.3	0.1
Other non-operating losses, net	6.3	0.3	1.8	0.1
	1,989.9	90.8	2,220.2	100.1
Income (loss) before income taxes	202.0	9.2	(1.6)	(0.1)
(Benefit from) provision for income taxes	(15.3)	(0.7)	74.9	3.3
Net income (loss)	217.3	9.9	(76.5)	(3.4)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(8.3)	(0.4)	(3.7)	(0.2)
Net income (loss) attributable to LifePoint Health, Inc.	$ 209.0	9.5 %	$ (80.2)	(3.6) %

(a) Our results of operations for the three months ended December 31, 2019 have been restated in accordance with the adoption of Accounting Standards Update ("***ASU***") 2016-02, "Leases" ("***ASU 2016-02***"). For additional information regarding the impact of the adoption of ASU 2016-02, refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

Revenues

The following table summarizes our key revenue metrics for the three months ended December 31, 2020 and 2019:

	Three Months Ended December 31,		Increase	% Increase
	2020	2019	(Decrease)	(Decrease)
Consolidated:				
Number of hospital campuses at end of period	88	88	-	- %
Revenues (in millions)	$ 2,191.9	$ 2,218.6	$ (26.7)	(1.2)%
Admissions	75,895	83,129	(7,234)	(8.7)%
Equivalent admissions	184,740	219,228	(34,488)	(15.7)%
Revenues per equivalent admission	$ 11,864	$ 10,120	$ 1,744	17.2 %
Case mix index	1.51	1.38	0.13	9.4 %
Inpatient surgeries	19,448	22,550	(3,102)	(13.8)%
Outpatient surgeries	75,763	86,271	(10,508)	(12.2)%
Total surgeries	95,211	108,821	(13,610)	(12.5)%
Emergency department visits	382,249	481,491	(99,242)	(20.6)%
Same-hospital:				
Number of hospital campuses at end of period	87	87	-	- %
Revenues (in millions)	$ 2,170.4	$ 2,185.8	$ (15.4)	(0.7)%
Admissions	75,192	81,912	(6,720)	(8.2)%
Equivalent admissions	182,641	216,737	(34,096)	(15.7)%
Revenues per equivalent admission	$ 11,884	$ 10,085	$ 1,799	17.8 %
Case mix index	1.51	1.38	0.13	9.4 %
Inpatient surgeries	19,280	21,975	(2,695)	(12.3)%
Outpatient surgeries	75,356	85,453	(10,097)	(11.8)%
Total surgeries	94,636	107,428	(12,792)	(11.9)%
Emergency department visits	378,700	476,408	(97,708)	(20.5)%

For the three months ended December 31, 2020, our consolidated revenues decreased $26.7 million, or 1.2%, to $2,191.9 million compared to $2,218.6 million for the same period last year. The decrease in our revenues was a direct result of declines in patient volumes across the majority of our markets and service lines, which we believe is related to the deferral of non-urgent and elective procedures in connection with the COVID-19 pandemic and the response of federal, state, and local governments to the pandemic. This decrease was partially offset by an increase in the overall acuity of services provided and improvements in both commercial and government pricing during the three months ended December 31, 2020 compared to the same period last year.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the three months ended December 31, 2020 and 2019 (dollars in millions):

	Three Months Ended December 31,			
	2020		2019	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 867.9	39.6 %	$ 844.2	38.1 %
Medicaid	358.5	16.4	374.2	16.9
HMOs, PPOs and other private insurers	908.5	41.4	944.1	42.6
Self-pay	13.7	0.6	14.2	0.6
Other	39.4	1.8	37.5	1.6
Revenue from contracts with customers	2,188.0	99.8	2,214.2	99.8
Rental income	3.9	0.2	4.4	0.2
Revenues	$ 2,191.9	100.0 %	$ 2,218.6	100.0 %

Salaries and Benefits

For the three months ended December 31, 2020, our consolidated salaries and benefits expense was $1,018.0 million, or 46.4% of revenues, compared to $1,023.4 million, or 46.1% of revenues, for the same period last year. The increase in our salaries and benefits expense as a percentage of revenues for the three months ended December 31, 2020 compared to the same period last year was primarily a result of the decrease in revenue associated with the COVID-19 pandemic.

Supplies

For the three months ended December 31, 2020, our consolidated supplies expense was $399.7 million, or 18.2% of revenues, compared to $374.1 million, or 16.9% of revenues, for the same period last year. The increase in our supplies expense was partially attributable to an increase in the overall level of acuity of services provided during the three months ended December 31, 2020 compared to the same period last year, in addition to higher costs and an increase in the utilization of supplies related to pharmaceuticals, laboratory supplies and personal protective equipment, primarily associated with the COVID-19 pandemic.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the three months ended December 31, 2020, our consolidated other operating expenses were $574.5 million, or 26.3% of revenues, compared to $545.1 million, or 24.6% of revenues, for the same period last year. The increase in our other operating expenses as a percentage of revenues for the three months ended December 31, 2020 compared to the same period last year was primarily related to increases in physician subsidies and an increase in the utilization of outsourced contracted services for laboratory testing associated with the COVID-19 pandemic.

Government Stimulus Income

As a result of the adverse impact of the COVID-19 pandemic on our business, we received direct grant aid payments from the Emergency Fund established under the CARES Act. For the three months ended December 31, 2020, we recognized $232.2 million of direct grant aid payments as other income. For a further discussion of the CARES Act and related financial impact, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Depreciation and Amortization

For the three months ended December 31, 2020, our consolidated depreciation and amortization expense was $90.7 million, or 4.1% of revenues, compared to $100.9 million, or 4.5% of revenues, for the same period last year. Our depreciation expense was higher during the three months ended December 31, 2019 due to the impact of the finalization of certain significant construction projects which resulted in additional depreciation expense.

Interest Expense, Net

For the three months ended December 31, 2020, our consolidated interest expense was $119.5 million, or 5.5% of revenues, compared to $132.5 million, or 6.0% of revenues, for the same period last year. The decrease in our interest expense was primarily attributable to the various debt financing activities completed during 2020, which resulted in a lower weighted average borrowing rate for the three months ended December 31, 2020 compared to the same period last year. Additionally, we recognized non-cash changes in the estimated fair value of our Interest Rate Swap through interest expense during the three months ended December 31, 2020 and 2019. For a further discussion of our debt and corresponding interest expense, refer to Notes 4 and 11 to our accompanying consolidated financial statements included elsewhere in this Report.

Debt Transaction Costs

For the three months ended December 31, 2020, we recognized $13.4 million of debt transaction costs associated with the offering of the 5.375% Unsecured Notes and the $500.0 million prepayment of the Term Loan Facility. For a further discussion of our debt transactions, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Merger, Integration and Other Transaction-Related Costs

For the three months ended December 31, 2019, we recognized merger, integration and other transaction-related costs of $39.1 million, primarily related to expenses associated with our sale-leaseback transaction with Medical Properties Trust, which became effective December 17, 2019 (the "***2019 Sale Leaseback Transaction***") and other integration-related expenses in connection with the LifePoint/RCCH Merger.

Other Non-Operating Losses, Net

For the three months ended December 31, 2020 and 2019, we recognized net other non-operating losses of $6.3 million and $1.8 million, respectively, primarily related to non-cash changes in the estimated fair value of certain contingent liabilities and miscellaneous disposals of property and equipment.

Income Taxes

For the three months ended December 31, 2020, we recognized a benefit from income taxes of $15.3 million, primarily related to differences in the current tax liabilities between the 2019 filed tax returns and amounts recorded in the 2019 tax provision that resulted from the significant revisions to the U.S. corporate tax laws due to the enactment of the CARES Act. For the three months ended December 31, 2019, we recognized a provision for income taxes of $74.9 million, primarily related to a gain, recognized for tax purposes only, resulting from the 2019 Sale Leaseback Transaction. For a further discussion of our income taxes, refer to Note 6 to our accompanying consolidated financial statements included elsewhere in this Report.

For the Years Ended December 31, 2020 and 2019

Summary

The following table summarizes our results of operations for the years ended December 31, 2020 and 2019 (dollars in millions):

	Years Ended December 31,			
	2020		2019 [a]	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 8,121.9	100.0 %	$ 8,752.8	100.0 %
Salaries and benefits	3,877.5	47.7	4,044.0	46.2
Supplies	1,417.6	17.5	1,471.7	16.8
Other operating expenses, net	2,207.2	27.3	2,150.3	24.6
Government stimulus income	(646.3)	(8.0)	-	-
Depreciation and amortization	377.4	4.6	376.5	4.3
Interest expense, net	528.1	6.5	568.6	6.5
Debt transaction costs	115.4	1.4	-	-
Merger, integration and other transaction-related costs	-	-	76.9	0.9
Impairments of goodwill and long-lived assets	-	-	3.3	-
Other non-operating losses, net	4.0	-	5.5	0.1
	7,880.9	97.0	8,696.8	99.4
Income (loss) before income taxes	241.0	3.0	56.0	0.6
(Benefit from) provision for income taxes	(63.7)	(0.8)	77.9	0.9
Net income (loss)	304.7	3.8	(21.9)	(0.3)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(21.5)	(0.3)	(19.3)	(0.2)
Net income (loss) attributable to LifePoint Health, Inc.	$ 283.2	3.5 %	$ (41.2)	(0.5) %

(a) Our results of operations for the year ended December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. For additional information regarding the impact of the adoption of ASU 2016-02, refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

Revenues

The following table summarizes our key revenue metrics on a consolidated basis for the years ended December 31, 2020 and 2019:

	Years Ended December 31,		Increase	% Increase
	2020	2019	(Decrease)	(Decrease)
Consolidated:				
Number of hospital campuses at end of period	88	88	-	- %
Revenues (in millions)	$ 8,121.9	$ 8,752.8	$ (630.9)	(7.2)%
Admissions	299,254	339,571	(40,317)	(11.9)%
Equivalent admissions	744,917	888,331	(143,414)	(16.1)%
Revenues per equivalent admission	$ 10,903	$ 9,853	$ 1,050	10.7 %
Case mix index	1.45	1.37	0.08	5.8 %
Inpatient surgeries	79,612	92,908	(13,296)	(14.3)%
Outpatient surgeries	277,777	344,919	(67,142)	(19.5)%
Total surgeries	357,389	437,827	(80,438)	(18.4)%
Emergency department visits	1,570,558	1,961,459	(390,901)	(19.9)%
Same-hospital:				
Number of hospital campuses at end of period	87	87	-	- %
Revenues (in millions)	$ 8,025.4	$ 8,589.5	$ (564.1)	(6.6)%
Admissions	295,790	333,106	(37,316)	(11.2)%
Equivalent admissions	735,833	874,480	(138,647)	(15.9)%
Revenues per equivalent admission	$ 10,907	$ 9,822	$ 1,085	11.0 %
Case mix index	1.45	1.37	0.08	5.8 %
Inpatient surgeries	78,335	90,262	(11,927)	(13.2)%
Outpatient surgeries	275,522	340,602	(65,080)	(19.1)%
Total surgeries	353,857	430,864	(77,007)	(17.9)%
Emergency department visits	1,555,257	1,920,176	(364,919)	(19.0)%

For the year ended December 31, 2020, our consolidated revenues decreased $630.9 million, or 7.2%, to $8,121.9 million compared to $8,752.8 million for the prior year. The decrease in our revenues was a direct result of declines in patient volumes across the majority of our markets and service lines, which we believe is related to the deferral of non-urgent and elective procedures in connection with the COVID-19 pandemic and the response of federal, state, and local governments to the pandemic. This decrease was partially offset by an increase in the overall acuity of services provided and improvements in both commercial and government pricing during the year ended December 31, 2020 compared to the prior year.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2020 and 2019 (dollars in millions):

	Years Ended December 31,			
	2020		2019	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,134.0	38.6 %	$ 3,338.1	38.1 %
Medicaid	1,392.4	17.1	1,495.3	17.1
HMOs, PPOs and other private insurers	3,381.9	41.6	3,698.6	42.3
Self-pay	54.5	0.7	59.2	0.7
Other	142.7	1.8	143.6	1.6
Revenue from contracts with customers	8,105.5	99.8	8,734.8	99.8
Rental income	16.4	0.2	18.0	0.2
Revenues	$ 8,121.9	100.0 %	$ 8,752.8	100.0 %

Salaries and Benefits

For the year ended December 31, 2020, our consolidated salaries and benefits expense was $3,877.5 million, or 47.7% of revenues, compared to $4,044.0 million, or 46.2% of revenues, for the prior year. The increase in our salaries and benefits expense as a percentage of revenues for the year ended December 31, 2020 compared to the prior year was primarily a result of the decrease in revenues associated with the COVID-19 pandemic.

Supplies

For the year ended December 31, 2020, our consolidated supplies expense was $1,417.6 million, or 17.5% of revenues, compared to $1,471.7 million, or 16.8% of revenues, for the prior year. The increase in our supplies expense was partially attributable to an increase in the overall level of acuity of services provided during the year ended December 31, 2020 compared to the same period last year, in addition to higher costs and an increase in the utilization of supplies related to pharmaceuticals, laboratory supplies and personal protective equipment, primarily associated with the COVID-19 pandemic.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the year ended December 31, 2020, our consolidated other operating expenses were $2,207.2 million, or 27.3% of revenues, compared to $2,150.3 million, or 24.6% of revenues, for the prior year. The increase in our other operating expenses was primarily related to increases in physician subsidies and an increase in the utilization of outsourced contracted services for laboratory testing associated with the COVID-19 pandemic.

Government Stimulus Income

As a result of the adverse impact of the COVID-19 pandemic on our business, we received direct grant aid payments from the Emergency Fund established under the CARES Act. For the year ended December 31, 2020, we recognized $646.3 million of direct grant aid payments as other income. For a further discussion of the CARES Act and related financial impact, refer to “Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19” and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Depreciation and Amortization

For the year ended December 31, 2020, our consolidated depreciation and amortization expense was $377.4 million, or 4.6% of revenues, which was comparable to $376.5 million, or 4.3% of revenues, for the prior year.

Interest Expense, Net

For the year ended December 31, 2020, our consolidated interest expense was $528.1 million, or 6.5% of revenues, compared to $568.6 million, or 6.5% of revenues, for the prior year. The decrease in our interest expense was primarily attributable to the various debt financing activities completed during 2020, which resulted in a lower weighted average borrowing rate for the year ended December 31, 2020 compared to last year. Additionally, we recognized non-cash changes in the estimated fair value of our Interest Rate Swap through interest expense during the year ended December 31, 2020 and 2019. For a further discussion of our debt and corresponding interest expense, refer to Notes 4 and 11 to our accompanying consolidated financial statements included elsewhere in this Report.

Debt Transaction Costs

For the year ended December 31, 2020, we recognized $115.4 million of debt transaction costs associated with the various debt financing activities completed during 2020. For a further discussion of our debt transactions, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Merger, Acquisition and Other Transaction-Related Costs

For the year ended December 31, 2019, we recognized costs of $76.9 million, primarily related to employee severance and retention costs and other integration-related expenses in connection with the LifePoint/RCCH Merger, as well as costs related to the 2019 Sale Leaseback Transaction.

Impairments of Goodwill and Long-lived Assets

For the year ended December 31, 2019, we recognized a goodwill impairment charge of $3.3 million related to one of our facilities. For a further discussion of impairments of goodwill and other long-lived assets, refer to Notes 1 and 5 to our accompanying consolidated financial statements included elsewhere in this Report.

Other Non-Operating Losses, Net

For the years ended December 31, 2020 and 2019, we recognized net other non-operating losses of $4.0 million and $5.5 million, respectively, primarily related to non-cash changes in the estimated fair value of certain contingent liabilities and miscellaneous disposals of property and equipment.

Income Taxes

For the year ended December 31, 2020, we recognized a benefit from income taxes of $63.7 million, primarily as a result of significant revisions to the U.S. corporate tax laws due to the enactment of the CARES Act. We were most notably impacted by an increase in the limitation in the tax deductibility of interest expense from 30% to 50% of adjusted taxable income for the years ended December 31, 2020 and 2019, as well as the ability to carry back net operating losses to each of the five tax years preceding the tax year of such loss. For the year ended December 31, 2019, we recorded a provision for income taxes of $77.9 million, primarily related to a gain recognized for tax purposes only resulting from the 2019 Sale Leaseback Transaction. For a further discussion of our income taxes, refer to Note 6 to our accompanying consolidated financial statements included elsewhere in this Report.

Non-GAAP Measures

Adjusted EBITDA

Included in net income for the three months and year ended December 31, 2020 is $232.2 million and $646.3 million, respectively, of CARES Act direct grant aid payments recognized as other income.

The following table presents a reconciliation of net income (loss) to EBITDA and Adjusted EBITDA on a consolidated basis for the three months and years ended December 31, 2020 and December 31, 2019 (in millions):

	Three Months Ended December 31,		Years Ended December 31,	
	2020	**2019 [a]**	**2020**	**2019 [a]**
Net income (loss)	$ 217.3	$ (76.5)	$ 304.7	$ (21.9)
Interest expense, net	119.5	132.5	528.1	568.6
Income taxes	(15.3)	74.9	(63.7)	77.9
Depreciation and amortization	90.7	100.9	377.4	376.5
EBITDA	412.2	231.8	1,146.5	1,001.1
(1) Debt transaction costs	13.4	-	115.4	-
(2) Merger, integration and other transaction-related costs	-	39.1	-	76.9
(3) Facility lease expense	(19.9)	(9.5)	(79.8)	(31.8)
(4) One-time costs, non-cash charges and non-recurring items	22.1	17.6	74.7	62.9
Subtotal	427.8	279.0	1,256.8	1,109.1
(5) Pro forma run rate adjustments	19.4	(6.4)	76.3	(4.5)
Adjusted EBITDA	$ 447.2	$ 272.6	$ 1,333.1	$ 1,104.6

(a) Our results of operations for the three months and year ended December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. The adoption of ASU 2016-02 had no impact on Adjusted EBITDA. For additional information regarding the impact of the adoption of ASU 2016-02, refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

* *Footnote references regarding EBITDA adjustments are included on the following page.*

(1) Represents costs associated with the various debt financing activities completed during 2020, including payments of early termination premiums and write-offs of previously capitalized debt issuance costs.

(2) Represents costs associated with the LifePoint/RCCH Merger, the 2019 Sale Leaseback Transaction and certain other transactions, including legal, financing and transaction advisory services, employee severance and retention costs and other integration-related expenses associated with such transactions.

(3) Represents cash interest expense in connection with certain finance leases. Pursuant to the terms of our financial covenants contained in our debt agreements, we are required to consider cash interest expense on hospital-related finance leases within the definition of Adjusted EBITDA.

(4) Represents the exclusion of certain one-time costs, non-cash charges and non-recurring items, including the elimination of EBITDA associated with facilities that have been divested, differences between cash payments and reported rent expense for facility operating leases, and certain accounting changes resulting from our adoption of ASU 2016-02.

(5) Represents the estimated pro forma EBITDA impact attributable to various strategic initiatives in accordance with our debt agreements. For the year ended December 31, 2020, such items primarily consist of (i) unrealized cost savings related to conversions of the revenue cycle management function in certain of our hospitals; (ii) new or expanded service lines, newly constructed facilities and other strategic investments; and (iii) the pro forma impact of our pending divestiture of Capital Medical Center. For the year ended December 31, 2019, such items primarily consist of (i) unrealized incremental lease expense associated with the 2019 Sale Leaseback Transaction; (ii) new acquisitions, new or expanded service lines, newly constructed facilities and other strategic investments; and (iii) unrealized cost savings related to synergies anticipated from the LifePoint/RCCH Merger.

Leverage

The following table illustrates our indebtedness and certain leverage ratios prepared in accordance with the calculations set forth in the Indentures and the Credit Agreements as of and for the years ended December 31, 2020 and 2019 (dollars in millions):

	December 31, 2020	December 31, 2019
Cash and cash equivalents [(a)]	$ 2,652.6	$ 748.1
ABL Facility	$ -	$ -
Term Loan Facility	3,214.5	3,523.4
6.75% Secured Notes	600.0	-
4.375% Secured Notes	600.0	-
8.25% Secured Notes	-	800.0
Total Secured Debt [(b)]	$ 4,414.5	$ 4,323.4
Net Secured Debt [(a)(b)]	$ 1,761.9	$ 3,575.3
9.75% Unsecured Notes	$ 1,425.0	$ 1,425.0
5.375% Unsecured Notes	500.0	-
11.5% Unsecured Notes	-	350.0
Total Debt [(b)]	$ 6,339.5	$ 6,098.4
Net Debt [(a)(b)]	$ 3,686.9	$ 5,350.3
Adjusted EBITDA	$ 1,333.1	$ 1,104.6
Total Secured Debt [(b)] / Adjusted EBITDA	3.31x	3.91x
Net Secured Debt [(a)(b)] / Adjusted EBITDA	1.32x	3.24x
Total Debt [(b)] / Adjusted EBITDA	4.76x	5.52x
Net Debt [(a)(b)] / Adjusted EBITDA	2.77x	4.84x

(a) Included in cash and cash equivalents at December 31, 2020 is $991.0 million of Medicare advance payments. For additional information regarding Medicare advance payments, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

(b) Excludes finance leases, which are not considered indebtedness for purposes of calculating the ratios set forth in the Indentures and the Credit Agreements, as well as unamortized debt issuance costs and premium.

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash generated by operations and borrowings under the ABL Facility. Our primary uses of cash are working capital requirements, debt service requirements and capital expenditures. Based on our current level of operations and available cash, we believe our cash flows from operations, combined with availability under the ABL Facility, will provide sufficient liquidity to fund our current obligations, projected working capital requirements, debt service requirements and capital spending requirements over the next twelve months. We cannot assure you, however, that our business will generate sufficient cash flows from operations or that future borrowings will be available to us under the ABL Facility, which is subject to a borrowing base, in an amount sufficient to enable us to pay principal and interest on the ABL Facility, the Term Loan Facility and the Notes, or to fund other liquidity needs. Our ability to do so depends on prevailing economic conditions, many of which are beyond our control. In addition, upon the occurrence of certain events, such as a change of control, we could be required to repay or refinance our indebtedness. We cannot assure you that we will be able to refinance any of our indebtedness on commercially reasonable terms or at all. Any future acquisitions, joint ventures or other similar transactions will likely require additional capital, and there can be no assurance that any such capital will be available to us on acceptable terms or at all. Any refinancing of our indebtedness could be at higher interest rates and may require us to comply with more onerous covenants that could further restrict our business operations. See "Item 1A, Risk Factors—Credit and Liquidity Risks" included elsewhere in this Report.

The following table presents summarized cash flow information for the years ended December 31, 2020 and 2019 (in millions):

	2020	2019
Net cash provided by operating activities	$ 1,920.3	$ 413.6
Net cash used in investing activities	(120.6)	(310.1)
Net cash provided by financing activities	104.8	585.7
Change in cash and cash equivalents	$ 1,904.5	$ 689.2

Operating Activities

For the year ended December 31, 2020, our net cash provided by operating activities were $1,920.3 million, including the receipt of $991.0 million of Medicare advance payments in connection with the CARES Act. Additionally, our net cash provided by operating activities for the year ended December 31, 2020 was positively impacted by our receipt and recognition of CARES Act direct grant aid payments, as well as changes in net working capital, including the deferral of payroll taxes, lower cash interest payments and improvements in the amount and timing of collections of outstanding patient and other receivables. These positive operating cash flows were partially offset by differences in the amount and timing of income tax payments made during the year ended December 31, 2020, compared to the receipt of net income tax refunds in the prior year.

For the year ended December 31, 2019, our cash flows from operating activities were $413.6 million, primarily driven by our strong operating performance, in addition to the collection of income tax refunds.

Investing Activities

For the year ended December 31, 2020, our net cash used in investing activities primarily consisted of purchases of property and equipment. We invested $170.4 million and $336.7 million in purchases of property and equipment for the years ended December 31, 2020 and 2019, respectively. Refer to "—Capital Expenditures" below for further information.

Financing Activities

Our net cash provided by financing activities for the year ended December 31, 2020 consisted of proceeds from the offering of our 6.75% Secured Notes, 4.375% Secured Notes, and 5.375% Unsecured Notes, in addition to the issuances of the Incremental Term Loan, partially offset by payments made in connection with the redemption and discharge of our 8.25% Secured Notes and 11.5% Unsecured Notes, and prepayments of our Term Loan Facility. Refer to "—Capital Resources" below for further information regarding our recent debt transactions.

For the year ended December 31, 2019, our net cash provided by financing activities primarily consisted of proceeds from the 2019 Sale Leaseback Transaction, net repayments of loans outstanding on our ABL Facility and installment payments on our Term Loan Facility.

Capital Expenditures

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

The following table summarizes our capital expenditures as a percentage of revenues and as a percentage of depreciation expense for the years ended December 31, 2020 and 2019 (dollars in millions):

	2020		2019	
	Amount	% of Revenues	Amount	% of Revenues
Capital expenditures	$ 170.4	2.1 %	$ 336.7	3.8 %
Depreciation expense	$ 376.1		$ 374.7	
Ratio of capital expenditures to depreciation expense	45.3 %		89.9 %	

We have a formal and intensive review procedure for the authorization of capital expenditures that exceed an established threshold. One of the most important financial measures of acceptability for a discretionary capital project is whether its projected discounted cash flow return on investment exceeds our projected cost of capital for that project. We expect to continue to invest in information systems, modern technologies, emergency room and operating room expansions, the construction of medical office buildings for physician expansion and the reconfiguration of the flow of patient care. Additionally, we may from time to time replace existing hospital buildings with new buildings as we evaluate ongoing repair and maintenance costs and other factors that impact the future operations of the existing buildings. For the year ended December 31, 2020, we intentionally decreased our capital expenditures by pausing on many of the growth and expansion projects during the early stages of the pandemic. Refer to "—Liquidity and Capital Resources Outlook" below for further information regarding our long-term capital expenditure commitments.

Capital Resources

ABL Facility

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we entered into the ABL Facility in an aggregate principal amount of up to $800.0 million with a maturity of five years. For further information regarding the ABL Facility, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Term Loan Facility

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we entered into the Term Loan Facility with an original aggregate principal amount of $3,550.0 million with a maturity of seven years and we repaid in full our Prior Term Facility. The Term Loan Facility was amended in connection with a refinancing transaction during the first quarter of 2020. For further information regarding the Term Loan Facility, including certain restrictive covenants and the refinancing transactions, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

6.75% Secured Notes

On April 13, 2020, we issued the 6.75% Secured Notes in an aggregate principal amount of $600.0 million with a maturity of five years. For further information regarding the 6.75% Secured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

4.375% Secured Notes

On February 13, 2020, we issued the 4.375% Secured Notes in an aggregate principal amount of $600.0 million with a maturity of seven years. For further information regarding the 4.375% Secured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

9.75% Unsecured Notes

On November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we issued the 9.75% Unsecured Notes in an aggregate principal amount of $1,425.0 million with a maturity of eight years. For further information regarding the 9.75% Unsecured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

5.375% Unsecured Notes

On December 4, 2020, we issued the 5.375% Unsecured Notes in an aggregate principal amount of $500.0 million with a maturity of eight years. For further information regarding the 5.375% Unsecured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

A roll-forward of our long-term debt, including current portions, during 2020 is as follows (in millions):

	December 31, 2019 [a]	Proceeds from Borrowings	Payments of Borrowings	Debt Issuance Costs [b]	Finance Lease Obligations [c]	December 31, 2020
Senior borrowings:						
ABL Facility	$ -	$ -	$ -	$ -	$ -	$ -
ABL FILO Term Loan	-	80.0	(80.0)			-
Term Loan Facility	3,523.4	600.0	(908.9)	-	-	3,214.5
6.75% Secured Notes	-	600.0	-	-	-	600.0
4.375% Secured Notes	-	600.0	-	-	-	600.0
8.25% Secured Notes	800.0	-	(800.0)	-	-	-
9.75% Unsecured Notes	1,425.0	-	-	-	-	1,425.0
5.375% Unsecured Notes	-	500.0	-	-	-	500.0
11.5% Unsecured Notes	350.0	-	(350.0)	-	-	-
Finance lease obligations	1,128.3	-	-	-	(80.1)	1,048.2
Unamortized debt issuance costs and premium	(191.8)	1.5	-	38.5	-	(151.8)
Subordinated borrowings, net	1.6	-	(1.7)	0.1	-	-
	$ 7,036.5	$ 2,381.5	$ (2,140.6)	$ 38.6	$ (80.1)	$ 7,235.9

(a) Our finance lease obligations as of December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. For additional information regarding the impact of the adoption of ASU 2016-02, refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

(b) Represents non-cash write-offs of $47.4 million and amortization of $26.0 million, partially offset by the capitalization of new debt issuance costs of $34.8 million.

(c) Represents finance lease obligations reclassified to liabilities held for sale of $111.3 million and amortization of $11.4 million, partially offset by new finance leases entered into during 2020 of $42.6 million.

We monitor the capital markets and our capital structure and make changes from time to time, with the goal of maintaining financial flexibility, preserving or improving liquidity and/or achieving cost efficiency. From time to time, we may elect to repurchase amounts of our outstanding debt for cash through open market repurchases or privately negotiated transactions with certain of our debt holders, although there is no assurance we will do so.

Liquidity and Capital Resources Outlook

We continue to have ongoing capital commitments in connection with several of our acquired facilities. At December 31, 2020, we estimated our total remaining capital expenditure commitments to be approximately $1,174.7 million, which generally have remaining terms of two to six years. Of this amount, more than one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the ABL Facility.

Our business strategy contemplates the selective acquisition of additional hospitals and other healthcare service providers, and we regularly review potential acquisitions. These acquisitions may, however, require additional financing. Our primary sources of liquidity are cash flows provided by our operations and our borrowings available under the ABL Facility. We believe that our internally generated cash flows and borrowing availability under the ABL Facility will be adequate to service existing debt, finance internal growth and fund capital expenditures and small to mid-size hospital acquisitions over the next twelve months and into the foreseeable future prior to maturity dates of our outstanding debt. Certain larger hospital acquisitions may, however, require additional financing.

Inflation

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

Contractual Obligations and Material Cash Requirements

We have certain material contractual obligations which are recorded as liabilities in our consolidated financial statements, primarily including:

- long-term debt obligations (refer to "—Capital Resources" above and to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report); and
- finance and operating lease obligations (refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report).

Additionally, we have certain other material cash requirements related to items that are not recognized as liabilities in our consolidated financial statements, primarily including:

- capital expenditure commitments (refer to "—Capital Expenditures" above and to Note 14 to our accompanying consolidated financial statements included elsewhere in this Report);
- shared centralized resource model arrangements with various third-parties to provide certain nonclinical business functions to us, including payroll, supply chain management and revenue cycle management;
- information technology services, including, but not limited to, financial, clinical, patient accounting and other information services;
- diagnostic imaging equipment maintenance and bio-medical services; and
- other minimum commitments to purchase miscellaneous goods or services under non-cancelable contracts.

Off-Balance Sheet Arrangements

We had letters of credit outstanding of approximately $45.3 million as of December 31, 2020, primarily related to the self-insured retention level of our general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements.

Adoption of Recently Issued Accounting Standards

Refer to Note 1 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of our adoption of recently issued accounting standards.

Critical Accounting Estimates

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

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

Our critical accounting estimates include the following areas:

- Accounting for CARES Act direct grant aid payments;
- Revenue recognition and accounts receivable;
- Goodwill impairment analysis;
- Accounting for income taxes; and
- Reserves for self-insurance claims.

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

Accounting for CARES Act Direct Grant Aid Payments

For the year ended December 31, 2020, we recognized $646.3 million of direct grant aid payments as other income under the caption "Government stimulus income" in our accompanying consolidated statement of operations included elsewhere in this Report. Payments made by the Emergency Fund to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers are required to file attestations acknowledging receipt of the payments and must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients and not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse. HHS has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the OIG, will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

We have accounted for the direct grant aid payments received as a government grant related to income in a manner consistent with International Accounting Standards 20, "Accounting for Government Grants and Disclosure of Government Assistance" ("***IAS 20***"). In accordance with IAS 20, government grants are recognized either as other income or a reduction to a related expense when there is reasonable assurance that the grant will be received, and the entity will comply with any conditions attached to the grant. There is currently limited, and sometimes changing, guidance available regarding the accounting treatment of funds that have been received by us and our facilities under the CARES Act and the related stimulus legislation. This lack of guidance requires us to apply professional judgement and make certain estimates and assumptions with respect to the presentation, amount and timing of our recognition of direct grant aid received under the CARES Act. For additional information regarding the CARES Act and related financial impact, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Revenue Recognition and Accounts Receivable

We recognize revenues in the period in which performance obligations are satisfied. Generally, we bill patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. Amounts we receive for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, HMOs, PPOs and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in our financial statements are recorded at the net consideration to which we expect to be entitled to receive in exchange for providing patient care.

Approximately 98.0%, 98.2% and 98.0% of our patient revenues recognized during the years ended December 31, 2020, 2019 and 2018, respectively, related to discounted charges, which were comprised of the following sources (as a percentage of our revenues):

	2020	2019	2018
Medicare	38.6 %	38.1 %	39.8 %
Medicaid	17.1 %	17.1 %	17.5 %
HMOs, PPOs and other private insurers	41.6 %	42.3 %	40.1 %
Self-pay	0.7 %	0.7 %	0.6 %

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

We monitor our processes for calculating contractual allowances through:

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

Medicare and Medicaid

The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e. gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under the Medicaid program's prospective reimbursement systems, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates.

Discounts for retrospectively cost-based revenues are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under these programs are subject to adjustment based on administrative review and audit by third-party intermediaries, which can take several years to resolve completely.

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

HMOs, PPOs and Other Private Insurers

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

The process of determining the allowance requires us to estimate the amount expected to be received based on payer contract provisions, historical collection data as well as other factors and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts for managed care plans would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third-party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. We evaluate these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. We estimate the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that we utilize include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that we expect to collect. Because we provide care to patients regardless of their ability to pay, we have determined that the differences between the amounts we bill based on gross or discounted charges and the amounts we expect to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and we account for this variable consideration in accordance with the provisions of ASC 606. Self-pay accounts receivable are written off after collection efforts have been followed in accordance with our policies.

Goodwill Impairment Analysis

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired businesses. Our goodwill included in our consolidated balance sheet as of December 31, 2020 was $2,918.5 million. Refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report for a detailed rollforward of changes in our goodwill during the years ended December 31, 2020 and 2019.

In accordance with ASC 350, "Intangibles — Goodwill and Other" ("***ASC 350***") goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. Prior to the LifePoint/RCCH Merger, we historically determined that each of our hospitals represented a reporting unit in accordance with ASC 280, "Segment Reporting" ("***ASC 280***") and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on our management team and business operations, we re-evaluated our reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that our consolidated business comprises a single reporting unit for goodwill impairment testing purposes. For the annual impairment evaluation, we determine fair value using a discounted cash flow ("***DCF***") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing our assumptions. The cash flows employed in the DCF analysis are based on our most recent financial budgets and business plans and, when applicable, various growth rates for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the respective reporting unit.

If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. Refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report for further discussion of the results of our annual goodwill impairment evaluation procedures.

Accounting for Income Taxes

Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or subsequently increase or decrease this allowance, we must include an adjustment as part of the income tax provision in our results of operations. Our deferred tax asset balances in our consolidated balance sheets were $537.3 million and $636.9 million as of December 31, 2020 and 2019, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $360.1 million and $493.6 million as of December 31, 2020 and 2019, respectively.

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

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

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

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

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

Our deferred tax assets exceeded our deferred tax labilities by $341.7 million as of December 31, 2020, excluding the impact of valuation allowances. Historically, we have not produced federal taxable income, and in connection with the LifePoint/RCCH Merger, we became highly leveraged. As such, we believe it is likely that the majority of our deferred tax assets will not be realized and thus have established a valuation allowance against these deferred tax assets as of December 31, 2020. In addition, we have subsidiaries with a history of tax losses in certain state jurisdictions, and, based upon those historical tax losses, we have assumed that the subsidiaries would not be profitable in the future for those states' tax purposes. If our assertion regarding the future profitability of those subsidiaries would have been different, then our deferred tax assets would be understated by the amount of the state valuation allowance of $164.2 million at December 31, 2020. Furthermore, the valuation allowance decreased $133.5 million during the year ended December 31, 2020, primarily as a result of the projected utilization of all federal NOLs, as well as the significant revisions to the U.S. corporate tax laws due to the enactment of the CARES Act, specifically relating to the increase in the interest expense limitation from 30 percent to 50 percent for tax years 2019 and 2020. The interest expense limitation percentage decreases to 30 percent for tax years 2021 and forward, which may result in our inability to deduct all of the annual interest expense currently.

Reserves for Self-Insurance Claims

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding SIR and deductible levels. At December 31, 2020, our SIR for professional liability claims is $15.0 million per claim at the majority of our facilities. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2020, our deductible for workers' compensation claims was $1.0 million per claim in all states in which we operate except for Montana, Ohio, Oklahoma, Washington and Wyoming. We participate in state-specific programs for our workers' compensation claims arising in these states. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

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

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

Our reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. Our reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. We have discounted our reserves for self-insured claims to their present value using a discount rate of 1.7% at December 31, 2020, 1.9% at December 31, 2019, and 1.8% at December 31, 2018. We select a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

The following table provides information regarding our reserves for self-insured claims at December 31, 2020 and 2019 (in millions):

	2020	2019
Undiscounted	$ 300.6	$ 275.8
Discounted (as reported)	$ 287.3	$ 261.0

As of December 31, 2020 and 2019, we estimated less than 1% of our reserves for self-insured claims represent reserves for settled and unpaid claims. Our average lag time between the settlement and payment of a self-insured claim ranges from 1 to 2 weeks.

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

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

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

Ultimately, from an actuarial standpoint, the sensitivity in the estimates of reserves for self-insured claims is reflected in the various actuarial confidence levels. Our best estimate of our reserves for self-insured claims utilizes an actuarial central estimate, which employs a statistical confidence level that approximates 50%. Higher statistical confidence levels, while not representative of our best estimate, reflect reasonably likely outcomes upon the ultimate resolution of related claims. Using a higher statistical confidence level would increase the estimated reserves for self-insured claims. At a 75% statistical confidence level, our estimated reserve would increase by $33.4 million. Changes in our estimates of reserves for self-insured claims are non-cash charges and accordingly, do not impact our liquidity or capital resources.

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of our quarterly and semi-annual actuarial calculations resulted in changes to our reserves for self-insured claims for prior years. As a result, for the years ended December 31, 2020 and 2018 our related self-insured claims expense decreased by $4.4 million and $3.9 million, respectively. For the year ended December 31, 2019, our related self-insured claims expense increased by $6.7 million.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk.***

Market Risk

Market risk is defined as the risk of loss resulting from changes in market prices as a result of changes in interest rates, credit and liquidity or general economic conditions. Our principal market risks in the ordinary course of business are credit risk, liquidity risk and interest rate risk. We currently do not have direct exposure to either market risk from trading activities or foreign currency exchange rate risk.

Credit Risk

We define credit risk as the risk that amounts payable by uninsured patients and remaining patient responsibility amounts (deductibles and co-payments) for patient accounts where the primary insurance carrier has paid the amounts covered by the applicable agreements will not be paid. The provision for doubtful accounts relates primarily to amounts due directly from patients. While we have experienced a reduction in uninsured patients, the risk of collection from insured patients and the amounts due, may increase as more individuals are enrolled in insurance plans with larger deductibles and/or co-payments, including those purchased on insurance exchanges. Additionally, the counterparty to our Interest Rate Swap exposes us to credit risk in the event of nonperformance. However, we do not anticipate nonperformance by our counterparty. We do not hold or issue derivative financial instruments for trading purposes.

Liquidity Risk

We define liquidity risk as the risk that we will not meet our payment obligations in a timely manner or the risk that market conditions or institution-specific events may reduce our ability to raise funds from market counterparties. An adverse institution-specific event such as a major loss that causes a perceived or actual deterioration in our financial condition or an adverse systemic event could affect our funding liquidity.

Interest Rate Risk

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. To manage this risk, we entered into an Interest Rate Swap. The terms of the Interest Rate Swap require us to pay a fixed rate of 2.63% on a notional amount of $1,100.0 million and, in exchange, we receive one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. We have not designated our Interest Rate Swap as a cash flow hedge in accordance with ASC 815. Therefore, all changes in the fair value of our Interest Rate Swap will be recognized through interest expense in our results of operations. Changes in the fair value of our Interest Rate Swap could result in a material effect on our consolidated results of operations and financial position; however, we do not anticipate that changes in the fair value of our Interest Rate Swap will have any impact on our cash flows.

As of December 31, 2020, we had total outstanding debt of $6,339.5 million, excluding finance leases and unamortized debt issuance costs and premium, of which $2,114.5 million, or 33.3%, was subject to variable rates of interest after giving effect to our Interest Rate Swap. If the interest rate on our variable rate long-term debt outstanding as of December 31, 2020, not subject to our Interest Rate Swap, were to increase by 100 basis points during any annual period, our cash flows would be negatively impacted by approximately $21.1 million.

Item 8. ***Financial Statements and Supplementary Data.***

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

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

None.

Item 9A. ***Controls and Procedures.***

The information that would be required to be disclosed under Part II, Item 9A of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

Item 9B. ***Other Information.***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance*.**

The following table provides information regarding our executive officers and the members of our Board of Directors (ages as of March 5, 2021):

Name	Age	Position(s)
David M. Dill	52	President and Chief Executive Officer
Michael S. Coggin	51	Executive Vice President and Chief Financial Officer
Victor E. Giovanetti	57	Executive Vice President, Hospital Operations
Robert F. Jay	53	Executive Vice President, Integrated Operations
Jennifer C. Peters	49	Executive Vice President, General Counsel and Corporate Secretary
Terry W. Terrill, Jr.	54	Executive Vice President, Administration
J. Michael Grooms	42	Senior Vice President and Chief Accounting Officer
Matthew H. Nord	41	Director and Chairman
Norman Brownstein	77	Director
Christopher J. Christie	58	Director
Maxwell David	30	Director
Michael P. Haley	70	Director
Steve Levin	55	Director
Holly McMullan	44	Director
Daniel Morissette	55	Director
Eric L. Press	55	Director
Martin S. Rash	66	Director
James H. Simmons III	54	Director
Olivia Wassenaar	41	Director
G. Rodney Wolford	74	Director

David M. Dill became our Chief Executive Officer upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Dill served in various roles at Legacy LifePoint as President since January 2011 and as Chief Operating Officer since April 2009. Mr. Dill served as Executive Vice President from February 2008 to January 2011. Mr. Dill joined Legacy LifePoint in July 2007 as Chief Financial Officer and continued to serve in that role until April 2009. From March 2006 until Mr. Dill joined Legacy LifePoint, he served as executive vice president of Fresenius Medical Care North America and as chief executive officer of one of two U.S. divisions of Fresenius Medical Care Services, a wholly owned subsidiary of Fresenius Medical Care AG & Co. KGaA. Mr. Dill previously served as executive vice president, chief financial officer and treasurer of Renal Care Group, Inc., a publicly-traded dialysis services company, from November 2003 until Renal Care Group was acquired by Fresenius Medical Care in March 2006. From 1996 to November 2003, Mr. Dill served in various finance and accounting roles with Renal Care Group, Inc. Mr. Dill served as a member of the board of directors of Psychiatric Solutions, Inc., a behavioral health services company, from 2005 until 2010.

Michael S. Coggin became our Executive Vice President and Chief Financial Officer upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Coggin served in various roles at Legacy LifePoint as Executive Vice President, Chief Financial Officer and Chief Accounting Officer, since September 2016. From December 2008 until September 2016, Mr. Coggin served as Senior Vice President and Chief Accounting Officer of Legacy LifePoint. From September 2007 until December 2008, Mr. Coggin served as chief financial officer of Specialty Care Services Group, a multi-service line healthcare provider primarily focused on providing perfusion and auto-transfusion services to hospitals. Mr. Coggin was a senior vice president in the finance, accounting and internal audit groups of Renal Care Group, Inc. from April 2004 until its acquisition by Fresenius Medical Care AG & Co. KGaA in March 2006. Following the acquisition, Mr. Coggin provided finance and accounting oversight for business units within the East Division of Fresenius. Prior to that time, Mr. Coggin was an audit manager at KPMG Peat Marwick in Nashville, Tennessee.

Victor E. Giovanetti became our Executive Vice President, Hospital Operations upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Giovanetti served as President of Legacy LifePoint's Eastern Group since January 2017. From July 2015 to January 2017, Mr. Giovanetti served as President of Legacy LifePoint's Western Group. Mr. Giovanetti joined Legacy LifePoint in July 2013 as Chief Operating Officer of Legacy LifePoint's Eastern Group. Mr. Giovanetti has more than 25 years of management experience in operations, financial, clinical and strategic aspects of healthcare administration. Prior to joining the Company, his positions included president of HCA Lewis-Gale Regional Health System in Roanoke, Virginia, chief executive officer and chief operating officer of Southern Hills Medical Center in Nashville, Tennessee, and various management roles with HCA, Symbion and other healthcare organizations in Georgia.

Robert F. Jay became our Executive Vice President, Integrated Operations upon consummation of the LifePoint/RCCH Merger. Mr. Jay previously served as RCCH's Executive Vice President and Chief Operating Officer, a position he held from January 2018. Mr. Jay has served in various roles with RCCH, including Executive Vice President Operations Support from May 2016 to September 2016 and Division President from September 2016 to January 2018. Prior to that he served as Chief Operating Officer for RCCH from January 2014 until May 2016. Prior to joining RCCH, he spent seven years at Vanguard Health Systems in a variety of operations and development positions. He joined Vanguard Health Systems as its Corporate Director Operations and Financial Analysis where he was responsible for managing and reporting operational, clinical, and financial results. In 2008, Mr. Jay was promoted to Vice President, Supply Chain Management of Vanguard where he oversaw the overall strategic direction and tactical execution of supply chain operations. In 2009 he transitioned to Vice President, Development of Vanguard where he led acquisition teams that closed on hospital transactions with combined net revenues of over $2.2 billion. Prior to joining Vanguard Health Systems, Mr. Jay worked as the Corporate Controller for Health Management Associates, Inc. in Naples, Florida. He has also served as a Controller in a not-for-profit hospital and also spent time at KPMG as an auditor.

Jennifer C. Peters became our Executive Vice President and General Counsel upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Ms. Peters served as Legacy LifePoint's General Counsel since April 2017 and Corporate Secretary since June 2017. Prior to that, Ms. Peters served as senior vice president and chief operations counsel of Legacy LifePoint, where she was responsible for overseeing the Company's operations lawyers and contract management team to ensure consistent legal guidance across all operational units. Prior to joining Legacy LifePoint in November 2013, Ms. Peters served as general counsel, secretary and chief compliance officer for Simplex Healthcare from October 2010 through November 2013. Ms. Peters has also served as vice president and associate general counsel at Community Health Systems. In addition, Ms. Peters has experience as a hospital administrator.

Terry W. "Sonny" Terrill, Jr. joined the Company in April 2019 as Executive Vice President, Human Resources. Mr. Terrill is responsible for providing leadership in developing and executing human resources strategies in support of the overall business plan and strategic direction of the organization. Mr. Terrill has three decades of HR experience, including executive coaching, full-cycle talent management and management of large-scale system and organizational integration. Before joining the Company, he served in a number of leadership roles, most recently as executive vice president, chief human resources officer for BrightSpring Health from August 2017 to March 2019 and human resources officer for CIGNA- HealthSpring from May 2005 to August 2017. He is also a Six Sigma Black Belt.

J. Michael Grooms became our Senior Vice President and Chief Accounting Officer upon consummation of the LifePoint/RCCH Merger. Mr. Grooms previously served as Chief Accounting Officer of Legacy LifePoint from June 2018 and as Vice President of Accounting and Financial Reporting from March 2012. Additionally, Mr. Grooms served in various other accounting financial reporting roles since joining Legacy LifePoint in September 2006. Prior to that time, he served as controller with Delek US from 2005 to 2006, and as an auditor with KPMG from 2001 to 2005.

Matthew H. Nord has been our Director since consummation of the Apollo/RegionalCare Acquisition in December 2015 and became Chairman of the Board in December 2018. Mr. Nord is the Co-Lead Partner of Apollo Private Equity, having joined in 2003. Prior to that time, he was a member of the Investment Banking division of Salomon Smith Barney Inc. Mr. Nord serves on the board of directors of Tech Data Corporation, ADT, Intrado, and Lifepoint Health. Mr. Nord also serves on the board of trustees of Montefiore Health System and on the Board of Advisors of the University of Pennsylvania's Stuart Weitzman School of Design. He graduated summa cum laude with a BS in economics from the University of Pennsylvania's Wharton School of Business.

Norman Brownstein became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Brownstein is the founding member and chairman of the board of the law firm of Brownstein Hyatt Farber Schreck, LLP. Mr. Brownstein is nationally recognized for his extensive experience in real estate law, commercial transactions and public policy advocacy, which spans the economic spectrum, extending to telecommunications, financial services, agriculture, tax and healthcare interests. Mr. Brownstein's firm is one of the leading lobbying firms in the U.S. Mr. Brownstein serves on the board of directors of National Jewish Health and the Simon Wiesenthal Center, and during the past five years has also served as a director of Ardent Healthcare Services. Mr. Brownstein received a B.S. from the University of Colorado and a J.D. from the University of Colorado Law School.

Christopher J. Christie became our Director in December 2018. Mr. Christie served two terms as Governor of New Jersey from 2010 to 2018. Prior to that, Mr. Christie served as U.S. Attorney for the District of New Jersey from 2002 to 2008. During his governorship, Mr. Christie chaired the President's Commission on Combating Drug Addiction and the Opioid Crisis in 2017. He currently serves as a legal and political commentator for ABC News. Mr. Christie is a graduate of the University of Delaware and Seton Hall University School of Law.

Maxwell David became our Director in December 2018. Mr. David is a Principal in Apollo Global Management's Private Equity business, having joined in 2014. Prior to that time, Mr. David was a member of the Investment Banking division of Bank of America Merrill Lynch. Mr. David serves on the board of directors of Camaro Parent, LLC (parent of CareerBuilder) and Aris Mortgage Holding Company, LLC (parent of Amerihome). Mr. David graduated cum laude from Dartmouth College with a B.A. in Economics.

Michael P. Haley became our Director in December 2018. Prior to that time, Mr. Haley served as a director of Legacy LifePoint since 2005 and as chair of its Audit Committee since 2016. Mr. Haley is also a member of the board of directors of American National Bankshares, Inc., a bank holding company. From 2005 until April 2018, Mr. Haley served as a director of Ply Gem Holdings, Inc., a producer of window, door and siding products for the residential construction industry. Mr. Haley served as an advisor to Fenway Partners, LLC, a private equity investment firm, from April 2006 to June 2015, and was a managing director of its affiliate, Fenway Resources, from 2008 to June 2015. Mr. Haley's previous executive leadership experience includes service as executive chairman of Coach America, a transportation services operator, and as chairman, president and chief executive officer of MW Manufacturers, Inc., a subsidiary of Ply Gem Industries, Inc. In addition, Mr. Haley has served on the Board of Trustees of Roanoke College (Virginia) since 2010 and previously served on the board of the Martinsville-Henry County United Way and as chairman of the board of trustees of Memorial Hospital of Martinsville and of the Martinsville-Henry County Economic Development Corporation.

Steven Levin became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Levin is the Chief Executive Officer of Quest Analytics, a payer network analytic company focused on improve access to quality healthcare in America. Previous, Mr. Levin was the chief strategy officer of Waystar, a healthcare revenue cycle technology platform. In 2018, Waystar acquired Connance, an analytics company that delivers workflow optimization technology for healthcare providers, which Mr. Levin founded in collaboration with Tenet Healthcare, FICO and Northbridge Venture Partners. Prior to Connance, Mr. Levin was a Partner at Monitor Company (now Monitor Deloitte) working with hospitals, HCIT companies and health insurers. Mr. Levin holds a B.A. from Dartmouth College and an M.B.A. from Harvard Business School.

Holly McMullan became our Director in December 2018. Ms. McMullan is a Partner in Apollo Global Management's Client and Product Solutions group, where she is responsible for fundraising efforts for Apollo's private equity and capital markets businesses, having joined in 2008. Prior to that time, Ms. McMullan was a Senior Vice President at Pequot Capital Management and was previously a member of Guggenheim Advisors, Bear Stearns, and Robertson Opportunity Capital. She currently serves on the following advisory boards: 30 % Coalition, McCombs Advisory Council, New York for McCombs (Chair) and the Hicks Muse Private Equity Research Center at the University of Texas at Austin. Ms. McMullan holds an M.B.A. with a concentration in Finance from the McCombs School of Business at the University of Texas at Austin and a B.A. (honors) in International Business from Sheffield Hallam University, Sheffield, UK.

Daniel Morissette became our Director upon consummation of the Transaction in April 2016. Mr. Morissette serves as Senior Executive Vice President and Chief Financial Officer for Common Spirit Health and served as Senior Executive Vice President/Chief Financial Officer for Dignity Health since February 2016. Previously, Mr. Morissette served as the Chief Financial Officer for Stanford Health Care. Mr. Morissette has over 25 years of experience in healthcare, consulting and international business development. During the past five years, Mr. Morissette served as a director for Optum360. Mr. Morissette received a B.S. from DePaul University and an M.B.A. from The University of Chicago, Booth School of Business.

Eric L. Press has been our Director since consummation of the Apollo/RegionalCare Acquisition in December 2015. Mr. Press is a Senior Partner at Apollo, having joined in 1998. In his time with Apollo, he has been involved in many of the firm's investments in basic industrials, metals, lodging/gaming/leisure and financial services. Prior to joining Apollo, Mr. Press worked at the law firm of Wachtell, Lipton, Rosen & Katz, specializing in mergers, acquisitions, restructurings and related financing transactions. Prior thereto, Mr. Press was a consultant with The Boston Consulting Group, a management consulting firm focused on corporate strategy. Mr. Press serves on the board of directors of ADT Inc., Gamenet Group S.p.A., Apollo Commercial Real Estate Finance, Inc., and Eagle LM5 Holdings Inc. He previously served on the board of directors of Caesars Entertainment Corporation, Princimar Chemical Holdings, LLC, PlayAGS, Inc., and Verso Corporation. He graduated magna cum laude from Harvard College, with an A.B. in economics, and Yale Law School, where he was a Senior Editor of the Yale Law Journal.

Martin S. Rash has been our director since October 2015 following the Apollo/RegionalCare Acquisition and served as Executive Chairman following the consummation of the RegionalCare/Capella Merger in April 2016 until October 2016. Additionally, Mr. Rash served as Chief Executive Officer and Chairman of RegionalCare from October 2016 until the consummation of the LifePoint/RCCH Merger. Mr. Rash served as the Executive Chairman at RegionalCare Hospital Partners, Inc. from March 2013 to January 2014 and served as its Chief Executive Officer from 2009 until March 2013. From December 1996 to 2005, Mr. Rash was Chairman and Chief Executive Officer of Province Healthcare, a $1 billion NYSE company that owned 21 hospitals and managed more than 50 facilities. Prior to his tenure at Province Healthcare, Mr. Rash served as Executive Vice President and Chief Operating Officer for Community Health Systems where he led the growth of the company from 10 to 41 hospitals in 17 states. Earlier in his 40-year healthcare career, he worked at numerous community hospitals in various administrative and financial roles. Mr. Rash's experience and leadership includes Board of Directorships in the past at Healthspring, a NYSE company, and Odyssey Healthcare, a Nasdaq company, serving as the chair of the compensation committee for both organizations. He is a past Chairman of the Federation of American Hospitals and of the Nashville Health Care Council. He holds both a B.A. and M.B.A. from Middle Tennessee State University. He currently serves as Chairman of American Pathology Partners; ReVIDA Recovery; and Unifeye Vison Partners.

James H. Simmons III has been our director since September 2020. Mr. Simmons is Chief Executive Officer and Founding Partner of Asland Capital Partners, serving as head of its investment committee with oversight over the day-to-day operations of the firm. Mr. Simmons has over two decades of real estate investment experience across the public and private sectors. Prior to founding Asland Capital Partners, Mr. Simmons was a Partner at Ares Management, where he led the Ares Domestic Emerging Markets Fund, and was previously a Partner at Apollo Real Estate Advisors. Mr. Simmons was also previously President and Chief Executive Officer of the Upper Manhattan Empowerment Zone Development Corporation and held prior roles at Bankers Trust and Salomon Smith Barney. Mr. Simmons currently serves on the Board of Directors of the Real Estate Executive Council (Vice Chair), The Dalton School and the Greater Jamaica Development Corporation. Mr. Simmons received a BS degree from Princeton University, an M.S. from the Virginia Polytechnic Institute and State University and an M.M. from Northwestern University's J.L. Kellogg Graduate School of Management.

Olivia Wassenaar became our Director in December 2018. Ms. Wassenaar is a Senior Partner at Apollo Global Management and is Co-Lead of Natural Resources, having joined in 2018. Prior to that time, Ms. Wassenaar was a Managing Director at Riverstone Holdings and was previously a member of the Investment Banking division of Goldman Sachs. Ms. Wassenaar also serves on the boards of directors of Talos Energy Inc., Jupiter Resources Ltd., Pegasus Optimization Partners, LLC, and High Road Resources, LLC (f/k/a American Petroleum Partners, LLC). During the past five years, Ms. Wassenaar also served as a director of Northern Blizzard Resources Inc. (from June 2011 to May 2017), USA Compression Partners, LP (from June 2011 to April 2018), Admiral Permian Resources, LLC (from March 2017 to May 2018), Hammerhead Resources Inc. (from June 2017 to May 2018), Canadian Non-Operated Resources GP Inc. (from August 2014 to May 2018), Eagle Energy Exploration LLC (from December 2013 to May 2018), Vesta Energy Corp. (from May 2017 to May 2018), Canera III (from 2015 to 2017), Niska Gas Storage Partners LLC (from July 2014 to June 2016) and Apex Energy, LLC (from September 2019 to December 2019). She received her A.B., magna cum laude, from Harvard College and an M.B.A. from the Wharton School at the University of Pennsylvania.

G. Rodney Wolford became our Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Wolford has over 40 years of wide-ranging experience in the healthcare industry, having served in leadership roles with healthcare providers, suppliers, consulting firms, associations and insurers. Redirecting his professional time from active executive leadership, he now focuses his professional time on multiple boards of directors and rural community economic development. Among his many executive positions, Mr. Wolford served as chief executive officer of Alliant Healthcare (now Norton Healthcare) in Louisville, KY, Sterling Diagnostic, a worldwide manufacturer of x-ray film, Forhealth Technologies, the inventor of the first robot dedicated to hospital IV production, and a senior executive of Blue Cross Tennessee. Mr. Wolford currently serves on the boards of Atlanta based D4C Brands, a pediatric dentistry company, and Liberate Medical, which develops electronic stimulation for ventilator patients, and as a fund manager of Bluegrass Angel Funds III and IV. During the past five years, Mr. Wolford has also served as a director of Haven Behavioral, Laboratory Supply Company and VetCor.

Code of Ethics

Our Board expects its members, as well as our officers and employees, to act ethically at all times and to acknowledge in writing their adherence to the policies comprising our Code of Conduct, which is known as "Common Ground," and, as applicable, our Code of Ethics for Senior Financial Officers and Chief Executive Officer.

Board Structure

The Board consists of 13 directors. The Board has the following standing committees: audit; compensation; nominating and governance; compliance; quality; and executive. In addition, the board of directors of our parent company, DSB Parent, also has a compensation committee that administers equity-based compensation plans in which our managers, officers, employees, consultants and directors participate. As a result of the LifePoint/RCCH Merger and the RegionalCare/Capella Merger, Apollo has the power to control us and our affairs and policies, including the designation of a majority of the members of our Board and the appointment of management.

Committees of our Board of Directors

The Board has adopted written charters for each of the following standing committees:

Audit Committee

The current members of our audit committee are Messrs. Morissette, Haley and Wolford. Mr. Morissette is the chairman of our audit committee. The principal duties and responsibilities of our audit committee are to assist the Board in overseeing:

- the integrity of our financial statements;
- the independent auditor's qualifications, independence and performance;
- the performance of our internal audit function; and
- our compliance with certain legal, ethical and regulatory requirements.

The audit committee has the authority to conduct or authorize investigations into or studies of matters within its scope of responsibilities. It also has the authority to retain and determine funding for independent legal, accounting or other advisors (without seeking Board approval) as it determines necessary or appropriate to carry out its duties and responsibilities.

Our Board has determined that each of Messrs. Morissette and Wolford is an "audit committee financial expert" within the meaning of applicable SEC regulations.

Compensation Committee

The current members of our compensation committee are Messrs. Nord and Press. Mr. Press is the chair of our compensation committee. The principal duties and responsibilities of our compensation committee are as follows:

- approving the non-equity-based compensation of our officers, directors and employees;
- administering our non-equity-based compensation plans; and
- making recommendations to DSB Parent for the equity-based compensation of DSB Parent and its subsidiaries' officers, directors and employees.

Nominating and Governance Committee

The current members of our nominating and governance committee are Messrs. Christie, Press and Rash. Mr. Press is the chair of our nominating and governance committee. The principal duties and responsibilities of our nominating and governance committee are as follows:

- to assist the Board in identifying individuals qualified to serve as members of the Board and/or its committees; and
- other duties and responsibilities that our Board may delegate to the nominating and governance committee.

Compliance Committee

The current members of our compliance committee are Messrs. Levin, Morissette, Wolford and Rash. Mr. Wolford is the chair of our compliance committee. The compliance committee is responsible for overseeing our legal and regulatory compliance program, including certain healthcare and regulatory compliance matters that affect us and our business operations.

Quality Committee

The current members of our quality committee are Messrs. Brownstein, David, Haley and Ms. McMullan. The quality committee is responsible for monitoring and evaluating the adequacy and effectiveness of our quality of care and patient safety programs and initiatives.

Executive Committee

The current members of our executive committee are Messrs. David, Nord and Press. Mr. Nord is the chair of our executive committee. The principal duties and responsibilities of our executive committee are as follows:

- to advise and counsel the Chief Executive Officer regarding company matters; and
- to take such actions as are necessary due to their urgent or highly confidential nature, or where convening the Board is impracticable, subject to certain limitations.

Item 11. *Executive Compensation.*

The information that would be required to be disclosed under Part III, Item 11 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

The information that would be required to be disclosed under Part III, Item 12 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

For a discussion of certain relationships and related party transactions, refer to the Offering Memorandum dated December 4, 2020 for the 5.375% Unsecured Notes.

Equity Repurchases

Since the closing of the LifePoint/RCCH Merger, through December 31, 2020, DSB Parent has repurchased 3,807,682 profits units and 385,319 capital units from various former employees of LifePoint. Repurchases are anticipated to continue to occur from time to time.

Item 14. *Principal Accounting Fees and Services*.

The Audit Committee has appointed Ernst & Young LLP as our independent registered public accounting firm. Services provided to us by Ernst & Young LLP in fiscal 2018 are described below.

Audit Fees. The aggregate audit fees billed by Ernst & Young LLP for professional services rendered for the audit of our annual consolidated financial statements and services that are normally provided by the independent registered public accounting firm in connection with statutory and regulatory filings totaled approximately $3.8 million for 2020 and approximately $4.3 million for 2019.

Audit-Related Fees. The aggregate fees billed by Ernst & Young LLP for assurance and related services other than those described under “Audit Fees” were approximately $0.8 million for 2020 and $2.4 million for 2019.

Tax Fees. The aggregate fees billed by Ernst & Young LLP for professional services rendered for tax compliance, tax advice and tax planning were approximately $0.3 million for both 2020 and 2019.

All Other Fees. There were no fees billed by Ernst & Young LLP for products or services other than those described above in 2020 or 2019.

PART IV

Item 15. ***Exhibits, Financial Statement Schedules*.**

(a) The following documents are filed as part of this Report:

1. *Consolidated Financial Statements*:

2. *Financial Statement Schedule*: All schedules for which provision is made in the applicable accounting regulations of the SEC are omitted because they either are not required under the related instructions, are inapplicable, or the required information is shown in the consolidated financial statements or notes thereto.

3. *Exhibits*: The exhibits required by Item 601 of Regulation S-K that would be disclosed under Part IV, Item 15 of an annual report on Form 10-K filed with the SEC have been omitted as permitted pursuant to Section 4.02(a) of the Indentures.

Ernst & Young LLP
222 2nd Avenue South
Suite 2100
Nashville, TN 37201

Tel: (615) 252 2000
Fax: (615) 242 9128
ey.com

Building a better working world

Report of Independent Auditors

Board of Directors and Shareholders of
LifePoint Health, Inc.

We have audited the accompanying consolidated financial statements of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.), which comprise the consolidated balance sheets as of December 31, 2020 and 2019, and the related consolidated statements of operations, comprehensive income (loss), equity and cash flows for each of the three years in the period ended December 31, 2020, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.) at December 31, 2020 and 2019, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2020 in conformity with U.S. generally accepted accounting principles.

Change in Accounting Principle

As discussed in Note 8 to the consolidated financial statements, LifePoint Health, Inc. has changed its method of accounting for leases due to the adoption of Financial Accounting Standards Board Accounting Standards Update No. 2016-02, Leases, effective January 1, 2019. Our opinion is not modified with respect to this matter.

Ernst + Young LLP

March 4, 2021

LifePoint Health, Inc.

Consolidated Statements of Operations
For the Years Ended December 31, 2020, 2019 and 2018
(In millions)

	2020	2019 [(a)]	2018
Revenues	$ 8,121.9	$ 8,752.8	$ 2,778.1
Salaries and benefits	3,877.5	4,044.0	1,329.4
Supplies	1,417.6	1,471.7	484.5
Other operating expenses, net	2,207.2	2,150.3	709.2
Government stimulus income	(646.3)	-	-
Depreciation and amortization	377.4	376.5	129.0
Interest expense, net	528.1	568.6	186.1
Debt transaction costs	115.4	-	8.2
Merger, integration and other transaction-related costs	-	76.9	141.5
Impairments of goodwill and long-lived assets	-	3.3	78.4
Other non-operating losses (gains), net	4.0	5.5	(0.4)
	7,880.9	8,696.8	3,065.9
Income (loss) before income taxes	241.0	56.0	(287.8)
(Benefit from) provision for income taxes	(63.7)	77.9	0.2
Net income (loss)	304.7	(21.9)	(288.0)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(21.5)	(19.3)	(5.7)
Net income (loss) attributable to LifePoint Health, Inc.	$ 283.2	$ (41.2)	$ (293.7)

(a) The consolidated statement of operations for the year ended December 31, 2019 has been restated in accordance with the adoption of Accounting Standards Update ("ASU") 2016-02, "Leases" ("ASU 2016-02"). Refer to Note 8 for additional information.

LifePoint Health, Inc.

Consolidated Statements of Comprehensive Income (Loss)
For the Years Ended December 31, 2020, 2019 and 2018
(In millions)

	2020	2019 [(a)]	2018
Net income (loss)	$ 304.7	$ (21.9)	$ (288.0)
Other comprehensive loss:			
Unrealized losses on changes in funded status of pension benefit obligations	(1.3)	(4.4)	(3.1)
Other comprehensive loss	(1.3)	(4.4)	(3.1)
Comprehensive income (loss)	303.4	(26.3)	(291.1)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(21.5)	(19.3)	(5.7)
Comprehensive income (loss) attributable to LifePoint Health, Inc.	$ 281.9	$ (45.6)	$ (296.8)

(a) The consolidated statement of comprehensive loss for the year ended December 31, 2019 has been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

LifePoint Health, Inc.

Consolidated Balance Sheets
As of December 31, 2020 and 2019
(In millions, except for share and per share amounts)

	2020	2019 [a]
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,652.6	$ 748.1
Accounts receivable	1,041.6	1,167.9
Inventories	238.6	225.9
Prepaid expenses	103.4	92.7
Other current assets	332.2	172.2
	4,368.4	2,406.8
Property and equipment:		
Land	226.5	232.4
Buildings and improvements	2,612.1	2,626.9
Equipment	1,552.3	1,383.6
Construction in progress	84.9	148.6
	4,475.8	4,391.5
Accumulated depreciation	(952.8)	(616.5)
	3,523.0	3,775.0
Intangible assets, net	58.3	65.4
Other long-term assets	731.0	772.9
Goodwill	2,918.5	2,961.2
Total assets	$ 11,599.2	$ 9,981.3
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 357.9	$ 340.6
Accrued salaries	295.4	319.3
Current portion of Medicare advance payments	369.8	-
Other current liabilities	591.3	489.0
Current maturities of long-term debt	30.0	69.7
	1,644.4	1,218.6
Long-term debt, net	7,205.9	6,966.8
Long-term portion of Medicare advance payments	621.2	-
Other long-term liabilities	759.7	719.6
Total liabilities	10,231.2	8,905.0
Redeemable noncontrolling interests	180.4	147.8
Equity:		
LifePoint Health, Inc. stockholders' equity:		
Common stock, $0.01 par value; 30,000 shares authorized; 100 shares issued and outstanding at December 31, 2020 and 2019	-	-
Capital in excess of par value	1,266.9	1,295.8
Accumulated other comprehensive loss	(8.8)	(7.5)
Accumulated deficit	(102.5)	(385.7)
Total LifePoint Health, Inc. equity	1,155.6	902.6
Noncontrolling interests	32.0	25.9
Total equity	1,187.6	928.5
Total liabilities and equity	$ 11,599.2	$ 9,981.3

(a) The consolidated balance sheet as of December 31, 2019 has been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

LifePoint Health, Inc.

Consolidated Statements of Cash Flows
For the Years Ended December 31, 2020, 2019 and 2018
(In millions)

	2020	2019 [(a)]	2018
Cash flows from operating activities:			
Net income (loss)	$ 304.7	$ (21.9)	$ (288.0)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:			
Depreciation and amortization	377.4	376.5	129.0
Other non-cash amortization	34.8	39.5	9.9
Non-cash interest expense	15.2	19.1	5.8
Debt transaction costs	115.4	-	8.2
Impairments of goodwill and long-lived assets	-	3.3	78.4
Other non-operating losses (gains), net	4.0	5.5	(0.4)
Deferred income taxes	1.1	2.2	(0.6)
Reserve for self-insurance claims, net of payments	30.3	(5.4)	2.3
Changes in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:			
Accounts receivable	110.0	(57.4)	(48.1)
Inventories, prepaid expenses and other current assets	(20.4)	(36.7)	(0.2)
Accounts payable, accrued salaries and other current liabilities	48.5	(53.6)	(9.6)
Medicare advance payments	991.0	-	-
Income taxes payable/receivable	(102.8)	134.2	53.0
Other	11.1	8.3	(12.7)
Net cash provided by (used in) operating activities	1,920.3	413.6	(73.0)
Cash flows from investing activities:			
Purchases of property and equipment	(170.4)	(336.7)	(319.7)
Acquisitions, net of cash acquired	(0.6)	(4.4)	(5,345.9)
Proceeds from sales of equity method investments and other ancillary businesses	23.8	6.4	-
Other	26.6	24.6	19.9
Net cash used in investing activities	(120.6)	(310.1)	(5,645.7)
Cash flows from financing activities:			
Proceeds from borrowings	2,381.5	-	5,125.0
Payments of borrowings	(2,140.6)	(28.3)	(189.3)
Net change in ABL Facility and Prior ABL Facility	-	(20.0)	10.0
Proceeds from lease financing	-	700.0	38.0
Payments of debt financing costs	(102.8)	(18.1)	(207.0)
Cash (distributed to) contributed by parent	-	(10.9)	1,000.0
Distributions and other cash transactions associated with noncontrolling interests and redeemable noncontrolling interests	(13.2)	(18.0)	(6.0)
Finance lease payments and other	(20.1)	(19.0)	(10.0)
Net cash provided by financing activities	104.8	585.7	5,760.7
Change in cash and cash equivalents	1,904.5	689.2	42.0
Cash and cash equivalents at beginning of period	748.1	58.9	16.9
Cash and cash equivalents at end of period	$ 2,652.6	$ 748.1	$ 58.9
Supplemental disclosure of cash flow information:			
Interest payments	$ 423.5	$ 515.8	$ 138.1
Capitalized interest	$ 1.7	$ 11.1	$ 17.4
Property and equipment acquired under finance leases	$ 42.6	$ 22.4	$ 3.1
Income tax payment (refunds), net	$ 38.0	$ (58.5)	$ (53.7)

(a) Certain items included within the reconciliation of net loss to net cash provided by operating activities for the year ended December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

LifePoint Health, Inc.

Consolidated Statements of Equity
For the Years Ended December 31, 2020, 2019 and 2018
(Dollars in millions)

	Common Stock		Capital in Excess of	Accumulated Other Comprehensive	Accumulated	Noncontrolling	
	Shares	Amount	Par Value	Loss	Deficit	Interests	Total
Balance at January 1, 2018	100	$ -	$ 308.1	$ -	$ (88.1)	$ -	$ 220.0
Comprehensive (loss) income	-	-	-	(3.1)	(293.7)	0.2	(296.6)
Stock-based compensation	-	-	7.0	-	-	-	7.0
Reclassification of vested stock-based compensation units to a liability	-	-	(6.8)	-	-	-	(6.8)
Capital contribution from parent	-	-	1,000.0	-	-	-	1,000.0
Noncontrolling interests assumed in LifePoint/RCCH Merger	-	-	-	-	-	29.9	29.9
Distributions to noncontrolling interests	-	-	-	-	-	(0.2)	(0.2)
Balance at December 31, 2018	100	-	1,308.3	(3.1)	(381.8)	29.9	953.3
Adoption of ASU 2016-02 [(a)]	-	-	-	-	37.3	-	37.3
Comprehensive (loss) income [(a)]	-	-	-	(4.4)	(41.2)	4.4	(41.2)
Stock-based compensation	-	-	4.8	-	-	-	4.8
Reclassification of vested stock-based compensation units to a liability	-	-	(2.9)	-	-	-	(2.9)
Distributions to parent	-	-	(3.2)	-	-	-	(3.2)
Fair value adjustments related to noncontrolling interests and redeemable noncontrolling interests	-	-	(11.2)	-	-	(0.2)	(11.4)
Distributions to noncontrolling interests	-	-	-	-	-	(8.2)	(8.2)
Balance at December 31, 2019 [(a)]	100	-	1,295.8	(7.5)	(385.7)	25.9	928.5
Comprehensive (loss) income	-	-	-	(1.3)	283.2	7.5	289.4
Stock-based compensation	-	-	2.4	-	-	-	2.4
Reclassification of vested stock-based compensation units to a liability	-	-	(0.2)	-	-	-	(0.2)
Reclassification of equity to redeemable noncontrolling interests related to Emory joint venture	-	-	(26.1)	-	-	-	(26.1)
Fair value adjustments related to redeemable noncontrolling interests	-	-	(5.0)	-	-	-	(5.0)
Distributions to noncontrolling interests	-	-	-	-	-	(1.4)	(1.4)
Balance at December 31, 2020	100	$ -	$ 1,266.9	$ (8.8)	$ (102.5)	$ 32.0	$ 1,187.6

(a) The consolidated statement of equity for the year ended December 31, 2019 has been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

Note 1. Organization and Summary of Significant Accounting Policies

Organization

LifePoint Health, Inc., a Delaware corporation, acting through its subsidiaries, owns or leases and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. At December 31, 2020, on a consolidated basis, LifePoint Health, Inc. operated 88 hospital campuses in 29 states throughout the United States ("U.S.").

Unless otherwise indicated or the context otherwise requires, references throughout these notes to the consolidated financial statements to the "Company" or "LifePoint" refer to LifePoint Health, Inc., and each of its consolidated subsidiaries after giving effect to the LifePoint/RCCH Merger (defined below) and (ii) "RCCH" refer to RegionalCare Hospital Partners Holdings, Inc. and each of its consolidated subsidiaries before giving effect to the LifePoint/RCCH Merger. References in this Report to the "Sponsor" refer to certain funds that are affiliates of the Company (the "Apollo Funds") that are ultimately controlled and/or managed by Apollo Management VIII, L.P. ("Apollo Management" and, when acting on behalf of the Apollo Funds, "Apollo"), which is an affiliate of Apollo Global Management, Inc.

Additionally, references throughout these notes to the consolidated financial statements to the "LifePoint/RCCH Merger" refer to the merger, which was effective on November 16, 2018, of Legend Merger Sub, Inc., a Delaware corporation and wholly owned subsidiary of RCCH ("Legend Merger Sub"), with and into LifePoint Health, Inc., a Delaware corporation ("Legacy LifePoint"), with Legacy LifePoint surviving the LifePoint/RCCH Merger as a subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners, Inc." to "LifePoint Health, Inc."

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through majority voting control and variable interest entities which the Company controls. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation. Noncontrolling interests in non-wholly-owned consolidated subsidiaries of the Company are presented as noncontrolling interests and redeemable noncontrolling interests and distinguish between the interests of the Company and the interests of the noncontrolling owners. Net income attributable to noncontrolling interests and redeemable noncontrolling interests represents the amounts attributable to the noncontrolling interests for each of the applicable periods presented. Investments in entities the Company does not control but does have a substantial ownership interest and can exercise significant influence are accounted for using the equity method.

The Company's financial statements have been presented on the basis of push down accounting in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") No. 805-50-S99. Under the push down basis of accounting, certain transactions incurred by the parent company which would otherwise be accounted for in the accounts of the parent are "pushed down" and recorded on the financial statements of the subsidiary. Accordingly, certain items resulting from the acquisition by Apollo have been recorded on the financial statements of the Company.

Use of Estimates

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

Revenue Recognition and Accounts Receivable

Overview

The Company recognizes revenues in the period in which performance obligations are satisfied. Generally, the Company bills patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. Amounts the Company receives for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in the Company's financial statements are recorded at the net consideration to which the Company expects to be entitled to receive in exchange for providing patient care.

The majority of the Company's performance obligations are satisfied over time for the delivery of patient care in both outpatient and inpatient settings. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected charges for services anticipated to be provided. The Company believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the remaining services needed to satisfy the obligation. Generally, unsatisfied or partially unsatisfied performance obligations at the end of the reporting period are related to patients admitted to the Company's hospitals that have not yet been discharged. The performance obligations for these patients are typically satisfied when the patients are discharged, which generally occurs within a matter of days of admission. Patients are generally billed when discharged, though they may be billed on an interim basis for longer stays. Accordingly, because all of the Company's performance obligations are part of a contract that is expected to have a duration of one year or less, the Company has elected to apply the exemption provided by ASC 606, "Revenue from Contracts with Customers" ("ASC 606") to not disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied as of period end.

Subsequent adjustments that are determined to be the result of an adverse change in the patient's or the payer's ability to pay are recognized as bad debt expense. With the adoption of ASC 606, bad debt expense is included under the caption "Other operating expenses, net" in the accompanying consolidated statements of operations, instead of separately as a deduction to arrive at revenue. Bad debt expense for the years ended December 31, 2020, 2019 and 2018 was not material for the Company.

Change in Accounting Estimate

During the year ended December 31, 2018, the Company recorded a decrease to revenues of $17.0 million as a result of a change in its accounting estimate of the collectability of accounts receivable. During the year ended December 31, 2018, the Company identified additional information which indicated that its current collection estimates might be different from its historical collection estimates. Management utilized this new information to further refine its estimation procedures to more precisely estimate the collectability of accounts receivable. The Company's change in its estimation procedures of the collectability of its accounts receivable is considered a change in accounting estimate in accordance with ASC 250, "Accounting Changes and Error Corrections."

Contractual Discounts

The Company derives a significant portion of its revenues from Medicare, Medicaid and other payers that receive discounts from the Company's established billing rates. The Company must estimate the total amount of these discounts to prepare its financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Company estimates contractual discounts on a payer-specific basis given its interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Subsequent changes in estimates for contractual discounts are reflected as an adjustment to revenues in the period of the change. Medicare, Medicaid and other discounted payer accounts receivables are written off after they have been final settled with the payer.

Cost Report Settlements

Cost report settlements under reimbursement agreements with Medicare, Medicaid and certain other payers for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the payment terms of the reimbursement agreement with the payer, correspondence from the payer, and the Company's historical experience. Estimated settlements are adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. For the years ended December 31, 2020, 2019 and 2018, the net adjustments to estimated cost report settlements and other reimbursement adjustments resulted in an increase to revenues of $33.5 million, an increase to revenues of $17.2 million, and a decrease to revenues of $4.0 million, respectively.

The net cost report settlements due from the Company at December 31, 2020 and 2019 were $2.0 million and $6.6 million, respectively, and are included under the caption "Other current liabilities" on the accompanying consolidated balance sheets. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs consistent with the constraints that are required by ASC 606.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third-party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. The Company evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. The Company estimates the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that the Company utilizes include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that the Company expects to collect. Because the Company provides care to patients regardless of their ability to pay, the Company has determined that the differences between the amounts it bills based on gross or discounted charges and the amounts the Company expects to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and the Company accounts for this variable consideration in accordance with the provisions of ASC 606. Self-pay accounts receivable are written off after collection efforts have been followed in accordance with the Company's policies.

Charity Care

The Company provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the years ended December 31, 2020, 2019 and 2018, the Company estimates that its costs of care provided under its charity care programs approximated $26.8 million, $34.1 million and $16.8 million, respectively. The Company does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Company's policy not to pursue collection of amounts related to these patients, and therefore contracts with these patients do not exist.

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

Financing Component

The Company has elected to apply the practical expedient permitted under ASC 606 and does not adjust the estimated amount of consideration from patients and third-party payers for the effects of a significant financing component due to the Company's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payer pays for that service will be one year or less.

Rental Income

The Company leases certain real estate assets it owns to unrelated third parties, primarily medical office buildings to non-employed physicians. The Company recognizes rental income for these operating lease arrangements in which the Company is the lessor on a straight-line basis over the lease term in accordance with ASC 842, "Leases" ("ASC 842").

Concentration of Revenues

The Company's revenues by payer and approximate percentages of revenues were as follows for the years ended December 31, 2020, 2019 and 2018 (dollars in millions):

	2020		2019		2018	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,134.0	38.6 %	$ 3,338.1	38.1 %	$ 1,105.3	39.8 %
Medicaid	1,392.4	17.1	1,495.3	17.1	486.3	17.5
HMOs, PPOs and other private insurers	3,381.9	41.6	3,698.6	42.3	1,113.8	40.1
Self-pay	54.5	0.7	59.2	0.7	17.2	0.6
Other	142.7	1.8	143.6	1.6	49.4	1.8
Revenue from contracts with customers	8,105.5	99.8	8,734.8	99.8	2,772.0	99.8
Rental income	16.4	0.2	18.0	0.2	6.1	0.2
Revenues	$ 8,121.9	100.0 %	$ 8,752.8	100.0 %	$ 2,778.1	100.0 %

During the years ended December 31, 2020, 2019 and 2018, approximately 55.7%, 55.2% and 57.3%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs, collectively. The Company's management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies.

Any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs could have an adverse effect on the Company's revenues or results of operations. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payer or geographic area that would subject the Company to any significant credit risks in the collection of its accounts receivable.

The Company's revenues by primary service type and approximate percentages of revenues were as follows for the years ended December 31, 2020, 2019 and 2018 (dollars in millions):

	2020		2019		2018	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Inpatient services	$ 3,379.0	41.6 %	$ 3,524.0	40.3 %	$ 1,188.3	42.8 %
Outpatient services	4,583.8	56.4	5,067.2	57.9	1,534.3	55.2
Non-patient (a)	159.1	2.0	161.6	1.8	55.5	2.0
Revenues	$ 8,121.9	100.0 %	$ 8,752.8	100.0 %	$ 2,778.1	100.0 %

(a) Represents revenues from ancillary goods, services and rental income.

General and Administrative Costs

The majority of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as "general and administrative" by the Company would include its corporate overhead costs, excluding depreciation and amortization, debt transaction costs and merger, integration and other transaction-related costs, which were $175.9 million, $179.5 million and $72.4 million for the years ended December 31, 2020, 2019 and 2018, respectively.

Cash and Cash Equivalents

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

Inventories

Inventories of supplies are stated at the lower of cost (first-in, first-out) or market and consist of purchased items. Inventories acquired in connection with business combinations are recorded at fair value which approximates replacement cost. Inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

Investments

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, under the equity method of accounting in accordance with ASC 323, "Investments – Equity Method and Joint Ventures" ("ASC 323"). The Company does not consolidate its equity method investments but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period. Refer to Note 9 for further discussion of the Company's equity method investments.

Property and Equipment

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

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

	Years		
Buildings and improvements (including those under finance leases)	3	-	40
Equipment	2	-	15
Equipment under finance leases	3	-	6

Depreciation expense (including amortization of finance lease obligations) totaled $376.1 million, $374.7 million and $128.5 million for the years ended December 31, 2020, 2019 and 2018, respectively.

Whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

There were no long-lived asset impairments recorded for the years ended December 31, 2020 and 2019. For the year ended December 31, 2018, the Company recognized an impairment charge of $24.5 million to reduce the carrying amounts of certain long-lived assets at one of its facilities to their estimated fair values, which is included under the caption "Impairments of goodwill and long-lived assets" in the accompanying consolidated statements of operations for the year ended December 31, 2018.

Goodwill and Intangible Assets

The Company accounts for its acquisitions in accordance with ASC 805 using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350, Intangibles – Goodwill and Other ("ASC 350"), goodwill and intangible assets with indefinite lives are reviewed by the Company annually for impairment on October 1. Prior to the LifePoint/RCCH Merger, the Company historically determined that each of its hospitals represented a reporting unit in accordance with ASC 280, "Segment Reporting" ("ASC 280") and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that the consolidated business comprises a single reporting unit for goodwill impairment testing purposes. For the annual impairment evaluation, the Company determines fair value using a discounted cash flow ("DCF") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates, profitability and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing the Company's assumptions. The cash flows employed in the DCF analysis are based on the Company's most recent financial budgets and business plans and, when applicable, various growth rates and profitability for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the reporting unit.

The Company's intangible assets primarily relate to contract-based physician minimum revenue guarantees; certificates of need and certificates of need exemptions; and licenses, provider numbers, accreditations and other. Contract-based physician minimum revenue guarantees are amortized over the terms of the agreements. The certificates of need, certificates of need exemptions, licenses, provider numbers, accreditations and other have been determined to have indefinite lives and, accordingly, are not amortized. Refer to Note 5 for further discussion of the Company's goodwill and intangible assets.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the income tax provision in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is not likely, a valuation allowance is established. The establishment or increase in a valuation allowance is included as an expense within the provision for income taxes in the consolidated statements of operations. The Company classifies interest and penalties related to its tax positions as a component of income tax expense. Refer to Note 6 for further discussion of the Company's accounting for income taxes.

Reserves for Self-Insurance Claims

Given the nature of the Company's operating environment, the Company is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("SIR") and deductible levels. At December 31, 2020, the Company's SIR for professional liability claims is $15.0 million per claim at the majority of its facilities. Additionally, the Company participates in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico, Pennsylvania and Wisconsin. At December 31, 2020, the Company's deductible for workers' compensation claims was $1.0 million per claim in all states in which it operates except for Montana, Ohio, Oklahoma, Washington and Wyoming. The Company participates in state-specific programs for its workers' compensation claims arising in these states. The Company's SIR and deductible levels are evaluated annually as a part of the Company's insurance program's renewal process.

The Company's reserves for self-insurance and deductible claims reflect the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The Company's expense for self-insurance and deductible claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's self-insured retention and deductible levels; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance and deductible claims was approximately $85.0 million, $75.6 million and $20.7 million for the years ended December 31, 2020, 2019 and 2018, respectively.

The Company's reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. These reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. The Company's reserves for self-insured claims have been discounted to their present value using a discount rate of 1.7% at December 31, 2020, 1.9% at December 31, 2019, and 1.8% at December 31, 2018. The Company's management selects a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

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

The following table provides information regarding the classification of the Company's reserves for self-insured claims at December 31, 2020 and 2019 (in millions):

	2020	2019
Current portion	$ 82.3	$ 64.5
Long-term portion	205.0	196.5
	$ 287.3	$ 261.0

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2020 and 2019 (in millions):

	2020	2019
Reserve at the beginning of the period	$ 261.0	$ 264.7
Increase for the provision of current year claims	88.3	69.2
Increase (decrease) for the provision of prior year claims	(4.4)	6.7
Payments related to current year claims	(5.9)	(5.2)
Payments related to prior year claims	(48.8)	(75.8)
Provision for the change in discount rate	1.1	(0.3)
Non-cash change in reserve for claims in excess of SIR levels	(4.0)	1.7
Reserve at the end of the period	$ 287.3	$ 261.0

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of the Company's quarterly and semi-annual actuarial calculations resulted in changes to its reserves for self-insured claims for prior years. As a result, the Company's related self-insured claims expense decreased by $4.4 million for the year ended December 31, 2020, increased by $6.7 million for the year ended December 31, 2019 and decreased by $3.9 million for the year ended December 31, 2018.

Point of Life Indemnity, Ltd.

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

Self-Insured Medical Benefits

The Company is self-insured for substantially all of the medical expenses and benefits of its employees. The reserve for medical benefits primarily reflects the current estimate of incurred but not reported losses based upon an annual actuarial calculation as of the balance sheet date. The undiscounted reserve for self-insured medical benefits was $37.7 million and $53.8 million at December 31, 2020 and 2019, respectively, and is included in the Company's accompanying consolidated balance sheets under the caption "Other current liabilities".

Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to the Company. The Company's accompanying consolidated financial statements include all assets, liabilities, revenues, and expenses at their consolidated amounts, which include the amounts attributable to the Company and the noncontrolling interest. The Company recognizes as a separate component of earnings that portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company. Refer to Note 10 for further discussion of the Company's noncontrolling interests and redeemable noncontrolling interests.

Variable Interest Entities

The Company's consolidated financial statements at December 31, 2020 include eight facilities that qualify as a variable interest entity in which the Company is the primary beneficiary under the provisions of ASC 810, "Consolidation," and in which the Company owns a controlling economic interest.

Stock-Based Compensation

The Company's indirect parent, DSB Parent L.P., a Delaware limited partnership ("DSB Parent"), has issued profits units (the "Units") to certain employees, directors and consultants under the terms and conditions of the Amended and Restated Limited Partnership Agreement of DSB Parent dated of December 3, 2015 (the "DSB Parent Partnership Agreement") and forms of award agreements. The Company accounted for these stock-based awards in accordance with the provisions of ASC 718, "Compensation – Stock Compensation" ("ASC 718"). In accordance with ASC 718, the Company recognized compensation expense based on the estimated grant date fair value of each stock-based award. The Company recognizes forfeitures of Units as they occur. Refer to Note 13 for further discussion of the Company's accounting for the Units.

Defined Benefit Pension Plans

In connection with the LifePoint/RCCH Merger, the Company acquired certain assets and assumed certain liabilities associated with two separate defined benefit pension plans covering certain employees at two of Legacy LifePoint's facilities. The Company accounts for its defined benefit pension plans in accordance with ASC 715, "Compensation – Defined Benefit Plans", ("ASC 715"). In accordance with ASC 715, the Company recognizes the unfunded liability of its defined benefit pension plans in the Company's consolidated balance sheets and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the defined benefit pension plans' assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligations are measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality. Refer to Note 12 for further discussion of the Company's defined benefit pension plans.

Defined Contribution Plans

The Company maintains two separate defined contribution retirement plans covering a majority of the Company's employees. These defined contribution retirement plans contain discretionary matching contribution formulas and definite non-elective contribution formulas for employees at certain facilities. Refer to Note 12 for further discussion of the Company's defined contribution plans.

Reclassifications

Certain reclassifications have been made to the prior years to conform to current year presentation. These reclassifications had no effect on results of operations, financial position or cash flows as previously reported.

Adoption of Recently Issued Accounting Standards

Accounting Standards Update ("ASU") 2016-02, "Leases"

In February 2016, the FASB issued ASU 2016-02, "Leases" (Topic 842) along with subsequent amendments, updates and an extension of the effective date (collectively, "ASU 2016-02"). ASU 2016-02 requires the rights and obligations arising from lease contracts, including existing and new arrangements, to be recognized as assets and liabilities on the balance sheet. As permitted, the Company adopted ASU 2016-02 early, during the fourth quarter of 2020, with an effective transition date of January 1, 2019 and retrospective application. As a result, the accompanying consolidated financial statements as of and for the year ended December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. The Company applied certain available practical expedients to facilitate the adoption of ASU 2016-02, including the package of practical expedients to not reassess whether a contract is or contains a lease, the lease classification and the initial direct costs. In conjunction with the adoption of ASU 2016-02, the Company has implemented a new information technology application as well as new processes, policies, procedures and controls. Refer to Note 8 for additional information regarding the impact of the adoption of ASU 2016-02.

Note 2. CARES Act

Overview

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was signed into law. The CARES Act is intended to provide over $2 trillion in stimulus funding for the U.S. economy. Among other things, the CARES Act contains a number of provisions that are intended to assist healthcare providers as they combat the effects of the COVID-19 pandemic. Those provisions include, among others:

- the temporary suspension of Medicare sequestration from March 1, 2020, to December 31, 2020;
- the delay of the planned reductions to the Medicaid disproportionate share hospital ("DSH") payments program until December 1, 2020;
- an appropriation of $180 million to Health Resources and Services Administration's Federal Office of Rural Health Policy that will be awarded to small rural hospitals by the states through the Small Rural Hospital Improvement Program;
- an appropriation of $250 million to the Hospital Preparedness Program; and
- an appropriation of $100 billion to the Public Health and Social Services Emergency Fund (the "Emergency Fund") for a new program to reimburse, through grants or other mechanisms, hospitals, healthcare providers and other approved entities for COVID-19-related expenses or lost revenues.

The Paycheck Protection Program and Health Care Enhancement Act was enacted on April 24, 2020, which, among other things, provides an additional allocation of $75 billion to the Emergency Fund and an allocation of $25 billion for COVID-19 testing.

On December 21, 2020, Congress adopted the Consolidated Appropriations Act, 2021 ("CCA"), which provides an additional $900 billion in COVID-19 relief, including an additional $3 billion allocation to the Emergency Fund. In addition, the CCA also, among other things, further extends the temporary suspension of Medicare sequestration through March 31, 2021, delays the planned reductions to the Medicaid DSH payments program through FFY 2023, adds additional reductions to the Medicaid DSH payments program in FFYs 2026 and 2027, provides for a 3.75% increase in PFS rates in CY 2021 and allocates $30 billion for the purchase and administration of COVID-19 vaccines and related therapeutics.

Direct Grant Aid Payments

With respect to payments being made to providers from the Emergency Fund, beginning April 10, 2020, the Emergency Fund distributed $50 billion to hospitals based on their 2018 net patient revenue. The remaining $50 billion originally appropriated to the Emergency Fund is being distributed to providers in areas particularly impacted by the COVID-19 outbreak, rural providers (including hospitals and rural health clinics), skilled nursing facilities, providers of services with lower shares of Medicare reimbursement or who predominantly serve Medicaid beneficiaries, and providers requesting reimbursement for the treatment of uninsured patients.

Payments made by the Emergency Fund to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers are required to file attestations acknowledging receipt of the payments and must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients and not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse. The Department of Health and Human Services ("HHS") has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the Office of Inspector General ("OIG"), will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

The Company has accounted for the direct grant aid payments received as a government grant related to income in a manner consistent with International Accounting Standards 20, "Accounting for Government Grants and Disclosure of Government Assistance" ("IAS 20"). In accordance with IAS 20, government grants are recognized either as other income or a reduction to a related expense when there is reasonable assurance that the grant will be received, and the entity will comply with any conditions attached to the grant. For the year ended December 31, 2020, the Company recognized $646.3 million of direct grant aid payments as other income under the caption "Government stimulus income" in the accompanying consolidated statement of operations.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, HHS temporarily expanded the Centers for Medicare and Medicaid Services ("CMS") Accelerated and Advance Payment Program to a broad group of Medicare Part A and Part B providers. Under the expanded Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period. The repayment of these accelerated/advance payments does not begin until one year after the date of the provider's or supplier's receipt of the payment, which means repayment of these amounts will not commence until the second quarter of 2021. Once the repayment period starts, the amounts previously advanced to the provider or supplier will automatically be recouped from the provider's or supplier's new Medicare claims at a rate of 25% for a period of 11 months. After the end of that 11-month period, the amounts previously advanced to the provider or supplier will be automatically recouped from the provider's or supplier's new Medicare claims at a rate of 50% for a period of six months. At the end of the 17-month recoupment period, a letter requesting repayment of any remaining balance will be issued, and the provider or supplier will have 30 days from the date of the letter to repay the balance in full. If the remaining balance is not repaid after 30 days, the unpaid balance will accrue interest at a rate of 4% from the date of the demand letter until the balance has been repaid in full.

Through December 31, 2020, the Company received a total of $991.0 million of Medicare advance payments under the Accelerated and Advance Payment Program, of which $369.8 million and $621.2 million are included under the captions "Current portion of Medicare advance payments" and "Long-term portion of Medicare advance payments", respectively, in the accompanying consolidated balance sheet at December 31, 2020. The Company does not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program.

Note 3. Merger, Acquisitions, Divestitures and Joint Ventures

LifePoint/RCCH Merger

Summary

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

The Company accounted for the LifePoint/RCCH Merger in accordance with ASC 805 under the acquisition method of accounting. The results of operations of Legacy LifePoint are included in the Company's results of operations beginning on November 17, 2018. Revenues from the operations acquired in the LifePoint/RCCH Merger included in the Company's consolidated statements of operations were $754.9 million for the year ended December 31, 2018. Income before income taxes from the operations acquired in the LifePoint/RCCH Merger was $50.9 million for the year ended December 31, 2018.

For the years ended December 31, 2019 and 2018, the Company recognized merger and integration-related costs of $47.1 and $134.7 million, respectively, primarily related to legal and transaction advisory services as well as employee severance and retention and other integration-related expenses in connection with the LifePoint/RCCH Merger. Included in the 2018 merger-related costs is a $55.0 million transaction fee paid by the Company to an affiliate of its Sponsor upon the closing of the LifePoint/RCCH Merger.

Equity Contribution

In connection with the LifePoint/RCCH Merger, the Apollo Funds, together with certain other co-investors investing through a co-investment vehicle controlled by the Company's Sponsor or its affiliates, indirectly contributed $1,000.0 million of newly invested capital to DSB Parent, which is the Company's indirect parent and is owned by the Apollo Funds, such co-investment vehicle and certain current or former directors, members of management, employees and consultants of the Company, and the $1,000.0 million of newly invested capital was further contributed to the Company to be used to partially fund the LifePoint/RCCH Merger.

Financing Transactions

Concurrently with the closing of the LifePoint/RCCH Merger, the Company (1) issued $1,425.0 million principal amount of 9.750% Senior Notes due 2026 (the "9.75% Unsecured Notes"), (2) entered into a new senior secured asset-based revolving credit facility (the "ABL Facility") in an aggregate principal amount of $800.0 million with a maturity of five years, (3) terminated its existing senior secured asset-based revolving credit facility, entered into on April 29, 2016 (the "Prior ABL Facility"), (4) entered into a senior secured term loan credit facility (the "Term Loan Facility") in an aggregate principal amount of $3,550.0 million with a maturity of seven years, and (4) repaid in full its $150.0 million term loan facility, entered into on April 25, 2018 (the "Prior Term Facility").

Acquisitions

Lourdes Health ("Lourdes")

At the close of business on August 31, 2018, the Company acquired Lourdes for $21.3 million, of which $17.5 million was financed from a sale-leaseback transaction with an affiliate of Medical Properties Trust ("MPT"), a Maryland corporation operating as a real estate investment trust. Lourdes is comprised of a 95 bed medical center and a 32 bed counseling center each located in Pasco, Washington. The results of operations of Lourdes are included in the Company's results of operations beginning on September 1, 2018.

Trios Health ("Trios")

At the close of business on August 3, 2018, the Company acquired Trios for $18.0 million. Trios is comprised of two hospital campuses with a total of 111 beds each located in Kennewick, Washington. In connection with the Trios acquisition, the Company entered into a sale-leaseback arrangement for a hospital building whose rent is contingent on the financial performance of the hospital and a sale-leaseback arrangement for a medical office building. The results of operations of Trios are included in the Company's results of operations beginning on August 4, 2018.

Pacific Medical Data Solutions ("PMDS")

Effective April 1, 2018, the Company acquired PMDS for $10.7 million. PMDS is a healthcare technology and software services company that provides revenue cycle, billing automation and software solutions to multi-specialty physician groups, ambulatory surgery centers and urgent care clinics.

Divestitures

Capital Medical Center

On December 23, 2020, the Company entered into a definitive agreement with an unrelated third-party to sell its majority ownership interest in Capital Medical Center, located in Olympia, Washington. Upon entry into the definitive agreement, the Company received a deposit of $5.0 million from the purchaser, which is included under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheet at December 31, 2020. The Company anticipates receiving additional cash proceeds of approximately $35.0 million upon the close of the transaction in exchange for its majority ownership interest, subject to the finalization of net working capital, in addition to the purchaser's assumption of certain finance lease obligations. The Company expects the transaction to close during the first half of 2021.

In connection with the entry into a definitive agreement to sell the Company's majority ownership interest in Capital Medical Center, the Company reclassified $142.9 million in total assets, comprised of property and equipment, allocated goodwill and working capital assets, and $129.4 million in total liabilities, comprised of finance lease obligations and working capital liabilities, to assets and liabilities held for sale, which are included under the captions "Other current assets" and "Other current liabilities", respectively, in the Company's accompanying consolidated balance sheet at December 31, 2020.

Teche Regional Medical Center ("Teche")

Effective October 1, 2019, the Company terminated its lease of Teche, located in Morgan City, Louisiana, and transferred the owned assets and operations of Teche to a new operator. Included in the Company's consolidated results of operations for the years ended December 31, 2019 and 2018 are net operating losses before income taxes attributable to Teche of $1.4 million and $0.6 million, respectively.

Joint Ventures

Emory Healthcare

Effective January 1, 2020, the Company formed a new joint venture with Emory Healthcare, Inc. ("Emory") to operate St. Francis Hospital ("St. Francis") located in Columbus, Georgia. Upon formation of the joint venture, the Company reclassified $26.1 million of its equity in St. Francis to redeemable noncontrolling interests representing the estimated fair value of Emory's ownership interest in St. Francis. The Company maintains a controlling interest in St. Francis such that it will continue to be included in the Company's consolidated financial statements. Additionally, the Company retained 100% ownership of the real and personal property of St. Francis through a wholly-owned subsidiary of the Company and leases such real and personal property to the joint venture.

In-Home Healthcare Partnership

The Company maintains a joint venture with a wholly-owned subsidiary of LHC Group, Inc. ("LHC"), In-Home Healthcare Partnership ("IHHP"), the purpose of which is to own and operate the Company's home health agencies and hospices and certain of LHC's home health agencies and hospices. The Company accounts for its ownership interest in IHHP as an equity method investment in accordance with ASC 323, "Investments." Effective January 1, 2020, the Company sold a portion of its ownership interest in IHHP to LHC for cash proceeds of $23.6 million.

Note 4. Long-Term Debt

The Company's long-term debt, including current portions and finance leases, consists of the following at December 31, 2020 and 2019 (in millions):

	2020	2019 [(a)]
Senior borrowings:		
ABL Facility	$ -	$ -
Term Loan Facility	3,214.5	3,523.4
6.75% Secured Notes	600.0	-
4.375% Secured Notes	600.0	-
8.25% Secured Notes	-	800.0
9.75% Unsecured Notes	1,425.0	1,425.0
5.375% Unsecured Notes	500.0	-
11.5% Unsecured Notes	-	350.0
Finance lease obligations	1,048.2	1,128.3
Unamortized debt issuance costs and premium	(151.8)	(191.8)
	7,235.9	7,034.9
Subordinated borrowings, net	-	1.6
Total debt	$ 7,235.9	$ 7,036.5

(a) The Company's finance lease obligations as of December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

Maturities of the Company's long-term debt outstanding at December 31, 2020, excluding finance lease obligations and unamortized debt issuance costs and premium, are as follows for the years indicated (in millions):

2021	$	-
2022		-
2023		-
2024		-
2025		3,814.5
Thereafter		2,525.0
	$	6,339.5

ABL Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Company and Legend Merger Sub (together, prior to the effective time of the LifePoint/RCCH Merger, the "Co-Borrowers") entered into the ABL Facility in an aggregate principal amount of $800.0 million with a maturity of five years. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint assumed all of the rights and obligations of Legend Merger Sub under the ABL Facility. The ABL Facility also includes both a letter of credit sub-facility and a swingline loan sub-facility (including in its capacity as co-borrower under the Term Loan Facility) entered into between the Co-Borrowers on November 16, 2018. In addition, the Company may request one or more incremental revolving commitments in an aggregate principal amount up to the greater of (x) the greater of (i) $255.0 million and (ii) 0.23 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, and (y) the amount by which the borrowing base exceeds the aggregate commitments under the ABL Facility, subject to certain conditions and receipt of commitments by existing or additional lenders.

As of December 31, 2020, the Company had no borrowings outstanding under the ABL Facility and approximately $45.3 million in letters of credit outstanding primarily related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements. Amounts available for borrowing under the ABL Facility were approximately $538.8 million as of December 31, 2020.

Collateral and Guarantors

All obligations under the ABL Facility are unconditionally guaranteed by DSB Acquisition, LLC, a Delaware limited liability company ("Holdings"), on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Co-Borrowers, subject to certain exceptions.

The obligations under the ABL Facility are secured by a pledge of the capital stock of the Co-Borrowers and substantially all of their assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy LifePoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the "ABL Priority Collateral" (which generally includes most accounts receivable and certain related assets of the Co-Borrowers and the subsidiary guarantors) and a second-priority lien with respect to the "Non-ABL Priority Collateral" (which generally includes most inventory and fixed assets, equity interests and intellectual property of the Co-Borrowers and the subsidiary guarantors). Additionally, certain of the Company's restricted subsidiaries that are not guarantors will pledge certain of their assets (the "Credit Support Party Collateral") on a first-priority basis, as further security of the obligations under the ABL Facility. The Credit Support Party Collateral will secure only the obligations under the ABL Facility.

All borrowings under the ABL Facility are subject to the satisfaction of customary conditions, including the absence of a default and the accuracy of representations and warranties.

Interest Rates and Fees

Borrowings under the ABL Facility bear interest at a rate equal to, at the Company's option, either (a) a London Interbank Offered Rate ("LIBOR") rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an initial applicable margin of 1.75% for LIBOR loans and 0.75% for base rate loans. The applicable margin for borrowings is subject to step-downs based on average availability thresholds.

In addition to paying interest on outstanding principal under the ABL Facility, the Co-Borrowers are required to pay a commitment fee under the ABL Facility in respect of the unutilized commitments under the ABL Facility at an initial rate equal to 0.375% per annum. The commitment fee may be subject to one step-down based on the average daily utilization under the ABL Facility. The Co-Borrowers will also be required to pay customary agency fees as well as letter of credit participation fees.

Restrictive Covenants and Other Matters

The ABL Facility contains certain customary affirmative covenants and events of default. The negative covenants in the ABL Facility include, among other things, limitations (none of which are absolute) on the Co-Borrowers and their subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates, enter into sale-leaseback transactions, change their lines of business, restrict dividends from their subsidiaries or restrict liens, change their fiscal year, and modify the terms of certain debt.

The ABL Facility requires that the Co-Borrowers and its restricted subsidiaries maintain a minimum fixed charge coverage ratio of not less than 1.00 to 1.00 at any time when availability is less than an agreed amount.

The ABL Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the ABL Facility are entitled to take various actions, including the acceleration of amounts due under the ABL Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the ABL Facility.

ABL FILO Term Loan

On April 13, 2020, the Company executed the ABL Facility Amendment that provided for an $80.0 million last-out term loan (the "ABL FILO Term Loan") with a maturity of 364 days, which was incremental to the existing $800.0 million of revolving commitments under the ABL Facility. The ABL FILO Term Loan was fully drawn at closing of the ABL Facility Amendment and then subsequently repaid in full on December 14, 2020, which effectively terminated the ABL FILO Term Loan.

Term Loan Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Co-Borrowers entered into the Term Loan Facility, which is a senior secured term loan credit facility in an aggregate principal amount of $3,550.0 million with a maturity of seven years. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint assumed all of the rights and obligations of Legend Merger Sub under the Term Loan Facility (including in its capacity as a Co-Borrower under the Term Loan Facility). In addition, the Company may request one or more incremental commitments in an aggregate principal amount up to the sum of (x) the greater of (i) $800.0 million and (ii) 0.75 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, plus additional amounts subject to certain agreed leverage requirements, certain other conditions and receipt of commitments by existing or additional lenders.

On January 21, 2020, the Company amended its Term Loan Facility to, among other things, reduce the applicable interest rate margin for the term loans by 0.75% to 3.75% with respect to LIBOR-based loans and 2.75% with respect to base rate loans.

On January 23, 2020, the Company made a prepayment of $400.0 million of term loans outstanding under the Term Loan Facility with a portion of the net proceeds from the sale-leaseback transaction with Medical Properties Trust completed effective December 17, 2019 (the "2019 Sale Leaseback Transaction"), which is discussed further in Note 8. After giving effect to the prepayment, the Company had prepaid all remaining quarterly amortization payments in respect of the Term Loan Facility.

On February 24, 2020, the Company closed the issuance of $600.0 million of incremental term loans (the "Incremental Term Loan") under the Term Loan Facility. The Incremental Term Loan bears interest at a rate equal to, at its option, (a) a LIBOR rate plus an applicable margin of 3.75% or (b) a base rate plus an applicable margin of 2.75%. There are no scheduled amortization payments required on the Incremental Term Loan prior to maturity. The net proceeds from the Incremental Term Loan, together with the net proceeds from the 4.375% Secured Notes and cash on hand, was used to fund the settlement of the tender offer, the redemption of the Company's 8.25% Senior Secured Notes due 2023 (the "8.25% Secured Notes") and the redemption of the Company's 11.5% Senior Notes due 2024 (the "11.5% Unsecured Notes") and to pay certain fees in connection with the refinancing transactions described herein.

On December 4, 2020, the Company made an optional prepayment of $500.0 million of term loans outstanding under the Term Loan Facility with the net proceeds from the offering of $500.0 million in aggregate principal amount of 5.375% Senior Notes due 2029 (the "5.375% Unsecured Notes"), together with cash on hand.

Collateral and Guarantors

All obligations under the Term Loan Facility are unconditionally guaranteed by Holdings on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Co-Borrowers, subject to certain exceptions. The obligations under the Term Loan Facility are secured by a pledge of the capital stock of the Company and substantially all of its assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy LifePoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the Non-ABL Priority Collateral and a second-priority lien with respect to the ABL Priority Collateral.

Interest Rates

Borrowings under the Term Loan Facility bear interest at a rate equal to, at the Company's option, either (a) a LIBOR rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an applicable margin of 3.75% for LIBOR loans and 2.75% for base rate loans.

Restrictive Covenants and Other Matters

The Term Loan Facility contains certain customary affirmative covenants and events of default. The negative covenants in the Term Loan Facility include, among other things, limitations (none of which are absolute) on the Co-Borrowers and their subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates enter into sale-leaseback transactions, change their lines of business, restrict dividends from subsidiaries or restrict liens, change their fiscal year and modify the terms of certain debt or organizational agreements.

The Term Loan Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the Term Loan Facility are entitled to take various actions, including the acceleration of amounts due under the Term Loan Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the Term Loan Facility.

6.75% Secured Notes

On April 13, 2020, the Company completed the offering of $600.0 million in aggregate principal amount 6.750% Senior Secured Notes due 2025 (the "6.75% Secured Notes"). The 6.75% Secured Notes will mature on April 15, 2025. Interest on the 6.75% Secured Notes will accrue at 6.75% per annum and will be paid semi-annually, in arrears, on April 15 and October 15 of each year, beginning October 15, 2020. The net proceeds from the offering were used for general corporate purposes.

The Company's obligations under the 6.75% Secured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Term Loan Facility and the 4.375% Senior Secured Notes due 2027 (the "4.375% Secured Notes"). The 6.75% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 6.75% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority Collateral.

Prior to April 15, 2022, the Company may redeem the 6.75% Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 6.75% Secured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to April 15, 2022, the Company may also redeem up to 40% of the original aggregate principal amount of the 6.75% Secured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 106.750%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 6.75% Secured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after April 15, 2022, the Company may redeem the 6.75% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of April 13, 2020 (as amended or supplemented from time to time, the "6.75% Secured Notes Indenture").

The 6.75% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions as described in the 6.75% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 6.75% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 6.75% Secured Notes Indenture also provides for customary events of default.

4.375% Secured Notes

On February 13, 2020, the Company completed the offering of $600.0 million in aggregate principal amount of its 4.375% Secured Notes. The 4.375% Secured Notes will mature on February 15, 2027. Interest on the 4.375% Secured Notes will accrue at 4.375% per annum and will be paid semi-annually, in arrears, on February 15 and August 15 of each year, beginning August 15, 2020. The net proceeds from the offering, together with the net proceeds from the Incremental Term Loan and cash on hand, were used to fund the settlement of the tender offer, the 8.25% Notes Redemption (as defined herein) and the 11.5% Notes Redemption (as defined herein) and to pay certain fees in connection with the refinancing transactions described herein.

The Company's obligations under the 4.375% Secured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Term Loan Facility. The 4.375% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 4.375% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority Collateral.

Prior to February 15, 2022, the Company may redeem the 4.375% Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 4.375% Secured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to February 15, 2022, the Company may also redeem up to 40% of the original aggregate principal amount of the 4.375% Secured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 104.375%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 4.375% Secured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after February 15, 2022, the Company may redeem the 4.375% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of February 13, 2020 (as amended or supplemented from time to time, the "4.375% Secured Notes Indenture").

The 4.375% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions as described in the 4.375% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 4.375% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 4.375% Secured Notes Indenture also provides for customary events of default.

9.75% Unsecured Notes

On November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Company issued $1,425.0 million aggregate principal amount of 9.75% Unsecured Notes. The 9.75% Unsecured Notes will mature on December 1, 2026. Interest on the 9.75% Unsecured Notes accrues at 9.750% per annum and will be paid semi-annually, in arrears, on June 1 and December 1 of each year, beginning June 1, 2019.

The Company's obligations under the 9.75% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 9.75% Unsecured Notes and the related guarantees are unsecured obligations of the Company and the subsidiary guarantors.

Prior to December 1, 2021, the Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 9.75% Unsecured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. Additionally, prior to December 1, 2021, the Company may redeem in the aggregate up to 40% of the aggregate principal amount of the 9.75% Unsecured Notes in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 109.750%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 9.75% Unsecured Notes must remain outstanding after each such redemption. On or after December 1, 2021, the Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of November 16, 2018 (as amended or supplemented from time to time, the "9.75% Unsecured Notes Indenture").

The 9.75% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 9.75% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 9.75% Unsecured Notes Indenture also provides for customary events of default.

5.375% Unsecured Notes

On December 4, 2020, the Company completed the offering of $500.0 million in aggregate principal amount of its 5.375% Unsecured Notes. The 5.375% Unsecured Notes will mature on January 15, 2029. Interest on the 5.375% Unsecured Notes will accrue at 5.375% per annum and will be paid semi-annually, in arrears, on January 15 and July 15 of each year, beginning July 15, 2021. The net proceeds of the offering, together with cash on hand, were used to prepay $500.0 million of the total aggregate principal amount outstanding under the Term Loan Facility and to pay related fees and expenses in connection with the offering.

The Company's obligations under the 5.375% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 5.375% Unsecured Notes and the related guarantees are unsecured obligations of the Company and the subsidiary guarantors.

Prior to January 15, 2024, the Company may redeem the 5.375% Unsecured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 5.375% Unsecured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to December 4, 2023, the Company may also redeem up to 40% of the original aggregate principal amount of the 5.375% Unsecured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 105.375%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 5.375% Unsecured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after January 15, 2024, the Company may redeem the 5.375% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of December 4, 2020 (the "5.375% Unsecured Notes Indenture").

The 5.375% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 5.375% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 5.375% Unsecured Notes Indenture also provides for customary events of default.

Tender Offer, Redemption and Discharge of 8.25% Secured Notes and 11.5% Unsecured Notes

On February 7, 2020, the Company commenced a tender offer and consent solicitation (the "tender offer") to purchase any and all of its outstanding (i) 8.25% Secured Notes issued pursuant to the indenture, dated as of April 29, 2016, among the Company, the guarantors party thereto and Wilmington Trust, National Association, as trustee (as amended, supplemented or otherwise modified, the "8.25% Secured Notes Indenture") and (ii) 11.5% Unsecured Notes issued pursuant to the indenture, dated as of April 29, 2016, among the Company, the guarantors party thereto and Wilmington Trust, National Association, as trustee (as amended, supplemented or otherwise modified, the "11.5% Unsecured Notes Indenture"). The early tender deadline for the tender offer was February 21, 2020, and the expiration date for the tender offer was March 6, 2020.

Upon expiration of the early tender deadline, on February 24, 2020, the Company accepted and purchased (i) $622.5 million of the aggregate principal amount of the 8.25% Secured Notes that were validly tendered for total consideration of $1,052.50 per $1,000 principal amount, plus accrued and unpaid interest thereon, and (ii) $84.1 million of the aggregate principal amount of the 11.5% Unsecured Notes that were validly tendered for a total consideration of $1,072.50 per $1,000 principal amount, plus accrued and unpaid interest thereon. Following the expiration of the tender offer, on March 9, 2020, the Company accepted and purchased an additional $0.2 million of the aggregate principal amount of the 8.25% Secured Notes that were validly tendered after the early tender deadline for a tender consideration of $1,022.50 per $1,000 principal amount, plus accrued and unpaid interest thereon. No additional 11.5% Unsecured Notes were tendered after the early tender deadline.

On March 9, 2020, (i) pursuant to the 8.25% Secured Notes Indenture, the Company provided notice to the holders that it had elected to redeem any and all of the 8.25% Secured Notes that remain outstanding after giving effect to the tender offer at a redemption price of 104.125%, plus accrued and unpaid interest thereon, on May 1, 2020 (the "8.25% Notes Redemption") and (ii) pursuant to the 11.5% Unsecured Notes Indenture, the Company provided notice to the holders that it had elected to redeem any and all of the 11.5% Unsecured Notes that remain outstanding after giving effect to the tender offer at a redemption price of 105.750%, plus accrued and unpaid interest thereon, on May 1, 2020 (the "11.5% Notes Redemption"). Concurrently with the delivery of the notices of redemption, on March 9, 2020, the Company (i) irrevocably deposited with the trustee for the 8.25% Secured Notes approximately $191.9 million, which was the amount sufficient to fund the 8.25% Notes Redemption and to satisfy and discharge the Company's obligations under the 8.25% Secured Notes and the 8.25% Secured Notes Indenture, and (ii) irrevocably deposited with the trustee for the 11.5% Unsecured Notes approximately $296.5 million, which was the amount sufficient to fund the 11.5% Notes Redemption and to satisfy and discharge the Company's obligations under the 11.5% Unsecured Notes and the 11.5% Unsecured Notes Indenture.

Debt Transaction Costs

During the year ended December 31, 2020, the Company recognized $115.4 million of debt transaction costs associated with the various debt financing activities completed during 2020. These debt transaction costs were comprised of $61.4 million of early termination premiums associated with the tender offer, 8.25% Notes Redemption and 11.5% Notes Redemption, the write-off of $47.4 million of previously capitalized debt issuance costs associated with the Term Loan Facility, the 8.25% Secured Notes and the 11.5% Unsecured Notes and $6.6 million of other miscellaneous legal and financing costs.

During the year ended December 31, 2018, the Company recognized $8.2 million of debt transaction costs associated with the extinguishment of the Prior ABL Facility and the Prior Term Facility.

Additionally, in connection with the offering of the 5.375% Unsecured Notes, the 6.75% Secured Notes, the 4.375% Secured Notes, the issuance of the Incremental Term Loan and the ABL FILO Term Loan, the Company capitalized $34.8 million of new debt issuance costs during the year ended December 31, 2020, which are included as a reduction to "Long-term debt, net" on the Company's accompanying consolidated balance sheet.

Finance Lease Obligations

Refer to Note 8 for discussion of the Company's finance lease obligations.

Interest Rate Swap Agreement

On December 21, 2018, the Company entered into an interest rate swap agreement with Citibank, N.A. as counterparty (the "Interest Rate Swap") whereby the Company pays a fixed rate of 2.63% on a notional amount of $1,100.0 million and receives one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and is scheduled to mature on February 19, 2022. Refer to Note 11 for additional information regarding the Company's accounting for its Interest Rate Swap.

Note 5. Goodwill and Intangible Assets

Goodwill

The following table presents the changes in the carrying amount of goodwill for the years ended December 31, 2020 and 2019 (in millions):

Balance at January 1, 2019	$	2,567.6
Finalization of purchase price allocations for the LifePoint/RCCH Merger		381.1
Adjustments related to acquisitions		17.0
Impairments		(3.3)
Write-off allocation related to IHHP transactions		(1.2)
Balance at December 31, 2019		2,961.2
Acquisitions of ancillary businesses		0.6
Allocation to assets held for sale related to Capital Medical Center		(41.2)
Write-off allocation related to IHHP transaction		(2.1)
Balance at December 31, 2020	$	2,918.5

Prior to the LifePoint/RCCH Merger, the Company historically determined that each of its hospitals represented a reporting unit in accordance with ASC 280 and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that the consolidated business comprises a single reporting unit for goodwill impairment testing purposes. There have been no changes in the Company's determination of reporting units for the year ended December 31, 2020.

Under the current methodology, for which the consolidated Company comprises a single reporting unit, the Company performed goodwill impairment tests as of October 1, 2020 and 2019 and did not incur any impairment charges. Under the prior reporting unit methodology, for which each of the Company's hospitals represented a reporting unit, the Company performed a goodwill impairment test as of October 1, 2019 and recorded a non-cash impairment charge of $3.3 million for the year ended December 31, 2019 related to one of its facilities. Additionally, for the year ended December 31, 2018, the Company recorded non-cash impairment charges in the aggregate of $53.9 million related to three of its facilities.

Intangible Assets

The following table provides information regarding the Company's intangible assets included in the accompanying consolidated balance sheets as of December 31, 2020 and 2019 (in millions):

	2020	2019 [(a)]
Amortizable intangible assets:		
Contract-based physician minimum revenue guarantees		
Gross carrying amount	$ 28.3	$ 34.7
Accumulated amortization	(12.1)	(12.7)
Net total	16.2	22.0
Other amortizable intangible assets		
Gross carrying amount	3.2	4.4
Accumulated amortization	(2.4)	(2.3)
Net total	0.8	2.1
Total amortizable intangible assets		
Gross carrying amount	31.5	39.1
Accumulated amortization	(14.5)	(15.0)
Net total	17.0	24.1
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	29.3	29.3
Licenses, provider numbers, accreditations and other	12.0	12.0
Net total	41.3	41.3
Total intangible assets:		
Gross carrying amount	72.8	80.4
Accumulated amortization	(14.5)	(15.0)
Net total	$ 58.3	$ 65.4

(a) Certain of the Company's other amortizable intangible assets as of December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

Contract-Based Physician Minimum Revenue Guarantees

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or "physician minimum revenue guarantees," with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460, "Guarantees" ("ASC 460"). In accordance with ASC 460, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized as a component of other operating expenses, in the accompanying consolidated statements of operations, over the period of the physician contract, which typically ranges from four to five years. As of December 31, 2020 and 2019, the Company's liability for contract-based physician minimum revenue guarantees was $8.3 million and $9.3 million, respectively. These amounts are included as a current liability under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheets.

Other Amortizable Intangible Assets

The Company has various other amortizable intangible assets that are amortized on a straight-line basis over the respective terms.

Certificates of Need and Certificates of Need Exemptions

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and certain equipment at the Company's facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. The Company has acquired facilities in certain states that have adopted certificate of need laws. The Company has determined that these intangible assets have an indefinite useful life.

Licenses, Provider Numbers, Accreditations and Other

To operate hospitals, the Company must obtain certain licenses, provider numbers and accreditations from federal, state and other accrediting agencies. The Company has acquired facilities in certain jurisdictions that require licenses, provider numbers and accreditations. The Company has determined that these intangible assets have an indefinite useful life.

Amortization Expense

Amortization expense for the Company's intangible assets during the years ended December 31, 2020, 2019 and 2018 was $8.6 million, $14.1 million and $4.7 million, respectively.

Total estimated amortization expense for the Company's intangible assets during the next five years are as follows (in millions):

2021	$ 8.1
2022	5.0
2023	2.5
2024	1.2
2025	0.2
Thereafter	-
	$ 17.0

Note 6. Income Taxes

For the year ended December 31, 2020, the Company recognized a benefit from income taxes of $63.7 million, compared to a provision for income taxes of $77.9 million and $0.2 million for the years ended December 31, 2019 and 2018, respectively. The benefit from income taxes recognized for the year ended December 31, 2020 was primarily a result of significant revisions to the U.S. corporate tax laws due to the enactment of the CARES Act. The Company was most notably impacted by an increase in the limitation in the tax deductibility of interest expense from 30% to 50% of adjusted taxable income for the years ended December 31, 2020 and 2019, as well as the ability to carry back net operating losses to each of the five tax years preceding the tax year of such loss.

The (benefit from) provision for income taxes for the years ended December 31, 2020, 2019 and 2018 consisted of the following (in millions):

	2020	2019	2018
Current:			
Federal	$ (72.5)	$ 67.5	$ -
State	7.8	8.2	1.3
	(64.7)	75.7	1.3
Deferred:			
Federal	98.7	(80.6)	(27.1)
State	38.4	(19.9)	(10.0)
	137.1	(100.5)	(37.1)
Change in valuation allowance	(136.1)	102.7	36.0
Total	$ (63.7)	$ 77.9	$ 0.2

The following table reconciles the differences between the statutory federal income tax rate to the Company's effective tax rate on net income (loss) before income taxes and including net income attributable to noncontrolling interests and redeemable noncontrolling interests for the years ended December 31, 2020, 2019 and 2018 (in millions):

	2020	2019	2018
Federal statutory rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal income tax benefits	3.8	(26.3)	2.2
Change in valuation allowance	(56.5)	171.0	(12.5)
Tax effect of goodwill write-offs and impairments	0.2	1.8	(2.3)
Noncontrolling interests and redeemable noncontrolling interests	(1.9)	(7.4)	0.4
State net operating loss carryforward expirations, refunds and rate change	10.4	-	-
Rate benefit from federal net operating loss carryback to 35% year	(3.8)	-	-
Nondeductible acquisition and merger-related costs	-	(24.2)	(8.2)
Other nondeductible expenses and other items	0.4	7.1	(0.7)
Effective income tax rate	(26.4) %	143.0 %	(0.1) %

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects were as follows as of December 31, 2020 and 2019 (in millions):

	2020	2019 [(a)]
Deferred income tax liabilities:		
Depreciation and amortization	$ (61.2)	$ (37.6)
Right-of-use operating lease assets	(99.0)	(98.4)
Tax deductible goodwill	(29.2)	(18.3)
Other	(6.2)	(6.3)
Total deferred income tax liabilities	(195.6)	(160.6)
Deferred income tax assets:		
Provision for doubtful accounts	63.8	48.1
Employee compensation	64.0	45.9
Acquisition and start-up costs	3.7	15.6
Net operating loss carryforwards	98.8	220.6
Insurance reserves	72.5	67.5
Prepaid rent	17.6	16.4
Section 163(j) interest expense carryforward	14.1	81.8
Investments in partnerships	60.3	14.3
Right-of-use operating lease obligations	99.9	99.6
Other	42.6	27.1
Total deferred income tax assets	537.3	636.9
Valuation allowance	(360.1)	(493.6)
Net deferred income tax assets	177.2	143.3
Deferred income taxes	$ (18.4)	$ (17.3)

(a) The Company's deferred income taxes as of December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

Noncurrent deferred income tax liabilities totaled $18.4 million and $17.3 million at December 31, 2020 and 2019, respectively. As of December 31, 2020, the Company had no federal net operating loss carryforwards ("NOLs") and state and local NOLs of approximately $1.9 billion that expire at various dates between 2021 and 2039. The Company has established a valuation allowance for deferred tax assets at December 31, 2020 and 2019, due to the uncertainty of realizing these assets in the future. The valuation allowance decreased $133.5 million during the year ended December 31, 2020, primarily as a result of the projected utilization of all federal NOLs, as well as the significant revisions to the U.S. corporate tax laws due to the enactment of the CARES Act.

The Company made federal income tax payments of $33.0 million for the year ended December 31, 2020. No federal income tax payments were made during the years ended December 31, 2019 or 2018. Net refunds of federal income taxes paid by Legacy LifePoint for tax years ended December 31, 2017 and November 16, 2018 in the amount of $59.5 million and $54.1 million were received during the years ended December 31, 2019 and 2018, respectively. The tax year 2017 refund resulted from an automatic accounting method change, for tax purposes, relating to income recognition made by Legacy LifePoint. The November 16, 2018 tax year-end refund resulted from estimated tax payments made by Legacy LifePoint prior to the announced LifePoint/RCCH Merger that were not needed due to the taxable loss generated for the year. The Company made net state and local income tax payments in the amount of $5.0 million, $1.0 million, and $0.4 million for the years ended December 31, 2020, 2019 and 2018, respectively.

The Company's policy is to accrue interest and penalties related to potential underpayment of income taxes within the provision for income taxes. Interest is computed on the difference between the Company's uncertain tax benefit positions and the amount deducted or expected to be deducted in our income tax returns.

The Company files a consolidated U.S. federal income tax return, as well as income tax returns in various state jurisdictions. All of the Company's tax years are subject to examination by the Internal Revenue Service and various state taxing authorities.

Note 7. Other Current Liabilities

The following table provides information regarding the Company's other current liabilities, which are included in the accompanying consolidated balance sheets at December 31, 2020 and 2019 (in millions):

	2020	2019 [(a)]
Accrued interest	$ 33.4	$ 49.6
Current portion of self-insurance reserves	82.3	64.5
Self-insured medical benefits liabilities	37.7	53.8
Income taxes payable	-	71.8
Current portion of right-of-use operating lease obligations	44.2	43.9
Accrued property taxes	19.8	18.6
Liabilities held for sale	129.4	-
Accrued expenses and other	244.5	186.8
	$ 591.3	$ 489.0

(a) Certain of the Company's other current liabilities as of December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. Refer to Note 8 for additional information.

Note 8. Leases

Adoption of ASU 2016-02

The Company adopted ASU 2016-02 early, during the fourth quarter of 2020, with an effective transition date of January 1, 2019 and retrospective application. As a result, the accompanying consolidated financial statements as of and for the year ended December 31, 2019 have been restated in accordance with the adoption of ASU 2016-02. The Company applied certain available practical expedients to facilitate the adoption of ASU 2016-02, including the package of practical expedients to not reassess whether a contract is or contains a lease, the lease classification and the initial direct costs.

The following is a summary of the line items impacted by the adoption of ASU 2016-02 in the Company's consolidated statement of operations for the year ended December 31, 2019 (in millions):

	As Originally Reported	Adoption of ASU 2016-02	As Currently Reported
Other operating expenses, net	$ 2,140.6	$ 9.7	$ 2,150.3
Depreciation and amortization	$ 378.7	$ (2.2)	$ 376.5
Interest expense, net	$ 577.6	$ (9.0)	$ 568.6
Total expenses	$ 8,698.3	$ (1.5)	$ 8,696.8
Income before income taxes	$ 54.5	$ 1.5	$ 56.0
Net loss	$ (23.4)	$ 1.5	$ (21.9)
Net loss attributable to LifePoint Health, Inc.	$ (42.7)	$ 1.5	$ (41.2)

The adoption of ASU 2016-02 primarily impacted the Company's other operating expenses and interest expense as a result changes in the accounting classification of certain leases from finance to operating, in addition to the derecognition of interest expense associated with a variable lease agreement that was previously accounted for as a finance lease.

The following is a summary of the line items impacted by the adoption of ASU 2016-02 in the Company's consolidated balance sheet as of December 31, 2019 (in millions):

	As Originally Reported	Adoption of ASU 2016-02	As Currently Reported
Land	$ 236.1	$ (3.7)	$ 232.4
Buildings and improvements	$ 2,709.9	$ (83.0)	$ 2,626.9
Property and equipment	$ 4,478.2	$ (86.7)	$ 4,391.5
Accumulated depreciation	$ (618.8)	$ 2.3	$ (616.5)
Property and equipment, net of accumulated depreciation	$ 3,859.4	$ (84.4)	$ 3,775.0
Intangible assets, net	$ 73.5	$ (8.1)	$ 65.4
Other long-term assets	$ 380.0	$ 392.9	$ 772.9
Total assets	$ 9,680.9	$ 300.4	$ 9,981.3
Other current liabilities	$ 446.0	$ 43.0	$ 489.0
Current maturities of long-term debt	$ 69.9	$ (0.2)	$ 69.7
Total current liabilities	$ 1,175.8	$ 42.8	$ 1,218.6
Long-term debt, net	$ 7,106.2	$ (139.4)	$ 6,966.8
Other long-term liabilities	$ 361.4	$ 358.2	$ 719.6
Total liabilities	$ 8,643.4	$ 261.6	$ 8,905.0
Accumulated deficit	$ (424.5)	$ 38.8	$ (385.7)
Total LifePoint Health, Inc. equity	$ 863.8	$ 38.8	$ 902.6
Total equity	$ 889.7	$ 38.8	$ 928.5
Total liabilities and equity	$ 9,680.9	$ 300.4	$ 9,981.3

The adoption of ASU 2016-02 primarily impacted other long-term assets and other long-term liabilities as a result of the recognition of right-of-use operating lease assets and obligations, respectively, on the Company's balance sheet. Additionally, the Company derecognized real property assets and finance lease obligations associated with a variable lease agreement, as well as changes in the accounting classification of certain leases from finance to operating. Lastly, the Company recorded a one-time transition adjustment through equity as a result of the derecognition of real property assets and finance lease obligations associated with a variable lease agreement, as well as changes in the Company's deferred income taxes.

Summary

The Company leases real property and equipment under finance and operating leases. The leases expire at various times and have various renewal options. For leases with terms greater than 12 months, the Company records the related assets and obligations at the present value of lease payments over the term. Interest rates used in computing the present value of the lease payments are based on the Company's incremental borrowing rate at the inception of the lease. The Company's lease agreements generally require the Company to pay maintenance, repairs, taxes and insurance costs.

The following table presents certain information related to the Company's lease assets and liabilities at December 31, 2020 and 2019 (dollars in millions):

	Balance Sheet Classification	2020	2019
Assets:			
Finance leases	Property and equipment	$ 678.3	$ 742.2
Operating leases	Other long-term assets	367.5	392.8
Total lease assets		$ 1,045.8	$ 1,135.0
Liabilities:			
Current:			
Finance leases	Current maturities of long-term debt	$ 30.0	$ 23.6
Operating leases	Other current liabilities	44.2	43.9
Long-term:			
Finance leases	Long-term debt, net	1,018.2	1,104.7
Operating leases	Other long-term liabilities	334.8	355.2
Total lease liabilities		$ 1,427.2	$ 1,527.4
Weighted-average remaining term (in years):			
Finance leases		22.6	24.5
Operating leases		12.9	13.5
Weighted-average discount rate:			
Finance leases		7.9 %	8.0 %
Operating leases		8.9 %	8.9 %

The following table presents certain information related to finance and operating lease expense for the years ended December 31, 2020 and 2019 (in millions):

	Statement of Operations Classification	2020	2019
Finance lease expense:			
Amortization related to lease assets	Depreciation and amortization	$ 46.8	$ 27.8
Interest related to lease liabilities	Interest expense, net	90.5	36.3
Operating lease expense	Other operating expenses, net	85.6	80.5
Short-term, variable and other lease expense	Other operating expenses, net	47.4	47.8
Total lease expense		$ 270.3	$ 192.4

The following table presents supplemental cash flow information related to finance and operating leases for the years ended December 31, 2020 and 2019 (in millions):

	2020	2019
Operating cash flows related to operating leases	$ 128.0	$ 122.9
Operating cash flows related to finance leases	$ 82.0	$ 33.1
Financing cash flows related to finance leases	$ 20.1	$ 19.0

The following table reconciles the undiscounted cash flows to the finance and operating lease obligations included in the consolidated balance sheet at December 31, 2020 (in millions):

	Finance Leases	Operating Leases
2021	$ 102.5	$ 74.8
2022	162.1	67.9
2023	91.0	52.1
2024	91.1	44.9
2025	92.8	39.4
Thereafter	2,013.2	390.9
Total minimum lease payments	2,552.7	670.0
Less: amounts attributable to interest	(1,557.5)	(291.0)
Present value of minimum lease payments	995.2	379.0
Non-cash residual value of finance lease obligations	53.0	-
Less: current portion of lease obligations	(30.0)	(44.2)
Long-term portion of lease obligations	$ 1,018.2	$ 334.8

2019 Sale Leaseback Transaction

Effective December 17, 2019, certain subsidiaries of the Company (collectively, the "LifePoint Entities") entered into a Real Property Asset Purchase Agreement (the "Real Property APA") with certain subsidiaries of MPT (the "2019 Sale Leaseback Transaction"). Pursuant to the Real Property APA, the LifePoint Entities sold the real estate of eleven medical facilities (the "2019 Master Lease Facilities") to certain affiliates of MPT, and immediately thereafter certain LifePoint Entities and certain affiliates of MPT entered into an agreed upon Master Lease Agreement (the "2019 Master Lease") pursuant to which such LifePoint Entities now lease or sublease the land and the buildings associated with the 2019 Master Lease Facilities from certain affiliates of MPT. The 2019 Master Lease has an initial term of 20 years (the "Initial Term"). However, the LifePoint Entities who are parties to the 2019 Master Lease have the option to extend the Initial Term for two additional five-year periods.

In connection with the 2019 Sale Leaseback Transaction, the Company received an aggregate amount of sale proceeds of $700.0 million and incurred $18.1 million of transaction-related expenses, which is included under the caption "Merger, acquisition and other transaction-related expenses" in the accompanying consolidated statement of operations for the year ended December 31, 2019.

Lease Covenants

Certain of the Company's lease agreements contain financial covenants based on certain fixed charges. The failure to meet or obtain a waiver of such covenants or otherwise cure such non-compliance could result in an event of default under the applicable lease. The Company has received a waiver of compliance with respect to the financial covenants associated with its amended and restated lease agreement with affiliates of MPT related to Capital Medical Center through March 31, 2022. Additionally, as more fully discussed in Note 3, on December 23, 2020, the Company entered into a definitive agreement with an unrelated third-party to sell its ownership interest in Capital Medical Center.

Note 9. Investments

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, under the equity method of accounting in accordance with ASC 323. The Company does not consolidate its equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period. The Company's equity method investments totaled $255.6 million and $274.3 million at December 31, 2020 and 2019, respectively, and are included under the caption "Other long-term assets" in the accompanying consolidated balance sheets.

Note 10. Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling Interests

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

The following table presents the changes in the Company's noncontrolling interests during the years ended December 31, 2020 and 2019 (in millions):

Balance at January 1, 2019	$	29.9
Finalization of purchase price allocations for the LifePoint/RCCH Merger		(0.2)
Net income attributable to noncontrolling interests		4.4
Distributions		(8.2)
Balance at December 31, 2019		25.9
Net income attributable to noncontrolling interests		7.5
Distributions		(1.4)
Balance at December 31, 2020	$	32.0

Redeemable Noncontrolling Interests

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

The following table presents the changes in the Company's redeemable noncontrolling interests during the years ended December 31, 2020 and 2019 (in millions):

Balance at January 1, 2019	$	136.1
Finalization of purchase price allocations for the LifePoint/RCCH Merger		(4.6)
Net income attributable to redeemable noncontrolling interests		14.9
Fair value adjustments		11.2
Distributions and repurchases		(9.8)
Balance at December 31, 2019		147.8
Reclassification of equity to redeemable noncontrolling interests related to Emory joint venture		26.1
Net income attributable to redeemable noncontrolling interests		14.0
Fair value adjustments		5.0
Distributions and repurchases		(11.8)
Reclassification of redeemable noncontrolling interests related to Capital Medical Center to liabilities held for sale		(0.7)
Balance at December 31, 2020	$	180.4

Note 11. Fair Value of Financial Instruments

Fair Value Hierarchy

Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the fair value hierarchy pursuant to ASC 820, "Fair Value Measurements and Disclosures" ("ASC 820") that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

Level 1: Quoted market prices in active markets for identical assets or liabilities.
Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.
Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability.

Cash and Cash Equivalents, Accounts Receivable, Accounts Payable and Other Current Liabilities

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

Long-Term Debt

The carrying amounts and fair values of the Company's ABL Facility, Term Loan Facility, 6.75% Secured Notes, 4.375% Secured Notes, 8.25% Secured Notes, 9.75% Unsecured Notes, 5.375% Unsecured Notes and 11.5% Unsecured Notes, excluding unamortized debt issuance costs and premium, as of December 31, 2020 and December 31, 2019 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2020	December 31, 2019	December 31, 2020	December 31, 2019
ABL Facility	$ -	$ -	$ -	$ -
Term Loan Facility	$ 3,214.5	$ 3,523.4	$ 3,210.5	$ 3,549.8
6.75% Secured Notes	$ 600.0	$ -	$ 640.5	$ -
4.375% Secured Notes	$ 600.0	$ -	$ 600.0	$ -
8.25% Secured Notes	$ -	$ 800.0	$ -	$ 849.0
9.75% Unsecured Notes	$ 1,425.0	$ 1,425.0	$ 1,556.8	$ 1,610.3
5.375% Unsecured Notes	$ 500.0	$ -	$ 496.3	$ -
11.5% Unsecured Notes	$ -	$ 350.0	$ -	$ 376.3

The fair values of the Company's long-term debt instruments were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820.

Interest Rate Swap

The Company measures its Interest Rate Swap at fair value on a recurring basis. The fair value of the Company's Interest Rate Swap is based on quotes from its counterparty. The Company considers those inputs to be Level 2 in the fair value hierarchy. At December 31, 2020 and 2019, the fair value of the Company's Interest Rate Swap was a total liability of $31.2 million and $24.6 million, respectively, of which $26.5 million and $10.7 million, respectively, is included under the caption "Other current liabilities" and $4.7 million and $13.9 million, respectively, is included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheets.

The Company has not designated its Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging." Accordingly, all changes in the fair value of the Company's Interest Rate Swap are recognized through interest expense in its statement of operations. For the years ended December 31, 2020, 2019 and 2018, the Company recognized non-cash interest expense of $6.6 million, $18.8 million and $5.8 million, respectively, related to changes in the fair value of its Interest Rate Swap.

Changes in the fair value of the Company's Interest Rate Swap could result in a material effect on its consolidated results of operations and financial position; however, the Company does not anticipate that changes in the fair value of its Interest Rate Swap will have any impact on its cash flows. The counterparty to the Interest Rate Swap exposes the Company to credit risk in the event of nonperformance. However, the Company does not anticipate nonperformance by its counterparty. The Company does not hold or issue derivative financial instruments for trading purposes.

Financial Liabilities

The Company has a contingent consideration liability payable to the former owners of Canyon Vista Medical Center ("Canyon Vista") that represents the Level 3 estimated fair value of the contingent consideration using unobservable inputs and assumptions available to the Company. The key assumptions used in estimating the fair value of the Canyon Vista contingent consideration liability are the range of probabilities that the payments will be earned by the seller and a discount rate adjusted for the Company's credit risk.

At December 31, 2020 and 2019, the Canyon Vista contingent consideration liability was recorded at an estimated fair value of $18.8 million and $13.6 million, respectively, of which $2.0 million is included under the caption "Other current liabilities" at December 31, 2020, and $16.8 million and $13.6 million, respectively, is included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheets. For the year ended December 31, 2020, the Company recognized a non-cash charge of $5.2 million related to the change in the estimated fair value of the Canyon Vista contingent consideration liability, which is included under the caption "Other non-operating losses (gains), net" on the accompanying consolidated statement of operations.

Note 12. Employee Benefit Plans

Defined Benefit Pension Plans

In connection with the LifePoint/RCCH Merger, the Company acquired certain assets and assumed certain liabilities associated with two separate defined benefit pension plans (i) associated with certain employees of Marquette General Hospital covered by a collective bargaining agreement (the "Marquette Pension Plan") and (ii) associated with certain non-union employees of Bell Hospital (the "Bell Pension Plan" and, collectively with the Marquette Pension Plan, the "Pension Plans"). Both Pension Plans are closed to new participants. Participants in the Marquette Pension Plan are required to make annual contributions totaling 6% of annual compensation to the Marquette Pension Plan to continue accruing benefits. Participants in the Bell Pension Plan no longer accrue benefits. The Company makes contributions to the Pension Plans sufficient to meet its minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended.

Status and Expense

The following table presents the changes in the benefit obligations and plan assets of the Pension Plans during the years ended December 31, 2020 and 2019 and the unfunded liability of the Pension Plans at December 31, 2020 and 2019 (in millions):

	2020	2019
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 70.1	$ 58.6
Service costs	0.6	0.5
Interest costs	2.1	2.4
Participant contributions	0.3	0.3
Actuarial loss	5.6	10.2
Benefits paid	(2.1)	(1.9)
Benefit obligation at end of year	76.6	70.1
Change in plan assets:		
Fair value of plan assets at beginning of year	47.1	38.5
Actual return on plan assets	6.9	8.1
Employer contributions	2.1	2.1
Participant contributions	0.3	0.3
Benefits and expenses paid	(2.1)	(1.9)
Fair value of plan assets at end of year	54.3	47.1
Unfunded liability included in other long-term liabilities in the Company's accompanying consolidated balance sheet	$ 22.3	$ 23.0

The Company recognizes changes in the funded status of the Pension Plans as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). For the years ended December 31, 2020 and 2019, the Company recognized comprehensive losses of $1.3 million and $4.4 million, respectively, as decreases in stockholders' equity through accumulated other comprehensive loss. The adjustments were primarily related to changes in the Company's unfunded pension liability due to changes in the discount rates and mortality assumptions used to measure the projected benefit obligation.

The following table summarizes the projected benefit obligation, accumulated benefit obligation and fair value of plan assets related to the Pension Plans as of December 31, 2020 and 2019 (in millions):

	2020	2019
Projected benefit obligation	$ 76.6	$ 70.1
Accumulated benefit obligation	$ 71.7	$ 65.4
Fair value of plan assets	$ 54.3	$ 47.1

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligation as of December 31, 2020 and 2019 (in millions):

	2020	2019
Discount rate	2.5 %	3.1 %
Rate of compensation increases, when applicable	3.0 %	3.0 %

Plan Assets

The investment policy for the Pension Plans has been formulated to achieve a risk adjusted return that balances the need for asset growth against the risk of significant fluctuations in asset prices and the need for significant contributions from the Company. On a quarterly basis, or more frequently as necessary, the current risk levels, asset performance and expected return on assets are reviewed and evaluated against goals and targets by a committee appointed to oversee investment of the Pension Plans' assets (the "Investment Committee"). The Investment Committee strives to maintain a balance between risk and return through the use of modern portfolio theory methods, in conjunction with Monte Carlo modeling to evaluate the behavior of the portfolio under different scenarios. At December 31, 2020, the Pension Plans' investments include a balance of mutual funds and money market funds in order to achieve an overall rate of return that minimizes the need for additional employer contributions. The Company measures the fair value of its

Pension Plans' assets in accordance with ASC 820.

The Pension Plans' investments in mutual funds are valued at the net asset value ("NAV") of shares reported in the active market in which the funds are traded. Because quoted prices are available for mutual funds and the markets in which they are traded are generally considered active, the Company has classified each of them as a Level 1 investment. The Pension Plans' investments in money market funds are valued at quoted prices in markets that are not active by a combination of inputs, including but not limited to dealer quotes who are market makers in the underlying funds and other directly and indirectly observable inputs. Because the inputs used to value money market funds are either directly or indirectly observable, but are not quoted prices in active markets, the Company has classified these assets as Level 2 investments.

The following table summarizes the assets of the Pension Plans, measured at fair value as of December 31, 2020 and 2019, by major asset category and aggregated by level within the fair value hierarchy (in millions):

	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
December 31, 2020:				
Mutual funds	$ 52.6	$ 52.6	$ -	$ -
Money market funds	1.7	-	1.7	-
Total	$ 54.3	$ 52.6	$ 1.7	$ -
December 31, 2019:				
Mutual funds	$ 44.5	$ 44.5	$ -	$ -
Money market funds	2.6	-	2.6	-
Total	$ 47.1	$ 44.5	$ 2.6	$ -

The Company expects to contribute approximately $1.7 million to the Pension Plans during the year ended December 31, 2021. Additionally, the Company expects to make future benefit payments from the Pension Plans as follows for the years indicated (in millions):

2021	$ 2.5
2022	2.6
2023	2.9
2024	3.0
2025	3.2
Five years thereafter	18.0
	$ 32.2

Multiemployer Pension Plan

In connection with the LifePoint/RCCH Merger, the Company assumed the obligation to contribute to a multiemployer pension plan on behalf of certain employees covered by collective bargaining agreements, in accordance with the terms of such collective bargaining agreements. The Company's contributions to the multiemployer pension plan are determined based on the terms of the applicable collective bargaining agreements. Multiemployer plans are different from single-employer plans because assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers. Also, if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers. If the Company stops participating in the multiemployer plan, the Company may be required to pay a withdrawal liability based on its portion of the unfunded status of the plan. Currently, the Company does not anticipate ending its participation in this plan.

Defined Contribution Plans

The Company maintains two separate defined contribution retirement plans covering a majority of the Company's employees. These defined contribution plans contain discretionary matching contribution formulas and definite non-elective contribution formulas for employees at certain facilities. The Company's expense related to its defined contribution plans was $31.4 million, $31.2 million and $5.6 million for the years ended December 31, 2020, 2019 and 2018, respectively.

Deferred Compensation Plans

The Company maintains supplemental deferred compensation plans with respect to certain of its employees and affiliated physicians. As of December 31, 2020 and 2019, the assets associated with these deferred compensation plans were $56.1 million and $46.2 million, respectively, and the liabilities were $60.4 million and $48.1 million, respectively. These amounts are included under the captions "Other long-term assets" and "Other long-term liabilities", respectively, on the accompanying consolidated balance sheets at December 31, 2020 and 2019.

Note 13. Stock-Based Compensation

DSB Parent is authorized to issue Units to employees, executives, consultants and directors of the Company, under the DSB Parent Partnership Agreement. The Company has determined that the Units are a substantive class of members' equity for accounting purposes because the Units are legal equity of DSB Parent, they have participation features, including distribution and liquidation rights which allow them to participate in the residual returns of the DSB Parent and vested interests are retained upon termination. As a result, these awards are accounted for under ASC 718.

There are 35,270,000 aggregate number of Units authorized for issuance. Service Units and Performance Units have been issued under the DSB Parent Partnership Agreement and forms of award agreements. The following table summarizes the activity with regards to units available for grant under the Company's stock-based compensation plan for the years ended December 31, 2020, 2019 and 2018:

	Units Available for Grant
January 1, 2018	5,407,989
Granted	(3,073,000)
Forfeited	1,653,720
December 31, 2018	3,988,709
Authorized for grant	16,400,000
Granted	(17,749,956)
Repurchased	3,750,184
Forfeited	735,704
December 31, 2019	7,124,641
Granted	(5,352,467)
Repurchased	57,498
Forfeited	240,100
December 31, 2020	2,069,772

Service Units

Service Units have been granted to certain members of the board of directors and Tranche A Units to certain employees, executives and consultants. Units that have been granted to members of the board of directors vest on a time-basis only, either in three equal installments on each of the first three anniversaries of the grant date or on the date that is the earliest of (i) six months and one day following November 16, 2018 or (ii) the date of the applicable director's termination of service due to death, disability or as a result of the director's removal from the board of directors other than for cause. Tranche A Units granted to certain employees, executives and consultants vest in equal installments on the last day of each of the first twenty calendar quarters that commence on or after the grant date or, in some cases, November 16, 2018. Service Units will automatically vest upon the sale of the Company. In the event of an initial public offering, all unvested Service Units will remain outstanding and continue to vest based on the stated vesting pattern. Unvested Service Units are forfeited upon a holder's termination of service.

Service Units are accounted for as equity awards and related compensation expense is recognized ratably over the vesting period. For employees and executives granted Service Units prior to November 16, 2018 who are severed during the 18-month period following the LifePoint/RCCH Merger under certain circumstances, Tranche A Units vest in full upon the eligible employee's termination date. On November 16, 2018, Service Units originally issued to approximately 40 employees and executives were modified in connection with the LifePoint/RCCH Merger. The Company calculated the fair value of the service units before and after the modification and recorded expense of $1.2 million and $2.4 million for the years ended December 31, 2020 and 2019, respectively, related to the modification and acceleration of service units. As of December 31, 2020, Service Units had unrecognized compensation expense of $7.9 million. The expense is expected to be recognized over a weighted-average period of 1.9 years from December 31, 2020.

Performance Units

Performance Units, which have been granted as Tranche B Units and Tranche C Units, will vest based upon equity holders of DSB Parent realizing certain targeted multiples of invested capital ("MOIC thresholds"). Performance Units are accounted for as equity awards with expense recognition occurring upon the realization of the stated MOIC thresholds due to a liquidity event. For employees and executives granted Performance Units prior to November 16, 2018 who were severed in connection with the LifePoint/RCCH Merger, Tranche B units vest in full upon the eligible employee's termination date and Tranche C units are forfeited in accordance with the original terms and conditions of the applicable Profits Units award agreement. On November 16, 2018, Tranche B Units previously issued to approximately 40 employees and executives were modified in connection with the LifePoint/RCCH Merger. The Company calculated the fair value of the Tranche B Units before and after the modification and recorded expense of $1.2 million and $2.7 million for the years ended December 31, 2020 and 2019, respectively, related to the modification and acceleration of Tranche B Units. For Performance Units not modified in connection with the LifePoint/RCCH Merger, the Company determined that a liquidity event was not probable, therefore no compensation expense has been recognized related to the unmodified Performance Units. Unvested Units that do not vest on termination are forfeited upon such termination, subject to certain conditions.

The following table summarizes the Company's total stock-based compensation expense for the years ended December 31, 2020, 2019 and 2018 (in millions):

	2020	2019	2018
Service Units	$ 2.4	$ 3.5	$ 3.4
Performance Units	-	1.3	3.6
	2.4	4.8	7.0
Modification expense for awards classified as a liability	2.5	2.8	-
Total stock-based compensation expense	$ 4.9	$ 7.6	$ 7.0

Valuation Assumptions

The fair value of all Units was determined using a Monte Carlo simulation framework. The following table shows the weighted average assumptions used by the Company to develop the fair value estimates and the resulting estimates of weighted-average fair value per Unit granted during the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
Common equity value of the Company (in millions)	$ 1,999.0	$ 1,671.9	$ 624.1
Expected volatility	48.0 %	38.0 %	24.0 %
Risk-free interest rate	0.60 %	2.90 %	1.60 %
Expected dividends	-	-	-
Average expected term (years)	3.7	5.0	3.2

Units Activity

The following represents the activity of the Units for the years ended December 31, 2020, 2019 and 2018:

	Service Units		Performance Units			
	Tranche A and Units to the Board	Weighted Average Grant Date Fair Value per Unit	Tranche B	Weighted Average Grant Date Fair Value per Unit	Tranche C	Weighted Average Grant Date Fair Value per Unit
Unvested at January 1, 2018	3,801,029	$ 0.71	5,262,169	$ 0.41	2,631,085	$ 0.30
Granted	1,229,200	1.43	1,229,200	0.68	614,600	0.37
Vested	(2,054,331)	0.82	(1,636,959)	0.46	-	-
Forfeited	(266,140)	0.70	(379,400)	0.41	(1,008,180)	0.31
Unvested at December 31, 2018	2,709,758	0.97	4,475,010	0.47	2,237,505	0.31
Granted	6,996,576	1.23	6,868,920	0.80	3,884,460	0.63
Vested	(2,893,910)	1.07	(891,400)	0.54	-	-
Forfeited	(85,044)	1.18	(136,640)	0.60	(514,020)	0.38
Unvested at December 31, 2019	6,727,380	1.19	10,315,890	0.68	5,607,945	0.53
Granted	2,197,487	1.08	2,103,320	1.08	1,051,660	1.08
Vested	(2,217,947)	1.10	-	-	-	-
Forfeited	(75,100)	1.19	(110,000)	0.74	(55,000)	0.60
Unvested at December 31, 2020	6,631,820	$ 1.19	12,309,210	$ 0.75	6,604,605	$ 0.61

Note 14. Commitments and Contingencies

Capital Expenditure Commitments

The Company is reconfiguring some of its facilities to more effectively accommodate patient services and to provide for a greater variety of services. The Company has incurred approximately $84.9 million in costs related to uncompleted projects as of December 31, 2020, which is included under the caption “Construction in progress” in the Company’s accompanying consolidated balance sheet. At December 31, 2020, these uncompleted projects had an estimated cost to complete of approximately $124.0 million. The estimated timeframe for completion of these projects generally ranges from less than one year up to two years. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities. At December 31, 2020, the Company estimated its total remaining capital expenditure commitments to be approximately $1,174.7 million, which generally have remaining terms of two to six years. Of this amount, more than one half represents obligations at certain facilities for which commitments are computed as a percentage of revenues, ranging from three to five percent, and for which the commitment periods generally span over a longer period of time.

Legal Proceedings and General Liability Claims

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

In addition, the Company is subject to the regulation and oversight of various state and federal governmental agencies. Further, under the False Claims Act, private parties have the right to bring qui tam, or “whistleblower,” suits against healthcare facilities that submit false claims for payments to, or improperly retain identified overpayments from, governmental payers. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or “whistleblower” actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act’s requirements for filing such suits. As a result, they could be proceeding without the Company’s knowledge. If a provider is found to be liable under the False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus substantial civil monetary penalties that are subject to annual adjustment for inflation for each separate false claim.

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

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

On November 6, 2019, following an internal review conducted by the Company with the assistance of outside counsel, the Company and one of its hospitals and a related physician practice initiated a voluntary self-disclosure to the DOJ related to concerns regarding the medical necessity of certain interventional cardiology procedures performed at the hospital by a physician employed at the related physician practice and the appropriateness of that physician's coding for evaluation and management services. The related physician practice has terminated the employment of the physician who was the subject of the internal review and that physician no longer practices at the hospital. On October 28, 2020, the hospital and the related physician practice entered into a settlement agreement, the terms of which require the hospital and the related physician practice to pay approximately $14.7 million in exchange for a release of claims by the U.S. and provide that the agreement itself is not an admission of liability by the hospital or the related physician practice. The settlement was consistent with the amount previously accrued for loss contingencies related to this matter. It is reasonably possible that the Company could incur additional losses related to this matter, but the Company is not able to predict or estimate such amounts at this time.

The Company accrues an estimate for a contingent liability when losses are both probable and reasonably estimable. The Company reviews its accruals each quarter and adjusts them to reflect the impact of developments, advice of legal counsel and other information pertaining to a particular matter.

Note 15. Subsequent Events

In accordance with the provisions of ASC 855, "Subsequent Events," the Company evaluated all material events subsequent to the balance sheet date through March 4, 2021, the date of issuance, for events requiring disclosure or recognition in the Company's consolidated financial statements. There were no subsequent events requiring disclosure or recognition in the Company's consolidated financial statements.

SIGNATURES

LifePoint Health, Inc. has caused this Report to be signed on its behalf by the undersigned thereunto duly authorized.

LIFEPOINT HEALTH, INC.

Date: March 4, 2021

By: /s/ Michael S. Coggin
Michael S. Coggin
Executive Vice President and Chief Financial Officer

ANNUAL REPORT

OF

LIFEPOINT HEALTH, INC.

FOR THE

FISCAL YEAR ENDED DECEMBER 31, 2021

PREPARED IN ACCORDANCE WITH

ANNUAL REPORT ON FORM 10-K
(AS MODIFIED UNDER DEBT AGREEMENTS)

LifePoint Health, Inc.
(Exact Name of Company as Specified in Its Charter)

Delaware	**27-0500485**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**
330 Seven Springs Way Brentwood, Tennessee	**37027**
(Address of Principal Executive Offices)	**(Zip Code)**

(615) 920-7000
(Company's Telephone Number, Including Area Code)

LifePoint Health, Inc.

Annual Report

For the Fiscal Year Ended December 31, 2021

TABLE OF CONTENTS

DISCLOSURE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report for the fiscal year ended December 31, 2021 (this "***Report***") contains forward-looking statements that involve risks and uncertainties. Forward-looking statements include any statements that address future results or occurrences. In some cases, you can identify forward-looking statements by terminology such as: "may," "might," "will," "would," "should," "could" or the negatives thereof. Generally, the words "anticipate," "believe," "continue," "expect," "intend," "estimate," "project," "plan" and similar expressions identify forward-looking statements. In particular, statements about our expectations, beliefs, plans, objectives, assumptions or future events or performance contained elsewhere in this Report are forward-looking statements. These forward-looking statements include statements that are not historical facts, including statements concerning our possible or assumed future actions and business strategies. We have based these forward-looking statements on our current expectations, assumptions, estimates and projections. While we believe these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks, uncertainties and other factors, many of which are outside of our control, which could cause our actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. Such factors include, among others, the following:

- uncertainty about the effect that the Kindred Transaction (as defined in this Report) may have on our employees, patients, local communities, business relationships and other parties, and the possibility that the anticipated benefits from the Kindred Transaction will not be realized within the timeframe expected or at all;
- the length and severity of the novel coronavirus ("***COVID-19***") pandemic, the measures we are taking to respond to the pandemic, the vaccination rates in the communities we serve, the number and severity of variants of the virus, the effectiveness of vaccines against the virus (and any variants) on a widespread basis and the impact of vaccine mandates;
- negative impacts on patient volumes and operating revenues for elective procedures and services provided to non-COVID-19 patients and the uncertainty of future patient volumes and related revenues, including shifts from in-person patient services to telehealth services;
- the impact of sudden increases and fluctuations in the volume of COVID-19 patients cared for across our facilities;
- the impact of existing or future COVID-19 related government and administrative regulation and stimulus, including the Families First Coronavirus Response Act, the Coronavirus Aid, Relief, and Economic Security Act (the "***CARES Act***") and other COVID-19 relief or stimulus legislation, and how these programs are administered and monitored and may be modified in the future;
- supply shortages, workforce disruptions or shortages and increased costs of providing care to our patients, including increased equipment, staffing and supply expenses and increased length of patient stay resulting from the COVID-19 pandemic;
- the emergence of and effects related to other pandemics, epidemics and highly contagious infectious diseases;
- payment changes, including policy considerations and changes resulting from federal and state budgetary restrictions;
- impact from or likelihood of the repeal of, or material modification to, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "***Affordable Care Act***"), as a result of court or legislative action;
- potential impact from the repeal of the penalties associated with the "***individual mandate***" to purchase health insurance under the Affordable Care Act, included in the Tax Cuts and Jobs Act of 2017;
- impact from changes to or limitations on Medicaid supplemental payment programs;
- our compliance with new and existing laws and regulations, including laws and regulations adopted in connection with the COVID-19 pandemic, as well as costs and benefits associated with compliance;
- any potential action brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the "qui tam" or "whistleblower" provisions of the federal False Claims Act (the "***False Claims Act***");
- impact from the changes in payer mix marked by a shift of patients from private insurance to Medicare and Medicaid programs;
- our acquisition strategy, including integration risks relating to future acquisitions;
- the potential for material obligations if we acquire facilities with unknown or contingent liabilities;
- claims and legal actions relating to professional liabilities and other litigation risks;
- delayed payments and repayments resulting from reviews of claims to Medicare and Medicaid for our services;
- impact of controls imposed by payers designed to reduce inpatient services;
- risks associated with outsourcing functions to third parties;
- our relationships with our joint venture partners;
- changes in physician employment regulations;
- increases in the amount and risk of collectability of patient accounts receivable, particularly in connection with the increase in the unemployment rate and number of underinsured and uninsured patients as a result of the COVID-19 pandemic;
- our need to make investments continually in our processes and information systems to protect the privacy of patients, employees and other persons and reduce the risk of successful cybersecurity attacks;
- damage to our reputation, regulatory penalties, legal claims and liability under state and federal laws that we could suffer upon any cybersecurity or privacy breaches;
- anticipated capital expenditures, including routine projects, investments in information systems and capital projects related to acquisitions, construction of new facilities and construction projects and the expectation that capital commitments could be a component of future acquisitions;

- effects of competition in a facility's market;
- changes in industry and general economic trends, including macroeconomic conditions negatively impacted by the COVID-19 pandemic;
- recruitment and retention of senior executives, providers and other healthcare employees;
- our ability to acquire facilities on favorable terms and successfully complete asset sales and divestitures;
- effects of union organizing activities;
- potential recoupment of previously recognized income from electronic health record ("***EHR***") incentive programs;
- timeframes for completion of capital projects;
- changes in depreciation and amortization expenses;
- accounting estimates and the impact of accounting methodologies and new accounting pronouncements;
- changes in interpretations, assumptions and expectations regarding tax legislation, including provisions of the CARES Act, and additional guidance that may be issued by federal and state taxing authorities;
- consolidation of commercial insurance companies and patient shifts to lower cost healthcare plans, including association health plans and short-term limited duration health insurance plans, which generally provide lower payment for services rendered;
- participation in the healthcare insurance exchanges (the "***Exchanges***") and the impact of increasing enrollment by patients in insurance plans with narrow networks, tiered networks, high deductibles or high co-payments;
- governmental or third-party investigations, legal actions and voluntary self-disclosures relating to overpayments or other regulatory compliance matters;
- the ability of our local management teams to identify and meet the needs of our patients, medical staffs and their communities;
- the efforts of insurers, healthcare providers and others to contain healthcare costs;
- our ability to obtain adequate levels of general and professional liability insurance;
- our ability to implement initiatives promoting cost reductions and operational efficiencies;
- possible future indebtedness that may be incurred; and
- other factors referenced under the caption "Risk Factors" in this Report.

Given these uncertainties, readers are cautioned not to place undue reliance on such forward-looking statements. We disclaim any obligation to update any such factors or to announce the result of any revisions to any of the forward-looking statements contained herein to reflect future results, events or developments.

Statements in this Report are made as of the date hereof unless stated otherwise. New factors emerge from time to time, and it is not possible to predict all such factors.

EXPLANATORY INFORMATION REGARDING THIS REPORT

This Report has been prepared in accordance with the obligations of the Company under (i) Section 4.02 of the Indenture, dated as of December 4, 2020 (the "***5.375% Unsecured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 5.375% Senior Notes due 2029 (the "***5.375% Unsecured Notes***"), (ii) Section 4.02 of the Indenture, dated as of April 13, 2020 (as amended or supplemented from time to time, the "***6.75% Secured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee and notes collateral agent, relating to the Company's 6.750% Senior Secured Notes due 2025 (the "***6.75% Secured Notes***"), (iii) Section 4.02 of the Indenture, dated as of February 13, 2020 (as amended or supplemented from time to time, the "***4.375% Secured Notes Indenture***") among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee and notes collateral agent, relating to the Company's 4.375% Senior Secured Notes due 2027 (the "***4.375% Secured Notes***") and (iv) Section 4.02 of the Indenture, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***9.75% Unsecured Notes Indenture***" and, together with the 5.375% Unsecured Notes Indenture, the 6.75% Secured Notes Indenture and the 4.375% Secured Notes Indenture , the "***Indentures***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee, relating to the Company's 9.750% Senior Notes due 2026 (the "***9.75% Unsecured Notes***" and, together with the 5.375% Unsecured Notes, 6.75% Secured Notes and the 4.375% Secured Notes, the "***Notes***"), (v) Section 5.04 of the Asset-Based Revolving Credit Agreement, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***ABL Agreement***"), among the Company, as Lead Borrower, DSB Acquisition, LLC, a Delaware limited liability company ("***Holdings***"), the lenders party thereto from time to time and Citibank, N.A., as administrative agent and collateral agent, and (vi) Section 5.04 of the First Lien Credit Agreement, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***Term Loan Agreement***" and, together with the ABL Agreement, the "***Credit Agreements***"), among the Company, as Lead Borrower, Holdings, the lenders party thereto and Citibank, N.A., as administrative agent and collateral agent. This Report has been prepared in all material respects in accordance with the rules and regulations of the Securities and Exchange Commission (the "***SEC***") applicable to an Annual Report on Form 10-K for the fiscal year ended December 31, 2021, except to the extent permitted to be excluded by the Indentures and the Credit Agreements.

USE OF NON-GAAP FINANCIAL INFORMATION

In this Report, we have provided pro forma same-facility information for the years ended December 31, 2021 and 2020, as if the Kindred Transaction had occurred on January 1 for each of the years then ended, EBITDA and Adjusted EBITDA (collectively, the "***Non-GAAP Measures***") because we believe they provide the holders of our Notes (the "***Holders***") and the lenders under our Credit Agreements ("***Lenders***") with additional information to measure our performance and evaluate our ability to service our indebtedness. We believe that the presentation of Non-GAAP Measures is appropriate to provide additional information to the Holders and Lenders about certain material non-cash items and about unusual items that we do not expect to continue or to continue at the same level in the future as well as other items. Further, we believe the Non-GAAP Measures provide a meaningful measure of operating profitability because we use them for evaluating our business performance and understanding certain significant items.

The Non-GAAP Measures are not presentations made in accordance with United States ("***U.S.***") generally accepted accounting principles ("***GAAP***"), and our use of these terms may vary from others in our industry. EBITDA and Adjusted EBITDA should not be considered as alternatives to operating income or any other performance measures derived in accordance with GAAP as measures of operating performance or cash flows as measures of liquidity. EBITDA and Adjusted EBITDA have important limitations as analytical tools, and you should not consider them in isolation or as substitutes for analysis of our results as reported under GAAP. Because of these limitations, we rely primarily on our GAAP results and use EBITDA and Adjusted EBITDA only as a supplement. Refer to "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" for a description of the calculation and limitations of these measures.

DOCUMENT SUMMARIES AND REQUESTS

This Report contains summaries believed to be accurate with respect to certain documents, but reference is made to the actual documents for complete information. All such summaries, which do not purport to be complete, are qualified in their entirety by such reference. Copies of the documents referred to herein will be made available without cost to Holders and Lenders by making a written or oral request to us. Any such request may be made to us at the following address and telephone number:

LifePoint Health
330 Seven Springs Way
Brentwood, Tennessee 37027
Attn: General Counsel
Tel. (615) 920-7000

FISCAL YEAR

All references to "fiscal year" are to the twelve months ended December 31 of the year referenced.

OTHER ITEMS

LifePoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.), a Delaware corporation, along with each of its consolidated subsidiaries, is referred to herein as the "***Company***," "***LifePoint***," "***we***," "***our***," "***us***," and, before giving effect to the LifePoint/RCCH Merger (as defined below), "***RCCH***," in each case, unless the context otherwise requires.

References in this Report to the "***LifePoint/RCCH Merger***" refer to the merger, which was effective on November 16, 2018, of Legend Merger Sub, Inc., a Delaware corporation and wholly-owned subsidiary of RCCH ("***Legend Merger Sub***"), with and into LifePoint Health, Inc., a Delaware corporation ("***Legacy LifePoint***"), with Legacy LifePoint surviving the LifePoint/RCCH Merger as a subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc." Subsequently, Legacy LifePoint converted from a corporation to a limited liability company.

References in this Report to the "***Sponsor***" refer to certain funds that are affiliates of the Company (the "***Apollo Funds***") that are ultimately controlled and/or managed by certain affiliates of Apollo Management Holdings, L.P. ("***Apollo Management***" and, when acting on behalf of the Apollo Funds, "***Apollo***"), which is an affiliate of Apollo Global Management, Inc.

PART I

Item 1. *Business*.

Our Company

We are a leading provider of healthcare serving patients, clinicians, communities and partner organizations across the healthcare continuum. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a growing diversified healthcare delivery network comprised of 65 community hospital campuses, 28 inpatient rehabilitation facilities ("***IRFs***"), three behavioral health facilities, and additional sites of care that include acute rehabilitation units ("***ARUs***"), outpatient centers and post-acute care facilities. As of December 31, 2021, we operated 96 healthcare facilities in 29 states throughout the U.S. with approximately 10,000 licensed beds and approximately 50,000 dedicated employees.

We seek to fulfill our mission of Making Communities Healthier® by (1) delivering high quality patient care, (2) supporting our physicians, (3) creating excellent workplaces for our employees, (4) taking a leadership role in our communities and (5) ensuring fiscal responsibility. We strive to create places where people choose to come for healthcare, physicians want to practice and employees want to work.

Our Business Strategy

The key elements of our business strategy include:

- *Commitment to the Delivery of Exceptional Quality Patient Care*. Providing high quality patient care is essential to our mission and will always be our top priority. We believe our quality efforts are central to creating places where people choose to come for care, physicians want to practice and employees want to work. Our National Quality Program provides a structured, evidence-based approach to enhancing quality and patient safety and is nationally renowned. Several factors contribute to providing high quality patient care, including leadership and accountability at all levels of our organization, aligning ourselves with talented physicians and medical staff who share our commitment to quality, and providing a clinical environment that is satisfactory to our patients, physicians and employees. We continually strive to improve physician and employee satisfaction, which we believe is critical to delivering quality patient care. We also partner with academic medical centers, regional health systems and specialty providers to better serve the needs of our communities. In addition, demonstrating our results in delivering high quality patient care is increasingly vital to achieving our operating and financial success, including with governmental and commercial payers.

- *Continue to Grow in Existing Markets by Expanding Services and Access Points to Care*. We regularly conduct in-depth strategic reviews of the major service lines offered at each of our facilities and evaluate additional services through which we could better serve our communities and grow in our markets. We leverage our market-specific knowledge together with input and guidance from our local physician and community leaders to prioritize the healthcare services our communities are seeking. Focus areas include: expansion of specialty service lines to meet unserved or underserved patient needs; expansion of access points to care, including outpatient, ancillary, retail and virtual health services; and investment in technology and equipment. We invest strategically in our markets in order to increase the quality and scope of services we provide, meet the needs of our communities and maintain our strong reputation as the healthcare provider of choice. This in turn helps us to continue recruiting physicians and growing the revenue of our facilities.

- *Leverage LifePoint Forward Innovation Strategy to Develop Solutions that Transform and Improve Community-based Healthcare Delivery*. Through our innovation strategy, LifePoint Forward, we are developing meaningful solutions to enhance quality, increase access to care, and improve value across the LifePoint footprint and communities across the country. This includes a significant focus on digital health capabilities that span the healthcare continuum. For example, we have already invested in or implemented new technologies for on-demand telehealth services, artificial intelligence functionality, online scheduling for in-person and telehealth visits, virtual check-in and waiting room options, remote patient monitoring, next best action campaigns, and computational linguistics designed to identify at-risk patients.

- *Continue to Recruit and Retain Leading Physicians*. Our physician engagement strategies drive our ability to enhance and expand our services to meet the healthcare needs of our communities. We have a comprehensive recruiting program that is directed by an experienced department at our Health Support Center ("***HSC***") and is supported at the local level by our hospital system chief executive officers ("***CEOs***") and Boards of Trustees. We supplement our local teams with experienced specialists at our HSC and several third-party recruiting firms to assist us in identifying candidates that match the profile of our physician needs. We maintain a flexible approach to aligning our goals with our physician partners, including our willingness to recruit physicians through multi-year employment and/or income guarantee arrangements. In addition, we believe our physicians are attracted to our facilities because of several factors, including our commitment to quality care, our focus on employing and developing high quality nurses and support staff and our integration into, and support of, the communities we serve.

- *Routinely Optimize Our Portfolio to Strengthen Our Position in Existing Markets and Expand into New Markets*. We evaluate and selectively pursue acquisitions of hospitals, outpatient and ancillary clinics and other healthcare facilities in new and existing markets, with the goal of improving our operating performance and better meeting the healthcare needs of our communities. We employ a rigorous and disciplined approach to new market acquisitions and focus on a range of criteria, including expected financial returns and strategic benefits, to evaluate a target's suitability and fit within our portfolio. We seek to operate health systems that are, or have the potential to become, market leaders in communities with favorable demographic trends. Furthermore, we routinely evaluate our existing portfolio to assess whether we are meeting our strategic and financial objectives in our markets. We evaluate and may seek to opportunistically divest assets that do not meet our strategic and/or financial objectives and which may deliver more value to our stakeholders and the respective communities through a sale.

- *Continue to Engage in Strategic Relationships with Local Partners*. We partner with several academic medical centers and regionally significant health systems to better serve our communities. For example, we have established partnerships with Duke University Health System ("***Duke***"), Norton Healthcare, Inc. ("***Norton***"), LHC Group, Inc. ("***LHC***"), University of Washington Health, and Billings Clinic.

- *Continue to Focus on Operational Efficiency*. We strive to improve our operating performance by making our revenue cycle processes more efficient, making an even higher level of purchases through our group purchasing organization, operating more efficiently and effectively, and working to appropriately standardize our policies, procedures and practices across all of our affiliated facilities. As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have partnered with various third parties to provide certain nonclinical business functions, including payroll processing, supply chain management and revenue cycle functions. We believe this model is the most cost effective and efficient approach to managing these nonclinical business functions across multi-facility enterprises. Additionally, in connection with our efforts to responsibly manage purchasing costs, we participate along with other healthcare companies in a group purchasing organization, HealthTrust Purchasing Group, which makes certain national supply and equipment contracts available to our facilities. We also implement this operating discipline when we enter a new market through acquisitions, where we focus on optimizing staffing levels to reduce labor costs, leveraging our national scale and group purchasing organizations to reduce supply costs and standardizing revenue cycle and information technology ("***IT***") systems. We have made substantial progress implementing these initiatives consistently across our network, and we believe that opportunity exists for continued improvement in the near term, particularly among our recently acquired facilities.

- *Experienced Executive Management and Leadership Teams.* Our executive management team has an average of more than 20 years of healthcare industry experience with a proven record of achieving strong operating and quality results. The executive management team is highly respected in the healthcare industry and has significant experience in managing and acquiring hospitals. Our executive management team is led by David Dill, who serves as our Chairman and Chief Executive Officer. Mr. Dill has more than 20 years of operational and financial leadership experience in the healthcare industry.

Our Background

LifePoint/RCCH Merger

Summary

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc." Subsequently, Legacy LifePoint converted from a corporation to a limited liability company.

Equity Contribution

In connection with the LifePoint/RCCH Merger, certain of the Apollo Funds, together with certain other co-investors investing through a co-investment vehicle controlled by our Sponsor or its affiliates, indirectly contributed $1,000 million of newly invested capital to DSB Parent L.P., a Delaware limited partnership (the "***Parent***"), which is our indirect parent and is indirectly owned by certain of the Apollo Funds, co-investment vehicles and certain current or former directors, members of management, employees and consultants of the Company and/or our affiliates, and the $1,000 million of newly invested capital was further contributed to the Company to be used to partially fund the LifePoint/RCCH Merger.

Financing Transactions

Concurrently with the closing of the LifePoint/RCCH Merger, we (1) issued the 9.75% Unsecured Notes, (2) entered into the ABL Agreement, which provides a senior secured asset-based revolving credit facility (the "***ABL Facility***") in an aggregate principal amount of $800 million with a maturity of five years, (3) terminated our existing senior secured asset-based revolving credit facility, which we entered into on April 29, 2016 (the "***Prior ABL Facility***"), (4) entered into the Term Loan Agreement, which provides a senior secured term loan credit facility (the "***Term Loan Facility***") in an aggregate principal amount of $3,550 million with a maturity of seven years, and (5) repaid in full our $150 million term loan facility, which we entered into on April 25, 2018 (the "***Prior Term Facility***").

Kindred Transaction

On June 18, 2021, we entered into a Securities Purchase Agreement (the "***SPA***") with TPG Kentucky Co-Invest, LP ("***TPG Co-Invest Seller***"), TPG VII Kentucky Holdings I, LP ("***TPG VII Seller***"), Kentucky Hospital Management, LLC ("***Management Seller***"), Kentucky Hospital GP, Inc. ("***Partnership GP Seller***" and each of TPG Co-Invest Seller, TPG VII Seller, Management Seller and Partnership GP Seller, a "***Direct Seller***"), TPG VII Kentucky AIV I, LP ("***TPG Blocker Seller***"), Welsh, Carson, Anderson & Stowe XII, L.P. ("***WCAS XII***"), Welsh, Carson, Anderson & Stowe XII Delaware, L.P. ("***WCAS XII Delaware***"), Welsh, Carson, Anderson & Stowe XII Delaware II, L.P. ("***WCAS XII Delaware II***"), Welsh, Carson, Anderson & Stowe XII Cayman, L.P. ("***WCAS XII Cayman***"), WCAS Management Corporation ("***WCAS Management***"), WCAS XII Co-Investors LLC ("***WCAS XII Co-Investors***," and collectively with WCAS XII, WCAS XII Delaware, WCAS XII Delaware II, WCAS XII Cayman and WCAS Management, the "***WCAS Blocker Sellers***"), Port-aux-Choix Private Investments Inc. ("***PSP Blocker Seller***" and each of TPG Blocker Seller, WCAS Blocker Sellers and PSP Blocker Seller, a "***Blocker Seller***" and, each of the Direct Sellers and each of the Blocker Sellers, a "***Seller***" and collectively, the "***Sellers***"), Kentucky Hospital Holdings JV, LP (the "***Knight***"), the indirect parent of Kindred Healthcare, LLC ("***Kindred***"), and solely in its capacity as the initial seller representative hereunder, Partnership GP Seller ("***Seller Representative***"), pursuant to which, upon the terms and subject to the conditions set forth therein and in accordance with applicable law, the Sellers, which directly and indirectly owned all of the issued and outstanding equity interests in the Knight and the Blockers (as defined in the SPA), agreed to sell such equity interests to LifePoint and/or affiliates of LifePoint. Upon the closing of the Kindred Transaction, as described below, the Company and Kindred established a new healthcare company operating under the name ScionHealth.

On November 30, 2021, Knight Health LLC, a Delaware limited liability company formed at the direction of certain affiliates of the Company ("***Knight Health***"), assumed from the Company and the Company assigned to Knight Health the rights and obligations of the Company under the SPA in respect of the purchase of all of the issued and outstanding equity interests of the Knight and the Blockers and the payment of the purchase price for such equity interests.

On December 23, 2021, the Company, Knight, Knight Health Holdings LLC (d/b/a ScionHealth), a Delaware limited liability company and direct parent of Knight ("***ScionHealth***"), and certain of their respective affiliates entered into reorganization agreements (the "***Reorganization Agreements***") that, among other things, provided for (i) the separation of the inpatient rehabilitation facility, behavioral health, contract rehabilitation service and certain support center businesses (collectively, the "***Knight Transferred Business***") from the businesses of Knight and its subsidiaries, (ii) the separation of the equity and assets comprising 18 select acute care hospitals of the Company (the "***Artemis Business***") from the business of the Company and its subsidiaries, (iii) the transfer of the Knight Transferred Business to the Company, (iv) the transfer of the Artemis Business to Knight (v) the acquisition by the Company of Class B Units of ScionHealth, with an aggregate value of $350 million, and (vi) reciprocal indemnification obligations with respect to the businesses transferred, in each case of clauses (i) through (vi), pursuant to the reorganization, separation and distribution steps described therein, including the assignment by Knight Health of certain rights and obligations under the SPA, including any post-closing purchase price adjustments (the "***Reorganization***"). The Class B Units of ScionHealth acquired by the Company are perpetual non-convertible non-voting units that accrue cumulative dividends at the rate of 10.00% per annum and, upon liquidation, are entitled to a return of their nominal value issue price plus accrued, unpaid dividends.

On December 23, 2021, concurrently with the consummation of the Reorganization, the Sellers, the Seller Representative, Knight and the assignees of the rights and obligations of the Company as initial buyer under the SPA, including Knight Health, consummated the Kindred Transaction. Pursuant to the consummation of the Kindred Transaction and the Reorganization, (i) ScionHealth indirectly holds all of the transferred interests in the Artemis Business, (ii) ScionHealth directly holds all of the issued and outstanding limited partnership interests in Knight, (iii) Kentucky Hospital Holdings JV GP LLC, a Delaware limited liability company and direct subsidiary of ScionHealth ("***Knight GP***"), holds all of the issued and outstanding general partnership interests in Knight, and (iv) the Company holds all of the transferred interests in the Knight Transferred Business and the Class B Units of ScionHealth described above. We refer to the foregoing transactions as the "***Kindred Transaction***".

In connection with the Kindred Transaction, we have entered into a number of transition services agreements and other ancillary agreements with ScionHealth and its subsidiaries with estimated proceeds of $61 million per year to LifePoint and an estimated cost of $3 million per year to LifePoint. In addition, we and ScionHealth are party to a number of commercial services agreements, pursuant to which the Knight Transferred Business provides ScionHealth with therapy services and rehabilitation unit management and development services, among other commercial services.

Our Operations

Services

We operate health systems that provide a broad range of general and specialized healthcare services across inpatient and outpatient settings, including general surgery, internal medicine, cardiology, radiology, oncology, orthopedics, women's services, neurology, rehabilitation services, behavioral services, pediatric services, emergency services and, primarily through our joint venture with LHC, home health and hospice services. In some of our health systems, we offer specialized services such as open heart surgery, skilled nursing, psychiatric care and neurosurgery. In many markets, we also provide outpatient services such as same day surgery, clinical laboratory services, diagnostic imaging services, respiratory therapy services, sports medicine services, urgent care services and lithotripsy. The services provided in any specific health system depend on many factors, including the community need for the service, whether physicians necessary to safely operate the service line are members of the medical staff of that hospital and the existence of any contractual or certificate of need restrictions.

Impact of COVID-19

During March 2020, the global COVID-19 pandemic began to significantly affect our facilities, employees, patients, communities, business operations and financial performance, as well as the U.S. economy and financial markets, as a whole. More than two years into the pandemic, we continue to be deeply committed to protecting the health of our communities and are continuing to respond to the evolving COVID-19 situation across the country. Importantly, we are taking every precaution to ensure we can continue providing quality care and safeguard the health and well-being of patients, employees, providers, volunteers and visitors in each community we serve. The national footprint of our health system, along with our HSC, has enabled us to support our communities during this challenging time.

Our internal COVID-19 taskforce, which was established during the early stages of the pandemic continues to meet regularly. Additionally, in November 2020, we established a COVID-19 vaccine team to help facilitate the successful distribution and administration of vaccines across our markets. This team continues to meet regularly to discuss the latest vaccine developments and keep a pulse on potential barriers our facilities may encounter as they work to increase vaccination rates locally.

The number and severity of COVID-19 variants, including the Delta and Omicron variants, continue as a concerning threat for the national healthcare system, including our hospitals and the communities we serve. The rapid spread of the Delta and Omicron variants, through largely unvaccinated populations resulted in a sharp rise in COVID-19 cases across the country. This activity and the threat of other COVID-19 variants has further emphasized the need for our hospitals and providers to continue endorsing COVID-19 vaccination as the primary means for protection.

Our top priorities continue to be protecting our patients, supporting our people, being leaders in our communities, and managing our financial health. We have put in place a number of protocols to protect our patients, providers, employees, volunteers and visitors.

Our evaluation of the measures taken across our health system in response to COVID-19 and variants of the virus is ongoing and additional updates to our policies, procedures and operations could occur as best practices continue to evolve. Furthermore, our facilities are located across a wide geographic range of communities, which may require us to modify measures we take at specific facilities based on local conditions, including the severity of COVID-19 and variants of the virus in the community served by a facility and changes in state and local executive orders that may restrict certain services or activities.

Additionally, although we recently repaid or declined funds that were available to us and our facilities under the CARES Act and related stimulus legislation, we cannot predict if we will need to seek such funds in the future, and we cannot assure you that we will be able to access such funds in a timely manner or at all.

For additional information about the risks presented by the COVID-19 pandemic, our responses to the pandemic, and the resources available to healthcare providers, refer to "—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" below and "Part I, Item 1A. Risk Factors" and "Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Developments, Trends and Operating Environment—Impact of COVID-19" included in this Report.

Management and Oversight

Our executive management team has extensive experience in operating multi-facility hospital networks and plays a vital role in the strategic planning for our facilities. A hospital's local management team is typically comprised of a CEO, chief operating officer, chief financial officer and a chief nursing officer. Local management teams work with the hospital's Board of Trustees and our HSC management teams to develop annual operating plans setting forth growth strategies through the expansion of current services, implementation of new services and the recruitment and retention of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each local management team to identify and meet the needs of our patients, medical staffs and the community as a whole is critical to the success of our facilities. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including quality of care, patient satisfaction and financial measures.

The Board of Trustees at each facility, consisting of local community leaders, members of the medical staff and the facility CEO, advises the local management teams and helps develop the strategic operating plan for their facility. In addition, it plays a key role in providing the patient care excellence that we demand. Members of each Board of Trustees are identified and recommended by our local management teams. The Boards of Trustees oversee policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

The majority of our facilities have a physician engagement group ("***PEG***") or a physician leadership group ("***PLG***") comprised of key physicians and members of the facility's administrative team. The mission of the PEG or PLG is to provide ongoing dialogue between hospital facility administration and members of the medical staff and community physicians primarily in the areas of operations, quality patient care, employee satisfaction and community relations.

We also provide support to the local management teams through our HSC resources in areas such as revenue cycle, business office, legal, managed care, clinical efficiency, physician services and other administrative functions. These resources allow for sharing best practices and standardization of policies and processes among all of our facilities.

Cost Management

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

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

Attracting Patients

We believe that the most important factors influencing a patient's choice in where to receive healthcare services are the quality of care delivered by the facility, the overall reputation of the facility, the availability and expertise of physicians and nurses, and the location and convenience of the facility. Other factors that affect utilization include local demographics and population growth, local economic conditions and the facility's success in contracting with a wide range of local payers.

Outpatient Services

The healthcare industry has experienced an accelerated shift during recent years from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology also have supported the shift to outpatient utilization. However, we expect the decline in inpatient admission use rates to moderate over the long term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through expanding service offerings and increasing the throughput and convenience of our emergency departments, outpatient surgery facilities and other ancillary units in our facilities.

Sources of Revenues

General

Our facilities generate revenues by providing healthcare services to our patients. Depending upon the patient's medical insurance coverage, we are paid for these services by governmental Medicare and Medicaid programs, commercial insurance, including health maintenance organizations ("***HMOs***"), preferred provider organizations ("***PPOs***") and plans offered through the Exchanges, private insurers, and directly by the patient. The amounts we are paid for providing healthcare services to our patients vary depending upon the payer. Governmental payers generally pay significantly less than the hospital's customary charges for the services provided. Insured patients are generally not responsible for any difference between customary hospital charges and the amounts received from commercial insurance payers. However, insured patients are responsible for payments not covered by insurance, such as exclusions, deductibles and co-payments.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2021, 2020 and 2019 (dollars in millions):

	2021		2020		2019	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,368	37.7 %	$ 3,134	38.6 %	$ 3,338	38.1 %
Medicaid	1,645	18.4	1,392	17.1	1,495	17.1
HMOs, PPOs and other private insurers	3,691	41.3	3,382	41.6	3,699	42.3
Self-pay	55	0.6	55	0.7	59	0.7
Other	156	1.8	137	1.7	144	1.6
Revenue from contracts with customers	8,915	99.8	8,100	99.7	8,735	99.8
Rental income	22	0.2	22	0.3	18	0.2
Revenues	$ 8,937	100.0 %	$ 8,122	100.0 %	$ 8,753	100.0 %

Medicare

For the year ended December 31, 2021, approximately 37.7% of our revenues related to patients participating in the Medicare program. Medicare provides hospital and medical insurance benefits, regardless of income, to persons aged 65 and over, some disabled persons and persons with end-stage renal or Lou Gehrig's disease. All of our hospitals are currently certified as providers of Medicare services.

Over the years, Congress and the Centers for Medicare and Medicaid Services ("***CMS***") have made several sweeping changes to the Medicare program and its reimbursement methodologies, including the numerous changes contained in the Affordable Care Act. Many of these changes have resulted in decreased reimbursement to healthcare providers. In addition, the Budget Control Act of 2011 ("***BCA***"), which is intended to reduce the federal deficit, imposed a 2% reduction in Medicare spending which began on April 1, 2013. Congress has extended the 2% reduction in Medicare spending on numerous occasions. The CARES Act and the Consolidated Appropriations Act, 2021 (the "***CAA***") temporarily suspended Medicare sequestration from May 1, 2020 until March 31, 2021. The temporary suspension was subsequently extended through December 31, 2021, by HR 1868, which, to offset the cost of the suspension, extended Medicare sequestration through 2030. The Protecting Medicare and American Farmers from Sequester Cuts Act (the "***Sequester Cuts Act***"), which was adopted December 10, 2021, further extends the temporary suspension of Medicare sequestration through March 31, 2022, and reduces the sequestration cuts for the period of April 1, 2022 through June 30, 2022, to 1%. In addition, the American Rescue Plan Act of 2021 ("***ARP***") increased the federal budget deficit in a manner that triggers an additional sequestration mandated under the Pay As You Go Act of 2010 ("***PAYGO Act***"); however, Congress has delayed implementation of this payment reduction until 2023. Additional reductions in Medicare reimbursement could result from changes to the Affordable Care Act, or as a result of the enactment of Medicare reform, deficit reduction or other legislation.

Medicare Inpatient Prospective Payment System

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

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor each federal fiscal year ("***FFY***"), which begin on October 1 (for example, FFY 2022 began on October 1, 2021). The index used to adjust the base MS-DRG payment rate, which is known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. For FFYs 2022, 2021, and 2020, the hospital market basket index increased 2.7%, 2.4%, and 3.0%, respectively. Generally, however, the percentage increase in the MS-DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the Bureau of Labor Statistics' 10-year moving average of changes in annual economy-wide productivity. For FFYs 2022, 2021, and 2020, the productivity adjustment equated to a 0.7%, 0.0%, and 0.4% reduction in the market basket increase, respectively. As a result of these reductions and other changes implemented by CMS, the MS-DRG-rate increased by 2.5% for FFY 2022.

On October 1, 2007, CMS replaced the previously existing 538 diagnosis related groups with 745 MS-DRGs. The MS-DRGs are intended to more accurately reflect the cost of providing inpatient services and eliminate any incentives that hospitals may have to only treat the healthiest and most profitable patients. The American Taxpayer Relief Act of 2012 ("***ATRA***") required CMS to recoup $11 billion from IPPS payments in FFYs 2014 through 2017 to offset an additional increase in aggregate payments to hospitals that Congress believes occurred from FFYs 2008 through 2013 solely as the result of the transition to the MS-DRG system. In FFYs 2014, 2015 and 2016, CMS applied negative 0.8% adjustments as part of the recovery process required by ATRA, and it applied a negative 1.5% adjustment in FFY 2017 to recover the remaining outstanding amount. CMS had previously indicated that the reductions required by ATRA would be fully restored in FFY 2018. However, under the Medicare Access and CHIP Reauthorization Act of 2015 ("***MACRA***"), those reductions will be restored in 0.5% increments over a six-year period from FFYs 2018 through 2023, which would result in a cumulative 3.0% increase in rates, which would be less than the 3.9% reduction that was imposed by CMS in FFYs 2014 through 2017. In addition, some of that restoration has been subject to further limits, such as under the 21st Century Cures Act (the "***Cures Act***") which further reduced the restoration for FFY 2018 from 0.5% to 0.4588%.

CMS has implemented a number of programs and requirements that are intended to promote value-based purchasing and to link payments to quality and efficiency. For example, all acute care hospitals are required to participate in CMS' Hospital Inpatient Quality Reporting Program (the "***IQR Program***") in order to receive the full hospital market basket update. Hospitals that do not participate in the IQR Program receive a 25% reduction in their IPPS annual payment update for the applicable FFY. Our acute care hospitals reported all quality measures required by CMS related to the IQR Program and nearly all will receive the full market basket update through FFY 2022. In addition, hospitals that are not meaningful EHR users are also subject to an additional 75% reduction of the hospital market basket increase.

In addition, the Affordable Care Act requires U.S. Department of Health and Human Services ("***HHS***") to implement a value-based purchasing program for inpatient hospital services. This program rewards hospitals based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period. As part of the program, the Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by 2.0% each FFY. HHS pools the amount collected from these reductions to fund payments to reward hospitals that meet and exceed certain quality performance standards established by HHS. Under the program, each hospital's performance is evaluated during a specified performance period, and hospitals receive points on each of a number of pre-determined measures based on the higher of (i) their level of achievement relative to an established standard or (ii) their improvement in performance from their performance during a prior baseline period. Each hospital's combined scores on all the measures are translated into value-based incentive payments. Hospitals that receive higher total performance scores receive higher incentive payments than those that receive lower total performance scores. Because the Affordable Care Act provides that the funds pooled and otherwise set aside for the value-based purchasing program will be fully distributed, hospitals with high scores may receive greater reimbursement under the value-based purchasing program than they would have otherwise, and hospitals with low scores may receive reduced Medicare inpatient hospital payments.

Medicare also does not allow an inpatient hospital discharge to be assigned to a higher paying MS-DRG if certain designated hospital acquired conditions ("***HACs***") were not present on admission and the identified HAC is the only condition resulting in the assignment of the higher paying MS-DRG. In those situations, the case is paid as though the secondary diagnosis was not present. In addition, hospitals that fall into the top 25.0% of national risk-adjusted HAC rates for all hospitals in the previous year receive a 1.0% reduction in their total Medicare payments.

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

In response to the COVID-19 public health emergency, CMS has announced that it will temporarily suppress, or not use, certain hospital performance data that has been affected by COVID-19 in any of its hospital quality measurement and payment programs. In addition, CMS has also announced that for FFY 2022, all hospitals will receive a neutral adjustment under the Medicare value-based purchasing program that is equal to the 2.0% that is withheld under the program.

Medicare Hospital Outpatient Prospective Payment System and Other Outpatient Services

CMS reimburses hospital outpatient services under the Medicare hospital outpatient prospective payment system ("***OPPS***"), and generally uses fee schedules to pay for durable medical equipment and physical, occupational and speech therapy, clinical diagnostic laboratory and independent diagnostic testing facility services. Under the OPPS, hospital outpatient services are classified into groups called ambulatory payment classifications ("***APCs***"). Services in each APC are clinically similar and are similar in terms of the resources they require. Depending on the services provided, a hospital may be paid for more than one APC for an encounter. CMS establishes a payment rate for each APC by multiplying the scaled relative weight for the APC by a conversion factor. The payment rate is further adjusted to reflect geographic wage differences. The APC conversion factors for calendar years ("***CYs***") 2022, 2021, and 2020 were $84,177, $82.797, and $80.793, respectively, after the inclusion of the productivity adjustments and other reductions that were required by the Affordable Care Act. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, acute care hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Reporting Program (the "***OQR Program***"). Hospitals that do not satisfy the reporting requirements of the OQR Program are subject to a reduction of 2.0% in their annual payment update under the OPPS. Our acute care hospitals reported all quality measures required by CMS related to the OQR Program and will receive the full market basket update through CY 2022.

Section 603 of the Bipartisan Budget Act of 2015 limits reimbursement for items and services that are furnished by certain off-campus outpatient provider-based departments ("***off-campus PBDs***") of hospitals. CMS included several provisions implementing Section 603 in the OPPS final rule for CY 2017. Under the final rule, CMS continues to make OPPS payments to off-campus PBDs that were billing Medicare as hospital departments under the OPPS prior to November 2, 2015 ("***grandfathered PBDs***"). However, grandfathered PBDs generally are not able to relocate, and CMS has indicated that it may adopt limitations on the expansion of the service lines provided at grandfathered PBDs in the future. In addition to grandfathered PBDs, CMS continues to reimburse all items and services that are furnished in a "dedicated emergency department" of a hospital, as such term is defined for the purposes of the Emergency Medical Treatment and Active Labor Act ("***EMTALA***"), regardless of whether the items and services are emergency items and services, and all items and services that are furnished in off-campus PBDs that are located within 250 yards of a remote location of a hospital, which is a facility that is either created or acquired by a hospital for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the hospital, under the OPPS. All items and services not provided at a grandfathered or otherwise excepted off-campus PBD are generally paid by CMS under Medicare physician fee schedule ("***PFS***") rates that are approximately 40% of the applicable OPPS rate (the "***PFS Adjusted Rate***"). In addition, in 2018, CMS issued a final rule that generally reimburses clinic visit services provided at all off-campus PBDs, including grandfathered PBDs, at a reduced Medicare PFS-equivalent payment rate. The payment reduction for clinic visit services provided at off-campus PBDs was to be phased in over a two year period beginning in FFY 2019.

In December 2018, a lawsuit was filed challenging the portion of CMS' final rule that reduced reimbursement for clinic visit services provided at grandfathered PBDs to the lower Medicare PFS-equivalent payment rate. On September 17, 2019, the U.S. District Court for the District of Columbia ruled that the reduction in reimbursement for clinic services provided at grandfathered PBDs exceeded CMS' statutory authority. As a result of the ruling, CMS paid claims for clinic visit services provided at grandfathered PBDs in CY 2019 at the full OPPS payment rate. However, in the OPPS final rule for CY 2020, CMS noted that the court's ruling only applied to clinic visit services provided in CY 2019, and, as a result, CMS moved forward with the planned phase-in of the second year of the clinic visit service payment reduction in CY 2020 while it appealed the court's decision. A new lawsuit was filed on January 13, 2020, challenging the continued phase-in of the reduction for CY 2020. On July 17, 2020, the U.S. Court of Appeals for the District of Columbia reversed the lower court's ruling regarding the CY 2019 reductions and upheld CMS' reimbursement reductions for clinic visit services provided at grandfathered PBDs. The ruling of the U.S. Court of Appeals for the District of Columbia was appealed to the U.S. Supreme Court, but the Supreme Court declined to hear the appeal. CMS has since reprocessed claims for clinic services provided at grandfathered PBDs in CY 2019 at the reduced payment rate.

In addition to those reimbursement reductions and in furtherance of its efforts to increase site neutrality in Medicare payments, CMS announced in the OPPS final rule for CY 2021 that it would eliminate the Medicare program's inpatient only procedure list over a three-year period, beginning with the removal of approximately 300 primarily musculoskeletal-related procedures, with the list being completely phased out by CY 2024. The elimination of the inpatient only procedure list would have made those procedures eligible to be paid by Medicare in the hospital outpatient setting when outpatient care was appropriate. However, in the OPPS final rule for CY 2022, CMS reversed course and reinstated the Medicare program's inpatient only procedure list. As a result, almost all of the procedures that had been removed from the Medicare inpatient only procedure list for CY 2021 have been added back to the list for CY 2022.

As part of the OPPS final rule for CY 2018, CMS also finalized a change to the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B Drug Pricing Program (the "***340B Program***"). The 340B Program allows certain non-profit and governmental hospitals and other healthcare providers to obtain substantial discounts on covered outpatient drugs (prescription drugs and biologics other than vaccines) from drug manufacturers. Under the final rule, CMS pays for separately reimbursable, non-pass through drugs and biologicals (other than vaccines) purchased through the 340B Program at the average sales price ("***ASP***") minus 22.5% rather than ASP plus 6%. CMS estimated that this change reduced Medicare payments for drugs and biologicals by $1.6 billion in CY 2018. To maintain budget neutrality, CMS implemented an offsetting increase in the conversion factor. As a result, OPPS reimbursement rates for non-drug items and services provided by all hospitals, including those not eligible to participate in the 340B Program, were increased in connection with the reduction to 340B Program payments. In the OPPS final rule for CY 2019, CMS expanded the 340B Program payment reductions to drugs that are obtained through the 340B Program and furnished by non-excepted, off-campus PBDs.

In September 2018, a lawsuit was filed challenging the authority of CMS to make the 340B Program payment reductions set forth in the OPPS final rule for CY 2018. On December 27, 2018, the U.S. District Court for the District of Columbia held that the payment reductions exceeded CMS' statutory authority and entered a permanent injunction against the reductions. However, because the 340B Program payment reductions were made in a budget-neutral manner and the savings derived from the reductions were used to increase reimbursement for all of the other items and services provided under the OPPS, the court ordered the parties to submit briefs as to how the issue should be remedied. The lawsuit was subsequently expanded to include the 340B Program payment reductions that were made in CY 2019, and an additional lawsuit has been filed against the 340B Program payment reductions being made by CMS in CY 2020. CMS appealed the District Court's rulings, and, on July 31, 2020, the U.S. Court of Appeals for the District of Columbia reversed the lower court's ruling and upheld CMS' 340B Program payment reductions. The ruling of the U.S. Court of Appeals for the District of Columbia was appealed to the U.S. Supreme Court, and the Supreme Court heard arguments in the case on November 30, 2021. We cannot predict whether the appeal will be successful, and, if successful, the amount (if any) by which OPPS payments to hospitals may be reduced. If OPPS payments to hospitals are reduced (either retroactively or prospectively) in connection with the 340B Program, we would be materially adversely affected.

Medicare Disproportionate Share Hospital Payments

Hospitals may also qualify for Medicare disproportionate share hospital ("***DSH***") payments, if they treat a high percentage of low-income patients (as determined by a ratio involving Medicare and Medicaid patients eligible to receive Supplemental Security Income). DSH payments are determined annually based on certain statistical information specified by HHS and are paid as an addition to MS-DRG payments. The Affordable Care Act requires Medicare DSH payments to providers to be reduced by 75% beginning in FFY 2014, subject to adjustment if the Affordable Care Act does not decrease uncompensated care to the extent anticipated. The amount that is withheld is reduced by the percentage change in uninsured individuals under the age of 65, and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. The IPPS final rule for FFY 2022 established the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2022 at approximately $7.2 billion, a decrease of approximately $1.1 billion from FFY 2021.

Medicare Dependent and Low Volume Hospital Programs

On April 16, 2015, MACRA was enacted. Among other things, MACRA extended the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by Medicare, and the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located a certain distance from another general acute care hospital and have less than a certain number of Medicare discharges each fiscal year, through September 30, 2017. The Bipartisan Budget Act of 2018 extended both of these programs through FFY 2022.

Medicare Inpatient Rehabilitation Facility Prospective Payment System

Under the Medicare program, IRFs and ARUs in acute care hospitals meeting certain criteria established by CMS are reimbursed under the Medicare inpatient rehabilitation facility prospective payment system ("***IRF-PPS***"). Payments under the IRF-PPS are made on a per-discharge basis and cover the inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) and, for teaching institutions, are adjusted to include reimbursement for graduate medical education costs. Under the IRF-PPS, patients are classified into case mix groups that reflect the relative resource intensity typically associated with the patient's clinical condition. IRFs and ARUs reimbursed under the IRF-PPS are paid a predetermined amount per discharge that reflects the patient's case mix group that is adjusted for facility-specific factors, such as area wage levels, proportion of low-income patients, and location in a rural area. Each FFY, payment rates under the IRF-PPS are updated using a market basket index, which is reduced by a productivity adjustment. For FFY 2022, CMS increased IRF-PPS payment rates by 1.9% based on a IRF market basket update of 2.6% minus a productivity adjustment of 0.7%. To receive the full increase, IRFs and ARUs must satisfy the reporting requirements of the Inpatient Rehabilitation Facility Quality Reporting Program (the "***IRF QRP***"). IRFs and ARUs that do not satisfy the reporting requirements of the IRF QRP are subject to a reduction of 2.0% in their annual payment update under the IRF-PPS. Our IRFs and ARUs reported all quality measures required by CMS related to the IRF QRP and will receive the full market basket update for FFY 2022.

In order to qualify for reimbursement under the IRF-PPS, at least 60% of an IRF's or ARU's inpatients during the most recent 12-month CMS-defined review period must have required intensive rehabilitation services for one or more of 13 specified conditions. IRFs and ARUs must also meet additional coverage criteria, including patient selection and care requirements relating to pre-admission screenings, ongoing coordination of care and involvement of rehabilitation physicians. An IRF or ARU that fails to meet the 60% threshold, or other criteria to be reimbursed under the IRF-PPS, will be paid under either the Medicare IPPS or OPPS, which generally provide for lower payment amounts.

Cost Reports

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

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

Medicare Bad Debt Reimbursement

Under Medicare, the costs attributable to the deductible and coinsurance amounts that remain unpaid by Medicare beneficiaries after reasonable collection efforts can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the Medicare administrative contractor (*"**MAC**"*) from prior cost report filings.

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

Medicare Physician Fee Schedule and other Medicare Part B Services

Professional medical services provided to Medicare beneficiaries by physicians, physician assistants, nurse practitioners, and certain other healthcare practitioners, outpatient physical, occupational, and speech therapy services, and telehealth services are reimbursed under the PFS. Under the PFS, CMS has assigned a national relative value unit ("***RVU***") to most medical procedures and services that reflects the various resources required by a physician or practitioner to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service and the practice overhead and malpractice insurance expenses that are attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs and are then aggregated. The aggregated amount is multiplied by a conversion factor to determine the payment rate for the service. The conversion factor is updated by CMS on an annual basis.

MACRA, which was adopted in 2015, significantly changed how CMS determines the annual updates to the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased annually by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the Bipartisan Budget Act of 2018, were increased by 0.25% for CY 2019. PFS payment rates are scheduled to remain at their CY 2019 levels through CY 2025. The final PFS rule for CY 2022 sets the PFS conversion factor for CY 2022 at $33.59, which is a decrease of $1.30 from the CY 2021 PFS conversion factor of $34.89 and reflects, among other things, the required statutory update of 0.0% and the expiration of the temporary 3.75% PFS payment increase for CY 2021 that was provided by the CAA. However, the Sequester Cuts Act, which was enacted on December 10, 2021, temporarily increases the PFS conversion factor by 3.0% for CY 2022.

In addition to revising the methodology that is used to update payments that are made under the PFS, MACRA also established a Quality Payment Program ("***QPP***") for incentivizing physician and practitioner care that meets certain value, quality, cost, and performance criteria. Beginning in CY 2019, amounts paid to physicians and practitioners under the PFS are subject to adjustment through the QPP and participation in either the Merit-Based Incentive Payment System ("***MIPS***") or an Advanced Alternative Payment Model ("***APM***") program. Physicians participate in MIPS unless they are participants of specific forms of APM, are newly enrolled in Medicare, or see a low volume of Medicare patients. Groups or eligible clinicians who choose not to participate and fall within specified circumstances may request an exception through a hardship application and incur no MIPS impact on Medicare payments. CMS also permits hardship applications, including, in 2020 and 2021, hardships based on circumstances arising from COVID related operational issues, through which clinicians can request reweighing of any or all performance categories if they encounter an extreme and uncontrollable circumstance or a public health emergency.

Physicians and practitioners who participate in the MIPS program, which essentially consolidated the prior Physician Quality Reporting System, the Value-Based Modifier, and the Meaningful Use of EHR incentive programs, are subject to positive, zero, or negative performance adjustments depending on how the physician's or practitioner's performance compared to a performance threshold. The payment adjustments are based on the physician's or practitioner's performance in the year that is two years prior to the current payment period. As a result, PFS payments in CY 2022 will be based on CY 2020 performance scores, and so on for the following years. HHS and CMS revise the MIPS reporting measures on an annual basis and have indicated that they intend to routinely increase the performance thresholds in connection with those revisions. In addition, from CY 2019 through CY 2024, MACRA provides $500 million per year for an additional performance adjustment for physicians and practitioners who participate in MIPS and achieve exceptional performance. Physicians and practitioners who participate in a specified APM program, which, among other things, requires the physician or practitioner to receive a substantial amount of their revenue from an APM, will receive, from CYs 2019 through 2024, a lump-sum payment equal to 5% of their Medicare payments in the prior year for services paid under the PFS. Beginning in CY 2026, PFS payment rates for physicians and practitioners participating in an APM program would be increased by 0.75% a year. Payments for other physicians and practitioners would be increased by 0.25% per year.

Medicaid

For the year ended December 31, 2021, approximately 18.4% of our revenues related to patients participating in the various state Medicaid programs. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. Medicaid programs are funded by both the federal government and states to provide healthcare benefits to limited categories of low-income individuals under 65 years of age. These programs and the reimbursement methodologies are administered by the states under approved plans and vary from state to state and from year to year. Amounts received under the Medicaid programs are often significantly less than the hospital's customary charges for the services provided. Most state Medicaid payments are made under a prospective payment system, fee schedule, cost reimbursement program, or some combination of these three methods. All of our hospitals are currently certified to participate in their respective state Medicaid programs.

As enacted, the Affordable Care Act essentially required states to expand Medicaid coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level ("FPL"). However, that portion of the Affordable Care Act was held to be unconstitutional by the U.S. Supreme Court, and, as a result, states may opt out of the expansion without losing their existing Medicaid funding. Therefore, the income level required for individuals to qualify for Medicaid varies widely from state to state. To offset the cost of the Medicaid program's expansion, the Affordable Care Act authorized the federal government to provide states with "matching funds," in the form of increases to the Federal Medical Assistance Percentage (the "***FMAP***" and, as increased, referred to as "***Enhanced FMAP***"), to cover the costs of covering the newly eligible individuals. The Enhanced FMAP was 100% for CYs 2014 through 2016; 95% in CY 2017; 94% in CY 2018; 93% in CY 2019; and will be 90% in CYs 2020 and thereafter. The ARP, which was signed into law on March 11, 2021, provides a new incentive, in the form of a temporary 5% increase to the FMAP, to states that have not yet expanded their Medicaid programs in an effort to encourage them to do so. In addition, to assist state Medicaid programs with the additional expenses attributable to the COVID-19 pandemic, the CARES First Act provides a 6.2% increase in the FMAP from January 1, 2020, until the Secretary of the HHS ends the official COVID-19 public health emergency.

In recent years, we have benefited from the expansion of Medicaid under the Affordable Care Act, and since January 1, 2020, Missouri, Oklahoma, and Utah, three additional states in which we operate, expanded their Medicaid programs. However, a number of states in which we operate have not expanded their Medicaid programs or are seeking waivers that could reduce their Medicaid-eligible populations. Several states have adopted or are considering legislation designed to reduce or control their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs, and imposing additional taxes on hospitals to help finance such states' Medicaid systems. Given the reductions in the Enhanced FMAP, the temporary nature of the assistance provided by the ARP and the CARES Act, and the potential for further modifications to the Affordable Care Act, we are unable to predict how many, if any, additional states in which we operate will expand their Medicaid programs or how many, if any, of the states in which we operate that have expanded their Medicaid programs will keep their expansions in place in the future.

The Affordable Care Act also included a number of provisions that are intended to improve the quality of care that is provided to Medicaid beneficiaries. Among other things, the Affordable Care Act prohibits federal funds from being used to reimburse providers for services related to provider preventable conditions, such as HACs, wrong site surgeries and other provider preventable conditions that may be designated by each state Medicaid program.

Medicaid Supplemental Payments

Medicaid supplemental payments ("***MSPs***") are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and Upper Payment Limit ("***UPL***") payments.

Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating those patients. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. Although federal Medicaid law defines some level of hospitals that must receive Medicaid DSH funding, states have broad discretion to define additional hospitals that also may qualify for Medicaid DSH payments and the amount of such payments. However, the total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law.

Pursuant to the Affordable Care Act, as amended by subsequent legislation, funding for Medicaid DSH programs was to be reduced by $4 billion in FFY 2020 and $8 billion per year from FFY 2021 through FFY 2025. Congress has delayed the reduction in funding for Medicaid DSH programs on a number of occasions, most recently through the CCA, which eliminates the scheduled Medicaid DSH reductions for FFYs 2021 through 2023 but adds additional Medicaid DSH reductions for FFYs 2026 and 2027. We cannot predict whether Congress will further delay or otherwise modify the reductions in the future. Because many of the states in which we operate have not expanded Medicaid programs as intended under the Affordable Care Act, the reduction in Medicaid DSH payments may take place without a coupled increase in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars. UPL programs have expanded in recent years, and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs.

On November 18, 2019, CMS released a proposed rule, the Medicaid Fiscal Accountability Rule, that was intended to increase federal oversight of MSPs and state Medicaid financing policies. Among other things, the proposed rule would have added new reporting requirements on UPL payment arrangements, imposed limitations on UPL payments that are made to physicians and certain other practitioners, and imposed limits on the use of healthcare provider taxes, intergovernmental transfers and certified public expenditures. CMS withdrew the proposed rule in 2020. However, some of the reporting requirements contained in the Medicaid Fiscal Accountability Rule were included in the CCA, and, beginning in FFY 2022, each state will be required to provide CMS with, among other things, (i) a description of the stated purpose and intended effects of the state's MSPs, (ii) an explanation of how the state's MSPs will result in payments that are consistent with the requirements of the Medicaid program, including the program's standards with respect to efficiency, economy, quality of care, and access, (iii) the criteria used to determine provider eligibility for the state's MSPs, (iv) a comprehensive description of the methodology used to calculate the amount of, and distribute, MSPs to each eligible provider, and (v) an assurance that the total Medicaid payments made by the state to inpatient hospital providers, including any MSPs, will not exceed the UPL. The CCA also further clarifies how third-party payments are to be considered when determining Medicaid DSH hospital-specific limits. We cannot predict the impact, if any, that the reporting requirements and other Medicaid provisions in the CCA will have on MSPs and UPL payments that are made by state Medicaid programs or whether Congress or CMS will adopt any additional legislation or regulations that will eliminate or otherwise limit MSPs and/or UPL payments. In addition, we cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease.

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

Medicaid Block Grants and Capped Federal Funding

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

On November 11, 2019, Tennessee, one of the states in which we operate, submitted an amendment to CMS for its Medicaid demonstration waiver that would convert federal funding for the Tennessee Medicaid program to a modified block grant program. CMS approved the amendment on January 8, 2021, and as required by state law, the Tennessee General Assembly approved the implementation of the amendment on January 15, 2021. Under the amendment, the Tennessee Medicaid program would receive federal matching funds for expenditures up to an aggregate annual cap. The aggregate cap would be based on the Tennessee Medicaid program's historical expenditures and would be increased to reflect a reasonable growth rate over time and for unexpected increases in enrollment. In exchange, the Tennessee Medicaid program would be given increased flexibility in how it operates and would be entitled to 55% of any savings that are achieved if spending is below the aggregate cap and the state meets certain quality targets. Any savings would generally be required to be re-invested in the Tennessee Medicaid or other health related programs. Despite being granted increased administrative flexibility, the Tennessee Medicaid program would be required to maintain the coverage and benefit levels that were in place as of December 31, 2020. A lawsuit was filed in the U.S. District Court for the District of Columbia on April 22, 2021, seeking to stop the conversion of the Tennessee Medicaid program to a modified block grant program. We cannot predict the outcome of that litigation, whether CMS will rescind its approval of the amendment to the Tennessee Medicaid program or the impact that the amendment and related changes to the Tennessee Medicaid program would have on our operations and revenues.

Recovery Audit and Other Review Contractors

Recovery audit contractors ("***RACs***") are used by CMS and state agencies to detect Medicare and Medicaid overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare and Medicaid claims filed by healthcare providers. RACs perform post-discharge audits of medical records to identify overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services and are paid on a contingency basis. Any claims identified as overpayments are subject to a RAC program appeals process. In 2016, in connection with the procurement of the new recovery audit contracts, CMS made a number of enhancements to the RAC program, including the establishment of a RAC program Provider Relations Coordinator, requiring RACs to maintain an overturn rate of less than 10% at the first level of appeal, requiring RACs to maintain an accuracy rate of at least 95%, and establishing additional documentation request limits based on a provider's compliance with Medicare rules, that are intended to address provider and other stakeholder concerns. CMS has also limited the number of claims that RACs may audit by limiting the number of records that RACs may request from hospitals based on each hospital's claim denial rate for the previous year.

In addition to RACs, CMS employs Unified Program Integrity Contractors ("***UPICs***"), which integrate the functions of the former Zone Program Integrity Contractors, Program Safeguard Contractors, and Medicaid Integrity Contractors, to perform post-payment audits of Medicare and Medicaid claims and identify overpayments. A number of state Medicaid agencies and other contractors have also increased their review activities.

Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our facilities have had Medicare claims audited by the RAC program. While our facilities have successfully appealed many of the adverse determinations raised by Medicare RAC audits, we cannot predict if this trend will continue or the results of any future audits. We cannot predict the volume or outcome of any future audits conducted by the various RACs and other review programs to which our facilities will be subject.

Utilization and Claim Review

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

In addition to utilization reviews, CMS has also adopted a nationwide claim review and provider education program known as the Targeted Probe and Educate ("***TPE***") program, which is intended to reduce errors in the claims submission process and focuses on items and services that pose the greatest risk to the Medicare program or that have a high national error rate, such as short inpatient stays. Under the TPE program, MACs use data analysis to identify providers who, for a particular item or service, have high claim denial rates or billing practices that vary significantly from their peers. Once a provider has been identified, the MAC reviews between 20 and 40 of the provider's claims for the item or service and, if issues are noted, offers the provider an individualized education session that is based on the results of the review. The provider is then generally given 45 days to improve its systems and processes, and, after that period has ended, the MAC conducts another review of the provider's claims. If additional issues are identified, the provider is given the opportunity for another education session. Providers are typically given three rounds of review and education before being referred to CMS for further action, potentially including pre-payment review, referral for RAC review, or in some cases revocation of billing privileges.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payers including HMOs, PPOs and other private insurers. Also included in this category are the patient responsibility portions for co-payment and deductible obligations under these programs. Our revenues from HMOs, PPOs and other private insurers were approximately 41.3% of our revenues for the year ended December 31, 2021. Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services or accept fixed, pre-determined fees for our services. These discounted contractual arrangements often limit our ability to increase charges or revenues in response to increasing costs. We actively negotiate with these payers in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payer with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. Additionally, plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when we are not a participating provider in the network, it can result in higher patient responsibility amounts that a patient may not have the ability to pay or may choose not to pay. We expect these trends to continue in the coming years.

Self-Pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Our revenues from self-pay patients were approximately 0.6% of our revenues for the year ended December 31, 2021. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities experienced in prior years, which included increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. We cannot predict how administrative or judicial interpretations, legislative actions or any other modifications to the Affordable Care Act that may be implemented or adopted, such as the cessation of cost sharing reduction payments or the repeal of the individual mandate, may impact our self-pay revenues. We also cannot predict whether the business closures and layoffs that are occurring as a result of the COVID-19 pandemic will increase the number of underinsured and uninsured patients that seek treatment at our facilities.

In addition, effective January 1, 2022, the No Surprises Act requires healthcare providers, including hospitals and other healthcare facilities, to provide uninsured patients with a good faith estimate of the provider's total expected charges for scheduled items or services, including any expected ancillary services, before providing the items or services to the patient. Uninsured patients will be able to utilize a patient-provider dispute resolution process to challenge the provider's charges if they receive a bill that is substantially higher than the good faith estimate that was provided by the healthcare provider. We cannot predict how the uninsured patient good faith estimate and dispute resolution provisions of the No Surprises Act will impact the amounts collected by the Company's facilities for self-pay patients.

Surprise Medical Billing

On December 21, 2020, Congress adopted legislation that is intended to limit the "surprise" medical bills that are often received by individuals receiving emergency and certain other services (such as anesthesia services) from out-of-network providers. Effective as of January 1, 2022, the No Surprises Act prohibits, among other things, out-of-network providers from balance billing patients for emergency care services that are provided by out-of-network facilities or at in-network facilities by out-of-network providers. The No Surprises Act also generally prohibits out-of-network providers from billing patients for non-emergency medical treatment unless the provider first notifies the patient of the provider's network status and estimated charges and the patient agrees to be financially liable for the additional amounts. Violations of the No Surprises Act are punishable by civil monetary penalties of up to $10,000, and the No Surprises Act may be enforced by both the state and federal governments.

When the prohibitions of the No Surprises Act apply, a patient's financial liability will generally be limited to his or her in-network amount. In addition, the patient's third-party payer must either pay the out-of-network provider an initial payment amount or issue a notice of denial to the provider for the services that were rendered within 30 days of the payer's receipt of the provider's claim. If the provider is not satisfied with the payer's initial payment amount, the provider and the payer will begin a 30-day negotiation period. If the provider and the payer cannot agree on a payment amount during the negotiation period, the parties may elect to initiate an independent dispute resolution ("***IDR***") process. The IDR process will be conducted by a neutral arbitrator that has been approved by the federal government. Under regulations that have been issued by HHS, the Department of Labor, and the Department of Treasury (collectively, the "***Departments***"), the arbitrator must begin with the presumption that the "qualifying payment amount," which will generally be the plan or the insurer's median contracted rate (the "***QPA***"), is the appropriate payment amount. A number of lawsuits have been filed against the Departments challenging the requirement that the arbitrator must begin with the presumption that the QPA is the appropriate payment amount, and at least one court has held that the presumption is inconsistent with the language of the No Surprises Act. The regulations that have been issued by the Departments in connection with the No Surprises Act also require certain healthcare providers and facilities to make publicly available, post on a public website and provide a one-page notice to individuals about the requirements and prohibitions applicable to the facility or provider under the No Surprises Act, any applicable state balance billing limitations or prohibitions, and how the individual can contact the appropriate state and federal agencies if he or she believes the provider or facility has violated the requirements set forth in the notice.

We cannot predict the outcome of the litigation that has been filed regarding the use of the QPA in the IDR process, how the No Surprises Act will be implemented by the Departments, or how it will ultimately be enforced by the federal and various state governments. We also cannot predict the amounts that will be received by our facilities and our employed providers for out-of-network services, whether the No Surprises Act will impact the in-network payment rates that are offered by third-party payers and the willingness of those payers to enter into participation agreements with us and our facilities in the future, or the costs we will incur in complying with the requirements of the No Surprises Act. In addition, a number of states are considering or have already adopted legislation to eliminate surprise medical billing. We cannot predict how state legislative actions to modify or pass these proposals may be implemented or adopted, or what impact, if any, those actions may have on our operations and revenues.

Price Transparency

Transparency in healthcare pricing has become a focal point for CMS, Congress, and many state legislatures. For example, effective as of January 1, 2021, hospitals generally are required to post their standard charges prominently on a publicly available website. Under CMS regulations, each hospital's standard charges must be posted in two ways: (1) a single machine-readable digital file containing the gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for all items and services provided by the hospital and (2) a public display in a consumer-friendly manner of cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for at least 300 "shoppable" services (70 CMS-specified and 230 hospital-selected). CMS is actively auditing and monitoring hospital compliance with its reporting requirements and has taken a number of steps to address hospital noncompliance, including issuing warning notices to and requesting corrective action plans from hospitals that are determined to be out of compliance with the price transparency requirements, implementing measures that are intended to increase the availability of the required machine-readable file, and increasing the civil monetary penalties that are applicable to violations of the price transparency requirements. In addition to the CMS hospital price transparency regulations, the Departments have issued regulations that require most private health plans, including group health plans and individual health insurance market plans, to disclose pricing and cost-sharing information to their beneficiaries. A number of states have also adopted their own healthcare price transparency and/or disclosure statutes.

In addition to addressing surprise billing, the No Surprises Act contains a number of provisions that are intended to promote provider and health plan price transparency. Among other things, under the No Surprises Act, healthcare providers will be required to provide "good faith estimates" of their total expected charges for scheduled items and services to the patient's health plan if the patient is insured prior to the item and/or service being provided. Health plans will be required to provide patients with an "advanced explanation of benefits" that includes: (1) information regarding the network status of the provider, (2) a copy of the provider's "good faith estimate," (3) an estimate of the amount that the patient will be expected to pay for the item or service, and (4) information on any applicable pre-authorization requirements.

Although we continue to evaluate, and are taking proactive steps in response to, the legislative and regulatory developments regarding price transparency, we cannot predict how existing regulations will be implemented or interpreted or whether any other requirements will be imposed on providers and health plans. We also cannot predict what affect the public disclosure of hospitals' or insurance providers' negotiated rates will have on our future negotiations with payers or the effect that the disclosure of pricing information by healthcare providers and health plans will have on our patient volumes and revenues.

Executive Order - Competition in the American Economy

On July 9, 2021, President Biden issued an executive order that is intended to promote competition in the American economy. Among other things, the executive order encourages the Federal Trade Commission (the "***FTC***") to ban or limit non-compete agreements, directs the Food and Drug Administration to work with states and tribes to import prescription drugs from Canada, directs HHS to increase its support for generic and biosimilar drugs, issue a comprehensive plan to combat high drug prices, and support existing price transparency rules, and encourages the Department of Justice ("***DOJ***") and the FTC to review and revise their merger guidelines to ensure that patients are not harmed by hospital mergers. We cannot predict how, if at all, the various initiatives set forth in the executive order will be implemented by the regulatory agencies involved or the impact that the executive order will have on our operations or future transactions.

Healthcare Reform

In recent years, Congress has passed a number of laws, including the Affordable Care Act, that are intended to effect major changes in the U.S. healthcare system. The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The net effect of the Affordable Care Act, as currently adopted, on our business continues to be subject to a number of variables, including the law's complexity, its changing and often incomplete implementation of regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. On June 17, 2021, the U.S. Supreme Court issued its decision in litigation that had been brought by a number of states against the federal government alleging that, in light of the repeal of the penalties associated with the individual mandate, the Affordable Care Act was unconstitutional. In its decision, the Court held that the states and other plaintiffs did not have standing to challenge the Affordable Care Act and ordered the case to be dismissed. While the U.S. Supreme Court rejected this most recent challenge to the Affordable Care Act, we cannot predict the outcome of other lawsuits that are still pending in lower courts regarding the implementation of various aspects of the Affordable Care Act or whether the U.S. Supreme Court will decide to hear future cases. Additionally, we cannot predict the impact that the current or future Presidential administrations and Congresses will have on the implementation and enforcement of the provisions of the Affordable Care Act or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

Expanded Coverage

Based on original Congressional Budget Office ("***CBO***") and CMS estimates, by 2020, the Affordable Care Act was originally expected to expand coverage for 32 to 34 million people, resulting in coverage of an estimated 95% of the legal U.S. population and an uninsured population of approximately 27 million individuals. This increased coverage was expected to occur through a combination of public program expansion and private sector health insurance and other reforms. In July 2021, the CBO estimated that, due to a number of factors, approximately 28 million people were uninsured in 2020 and that the number of uninsured individuals would remain relatively consistent through 2031.

Public program expansion has been driven primarily by expanding the categories of individuals who are eligible for Medicaid coverage and allowing individuals with relatively higher incomes to qualify for Medicaid coverage. When the Affordable Care Act was adopted, it essentially made the expansion of the Medicaid program mandatory. However, in 2012, the U.S. Supreme Court held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that chose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. Based on the U.S. Supreme Court's ruling, a number of states, including several in which the Company has facilities, have opted not to expand their Medicaid programs. Additional public program expansion has occurred through provisions of the Affordable Care Act that authorize the federal government to subsidize states that create non-Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL and allow Medicaid participating hospitals to make presumptive determinations of Medicaid eligibility for certain categories of individuals, such as pregnant women, infants, children, and parents and other caretaker relatives and their spouses. If an individual is found to be presumptively eligible for Medicaid benefits, the hospital will get paid for the services it provides during the temporary presumptive eligibility period, just as though the patient were already enrolled in the Medicaid program.

The expansion of health coverage through the private sector as a result of the Affordable Care Act has occurred through new requirements on health insurers, employers and individuals. For example, commencing January 1, 2014, health insurance companies were prohibited from imposing annual coverage limits, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. In addition, since January 1, 2011, each health plan has been required to keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. Also, since September 23, 2010, health insurers have not been permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old. Larger employers are subject to new requirements and incentives to provide health insurance benefits to their full-time employees, and, effective January 1, 2016, all employers subject to the requirement were required to offer health insurance coverage to 95% of their full-time employees and their dependents in order to avoid penalties.

To facilitate the purchase of health insurance by individuals and small employers, each state was required to establish an Exchange by January 1, 2014. For individuals and families below 400% of the FPL, the cost of obtaining health insurance through the Exchanges is subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. The ARP temporarily extends the availability of those subsidies to individuals and families with incomes over 400% of the FPL and increases the amount of the subsidies that are available for individuals and families who were already eligible for financial assistance under the Affordable Care Act. Health insurers participating in the Exchanges must offer a set of minimum benefits to be defined by HHS and may offer more benefits. Any benefits to us from the expansion of private sector coverage depend in large part on our success in contracting with payers whose policies are listed on the Exchanges. We currently have contracts with Exchange payers in every state in which we operate, and the reimbursement rates paid under those contracts generally are comparable to that paid to us by other private payers.

Public Program Spending

The Affordable Care Act provides for a number of Medicare, Medicaid and other federal healthcare program spending reductions. The CBO previously estimated that between 2013 and 2023, these program spending reductions would include $415 billion in Medicare fee-for-service market basket and productivity reimbursement reductions for all providers, the majority of which ($260 billion) would come from hospitals. The CBO's estimate also included an additional $56 billion in reductions of Medicare and Medicaid DSH funding. CMS had originally estimated that the Affordable Care Act would result in $64 billion in reductions of Medicare and Medicaid DSH funding, with $50 billion of the reductions coming from Medicare. Some of those reductions, most notably the Medicaid DSH funding reductions, have been delayed by subsequent legislation, and we cannot predict whether the public program spending reductions required by the Affordable Care Act will be further delayed or modified in the future.

Accountable Care Organizations

The Affordable Care Act required HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("***ACOs***"). ACOs are groups of hospitals and/or physicians and other designated professionals and suppliers who come together voluntarily to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS are eligible to share in a portion of the amounts saved by the Medicare program. There are several types of ACO programs, and as of January 1, 2022, 483 ACOs had been established to participate in the Medicare Shared Savings Program, and additional ACOs are being established by private payers. A few of our facilities currently participate in ACOs.

Bundled Payment Pilot Programs

The Affordable Care Act created the Center for Medicare & Medicaid Innovation ("***CMMI***") and made it responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs while improving quality of care. Under these projects and initiatives, participating providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care and accept accountability for costs and the quality of care that is provided. By financially rewarding providers for quality, cost-effective care and penalizing providers when costs exceed a certain amount, these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. In connection with these programs, CMMI has developed a voluntary Bundled Payment for Care Improvement Advanced Model ("***BPCI Advanced***") to test innovative payment and service delivery models that have the potential to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care for beneficiaries. Participation in bundled payments programs is generally voluntary, but CMS does currently require hospitals in certain geographic areas to participate in the Comprehensive Care for Joint Replacement model, which covers certain extremity joint replacement procedures and is scheduled to end in 2024. CMS has developed a radiation oncology bundled payment program that was expected to begin on January 1, 2022, but has been delayed until at least January 1, 2023, by the Sequester Cuts Act. CMS has indicated that it expects to develop additional voluntary and mandatory bundled payment models in the future. Several of our facilities currently participate in bundled payment programs.

Specialty Hospital Limitations

Over the last decade, we have faced competition from hospitals that have physician ownership. The Affordable Care Act prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand. As of December 31, 2021, we operated two hospitals through joint ventures with physicians in which we own a controlling interest.

Competition for Patients

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

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

In addition, tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, exemptions from sales, property and income taxes, and participation in the 340B Program. In certain states, some not-for-profit hospitals are permitted by law to directly employ physicians while for-profit hospitals are prohibited from doing so.

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

Human Capital Resources

Our facilities must compete with other healthcare providers for professional talent. A significant factor in our future success will be the ability of our facilities to attract and retain physicians, as it is physicians who decide whether a patient is admitted to the hospital and the procedures to be performed.

We also compete with other healthcare providers in recruiting and retaining qualified management and other healthcare providers such as nurses, pharmacists, and lab technicians and other non-physician personnel responsible for day-to-day operations of each of our facilities. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue, which has been heightened by the COVID-19 pandemic. This shortage has required, and may continue to require us, to enhance wages and benefits to recruit and retain nurses and other medical support personnel, recruit personnel from foreign countries, and hire more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate.

Overview

At December 31, 2021, our subsidiaries collectively had approximately 50,000 employees, including approximately 12,000 part-time employees. The majority of these employees are hospital-based, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our facilities. We understand that, to fulfill our mission of Making Communities Healthier®, we must create places where people choose to come for healthcare, physicians want to practice, and employees want to work. To support this mission, talent development has been a longstanding strategic pillar for the organization.

Diversity, Equity and Inclusion

We are committed to creating an inclusive, community-based healthcare delivery system that provides equitable opportunities for all people, starting with our employees. We appointed a Chief Diversity and Patient Experience officer in early 2021 who is leading an enterprise-wide strategy focused on training and education of our workforce, targeted efforts to address health equity in our communities, and the recruitment and development of diverse talent. This includes the creation of new formal partnerships to recruit more diverse talent and match new recruits with carefully selected mentors and sponsors within our organization.

Recruitment and Retention

We believe that healthcare is best delivered close to home, and our facilities strive to recruit and retain qualified management and staff personnel. Our frontline caregivers, including nurses, are the heartbeat of our organization, and we have a robust strategy to enhance the recruitment and retention of clinical staff into the future. This strategy includes meaningful education and career advancement opportunities, and competitive compensation. The scarce availability of nurses and other medical support personnel in some markets, which has been heightened by the COVID-19 pandemic, has required us to enhance wages and benefits and/or hire more expensive temporary personnel in certain situations.

Our facilities also employ and have affiliations with physicians. Many physicians today prefer to be employed, rather than operating their own practices or joining existing medical groups. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians and incur additional expenses as a result. We expect this trend to continue.

We seek to attract both employed and affiliated physicians by maintaining a sharp focus on quality, driven by our National Quality Program; employing high performing talent; equipping our facilities with technologically advanced equipment and an attractive, up-to-date physical plant; and otherwise creating an environment within which physicians choose to practice. While physicians may terminate their association with our facilities at any time, we believe that by striving to maintain and improve the quality of care at our facilities and by maintaining ethical and professional standards, our facilities will be better positioned to attract and retain qualified physicians with a variety of specialties.

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

Labor Costs and Union Activity

Approximately 2,000 of our employees across certain of our facilities are unionized. While some of our non-unionized facilities experience union organizing activity from time to time, currently we do not expect these efforts to affect our future operations materially. Our facilities, like most facilities, have experienced rising labor costs and increases in the rate and utilization of contract labor. Our labor costs also may increase at higher rates among unionized employees. Unionized employees also may have rights under their collective bargaining agreements that restrict the ability of a facility to take certain actions with respect to these employees.

Government Regulation

Overview

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

Legislative and Regulatory Developments in Response to COVID-19

Numerous recent legislative and regulatory actions have been taken in an attempt to provide businesses, including healthcare providers, with relief from the negative impacts of the COVID-19 pandemic. The legislative and regulatory responses to COVID-19 generally impact many of the statutes, regulations and policies summarized or discussed throughout this Report. Unless otherwise noted, such summaries or discussions have not been updated to reflect the impact of the COVID-19 legislative and regulatory developments.

CARES Act and Related Stimulus Legislation

The CARES Act was signed into law on March 27, 2020. Among other things, the CARES Act contains a number of provisions that are intended to assist healthcare providers as they combat the effects of the COVID-19 pandemic. Those provisions include, among others:

- the temporary suspension of Medicare sequestration from March 1, 2020, to December 31, 2020;
- the delay of the planned reductions to the Medicaid DSH payments program until October 1, 2023;
- an appropriation of $180 million to Health Resources and Services Administration's Federal Office of Rural Health Policy that will be awarded to small rural hospitals by the states through the Small Rural Hospital Improvement Program;
- an appropriation of $250 million to the Hospital Preparedness Program; and
- an appropriation of $100 billion to the Public Health and Social Services Emergency Fund (the "***Emergency Fund***") for a new program to reimburse, through grants or other mechanisms, hospitals, healthcare providers and other approved entities for COVID-19-related expenses or lost revenues.

The Paycheck Protection Program and Health Care Enhancement Act was enacted on April 24, 2020, and, among other things, provides an additional allocation of $75 billion to the Emergency Fund and an allocation of $25 billion for COVID-19 testing.

On December 21, 2020, Congress adopted the CAA, which provides an additional $900 billion in COVID-19 relief, including an additional allocation of $3 billion to the Emergency Fund. In addition, the CAA, among other things, delays the planned reductions to the Medicaid DSH payments program through FFY 2023, adds additional reductions to the Medicaid DSH payments program in FFYs 2026 and 2027, provided for a 3.75% increase in the Medicare PFS rates in CY 2021 and allocates $30 billion for the purchase and administration of COVID-19 vaccines and related therapeutics. In addition, the CAA extended the temporary suspension of Medicare sequestration through March 31, 2021. The temporary suspension was subsequently extended through December 31, 2021, by HR 1868, which, to offset the cost of the suspension, extended Medicare sequestration through 2030. The Sequester Cuts Act further extends the temporary suspension of Medicare sequestration through March 31, 2022, and reduces the sequestration cuts for the period of April 1, 2022, through June 30, 2022, to 1%. The Sequester Cuts Act also delays application of 4% cuts to Medicare and other federal programs resulting from the requirements of the Statutory Pay-As-You-Go-Act of 2010 that were scheduled to go into effect in CY 2022 until CY 2023.

On March 11, 2021, the ARP was signed into law. Among other things, the ARP allocates approximately $70 billion for COVID-19 testing and vaccine efforts; provides $8.5 billion to reimburse rural healthcare providers, such as sole community hospitals, rural referral centers, rural health clinics, and providers located outside metropolitan statistical areas, for expenses and lost revenues attributable to COVID-19; provides incentives, in the form of temporary increases to the FMAP, to encourage states that have not expanded their Medicaid programs as permitted by the Affordable Care Act to do so; permits states to expand the availability and duration of Medicaid postpartum coverage; and temporarily expands the subsidies that are available to individuals who purchase insurance through the Exchanges.

Stimulus Payments

The Emergency Fund distributed approximately $43 billion to hospitals based on their 2018 net patient revenue. Additionally, since that time, the Emergency Fund has distributed more than $90 billion to a number of different types of healthcare providers, including participants in state Medicaid/CHIP programs, providers in areas particularly impacted by the COVID-19 outbreak, rural providers (including hospitals and rural health clinics), skilled nursing facilities, dentists, providers of services with lower shares of Medicare reimbursement or who predominantly serve Medicaid beneficiaries, and providers requesting reimbursement for the treatment of uninsured patients.

Payments made by the Emergency Fund to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, filing attestations acknowledging receipt of payments, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients, not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse, and submitting such reports as may be required by HHS regarding the provider's compliance with the terms and conditions of the Emergency Fund. Healthcare providers that received more than $10,000 from the Emergency Fund between April 10, 2020 through June 30, 2020 (the "***First Payment Received Period***") were required to submit a report on their use of those funds no later than September 30, 2021. We successfully submitted the required reports for all of our providers that received and retained payments from the Emergency Fund during First Payment Received Period prior to the deadline. However, we will be required to submit additional reports in the future for payments that were received and retained by our providers from the Emergency Fund after the end of the First Payment Received Period. The reporting requirements and guidance from HHS related to the Emergency Fund have been subject to frequent clarifications and revision, and there can be no assurance that we will not be required to submit additional reports or provide additional information related to the payments we received from the Emergency Fund in the future. In addition, HHS has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the Office of Inspector General of HHS (the "***OIG***"), will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, HHS temporarily expanded the CMS Accelerated and Advance Payment Program to a broad group of Medicare Part A and Part B providers. Under the expanded Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period.

We received a total of $991 million of Medicare advance payments under the CMS Accelerated and Advance Payment Program during the year ended December 31, 2020. During the year ended December 31, 2021, we fully repaid all Medicare advance payments, and we do not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program.

COVID-19 Waivers and Temporary Suspension of Certain Regulatory Requirements

In addition to the financial relief that has been provided by the federal government under the CARES Act and other legislation that has been passed by Congress, CMS and many state governments have also issued a number of waivers or temporarily suspended a number of healthcare facility licensure and reimbursement requirements in order to provide hospitals, skilled nursing facilities, and other types of healthcare providers with increased flexibility to meet the challenges that are being presented by the COVID-19 pandemic. For example, CMS has temporarily waived the enforcement of certain requirements of the Medicare hospital conditions of participation and the Stark law to enable hospitals to treat patients in temporary locations and to obtain services from physicians in a more efficient and timely manner. Likewise, many states have also suspended the enforcement of certain certificate of need and licensure requirements to ensure that hospitals and other healthcare providers have sufficient capacity to treat COVID-19 patients. Our facilities have utilized the waivers and regulatory flexibility that is being provided to the extent necessary to appropriately respond to the COVID-19 pandemic.

CARES Act Tax Provisions

The CARES Act also provides for certain federal income tax changes, including an increase in the interest expense tax deduction limitation, the deferral of the employer portion of Social Security payroll taxes, refundable payroll tax credits, employee retention tax credits, net operating loss carryback periods, alternative minimum tax credit refunds and bonus depreciation of qualified improvement property. During the year ended December 31, 2020, we deferred cash payments of approximately $84 million related to Social Security payroll tax payments. During the year ended December 31, 2021, we fully repaid all previously deferred Social Security payroll taxes.

The federal income tax changes brought about by the CARES Act are complex and further guidance is expected. We may change our provision for income taxes and our deferred income taxes as our understanding of the CARES Act tax provisions evolves due to additional U.S. Department of Treasury guidance. Any such adjustments could materially impact our provision for income taxes and, as a result, our financial results in the relevant periods.

Fraud and Abuse Laws

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

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

Anti-kickback Statute

The federal Anti-kickback Statute is a criminal statute that generally prohibits the payment, receipt, offer or solicitation of anything of value, whether in cash or in kind, with the intent of generating referrals or orders, or recommending or arranging for services or items covered by a federal or state healthcare program. Violations of the Anti-kickback Statute are punishable by, among other things, imprisonment, criminal fines, substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation, damages equal to three times the total remuneration associated with the unlawful referrals or services, and/or possible exclusion from participating in Medicare, Medicaid or other governmental healthcare programs. Violations of the Anti-kickback Statute can also result in liability under the False Claims Act.

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

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

In 1998, the OIG published the Provider Self-Disclosure Protocol (which was subsequently replaced in 2013 and further amended in 2021 and renamed the Health Care Fraud Self-Disclosure Protocol) to establish a process for persons to voluntarily identify, disclose, and resolve instances of potential fraud involving federal healthcare programs and provide guidance on how to investigate this conduct, quantify damages, and report the conduct to OIG to resolve liability under OIG's civil monetary penalty authorities. We have a variety of financial relationships with physicians who refer patients to our facilities, including employment contracts, independent contractor agreements, professional service agreements, leases and joint ventures. We provide financial incentives to recruit physicians to relocate to communities served by our facilities. These incentives for relocation include minimum revenue guarantees and, in some cases, loans. The OIG is authorized to publish regulations outlining activities and business relationships that would be deemed not to violate the Anti-kickback Statute. These regulations are known as "safe harbor" regulations. Failure to comply with the safe harbor regulations does not, by itself, make conduct illegal, but instead the safe harbors delineate standards that, if complied with, protect conduct that might otherwise be deemed in violation of the Anti-kickback Statute. We intend for all our business arrangements to be in full compliance with the Anti-kickback Statute and seek to structure each of our arrangements with physicians to fit as closely as possible within an applicable safe harbor. However, not all of our business arrangements fit wholly within safe harbors, so we cannot guarantee that these arrangements will not be scrutinized by government authorities or, if scrutinized, that they will be determined to be in compliance with the Anti-kickback Statute or other applicable laws.

Eliminating Kickbacks in Recovery Act

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

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

Stark Law

The federal Stark law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship if those entities provide certain "designated health services" unless an exception applies. The Stark law also prohibits entities that provide designated health services reimbursable by Medicare and Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires entities to refund amounts received for items and services provided pursuant to a prohibited referral on a timely basis. "Designated health services" include, among other things, inpatient and outpatient hospital services, laboratory services and radiology services. A violation of the Stark law may result in (i) a denial of payment, (ii) substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation or circumvention scheme and (iii) exclusion from participation in the Medicare and Medicaid programs and other governmental healthcare programs. In addition, violations of the Stark law could also result in penalties under the False Claims Act.

There are ownership and compensation arrangement exceptions to the self-referral prohibition. There are also exceptions for many of the customary financial arrangements between physicians and facilities, including employment contracts, leases and recruitment agreements, and there is a "whole hospital exception," which allows a physician to make a referral to a hospital if, among other things, the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. The Affordable Care Act significantly modified the requirements of the whole hospital exception and placed a number of restrictions on the ownership structure, operations, and expansion of physician owned hospitals. Two of our facilities are subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations.

In recent years, CMS has issued a number of proposed and final rules modifying and/or clarifying the Stark law exceptions. For example, on November 20, 2020, HHS published two final rules related to the Anti-kickback Statute and the Stark law that are intended to reduce regulatory barriers to care coordination and ease unnecessary compliance burdens for physicians and other healthcare providers. Among other things, the rules create new Anti-kickback Statute safe harbors and Stark law exceptions for value-based and cyber-technology arrangements and provide new guidance and clarification as to how the Anti-kickback Statute and Stark law will be interpreted and enforced by the OIG and CMS, respectively. We cannot predict the impact that the final rules will have on our facilities and our operations or whether the recent trend toward reducing provider compliance burdens will continue in the future. We also anticipate that there will be further changes to the regulations that implement the Anti-kickback Statute and/or the Stark law, and those changes may require us to modify our activities.

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

False Claims Act

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

Changes in the Regulatory Environment

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

In addition to the changes mentioned above, the Affordable Care Act created False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. On February 11, 2016, CMS published a final rule that provides clarification around the meaning of overpayment identification and generally establishes a six-year lookback period for Medicare Part A and Part B providers and suppliers. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments, accurately prepare cost reports and timely resolve credit balances. In light of the provisions of FERA and the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law, including technical violations of certain fraud and abuse laws, and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

State Laws

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

Emergency Medical Treatment and Active Labor Act

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

Administrative Simplification Provisions and Privacy and Security Requirements

We are subject to the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***") which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. Additionally, we are subject to the privacy, security and breach notification regulations promulgated under HIPAA and the Health Information Technology for Economic and Clinical Health Act (the "***HITECH Act***"), which are designed to protect the confidentiality, availability and integrity of protected health information ("***PHI***") and establish an array of patient rights with respect to such information. The HIPAA privacy, security and breach notification regulations apply to covered entities, which include health plans, healthcare clearinghouses, and healthcare providers that conduct certain standard transactions (such as billing insurance) electronically. In addition, certain provisions of the privacy, security and breach notification regulations apply to business associates, which are entities that perform certain functions or activities on behalf of covered entities that require access to or the use or disclosure of protected health information. In certain circumstances, a covered entity may be held liable for the actions of its business associate if HHS determines an agency relationship exists between the covered entity and the business associate under federal agency law.

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

HIPAA enforcement actions arise from audits, complaints, and breach notifications. Violations of the HIPAA regulations may result in criminal penalties and substantial civil monetary penalties subject to a limit for violations of the same requirement in a calendar year, based on the level of culpability associated with the violation. The civil monetary penalties are also subject to annual inflation adjustments. In addition, state attorneys general are authorized to bring civil actions seeking either injunction or damages up to $25,000 for violations of the same requirement in a calendar year in response to HIPAA violations that affect their state residents. HHS has the discretion in many cases to resolve HIPAA violations through informal means without the imposition of penalties. However, the HIPAA privacy, security and breach notification regulations have and will continue to impose significant costs on our facilities in order to comply with these standards. In recent years, enforcement of the HIPAA regulations has increased significantly, and we expect the increased level of enforcement to continue in the future.

Our facilities continue to remain subject to other applicable federal or state laws that are more restrictive than the HIPAA privacy and security regulations, which could impose additional penalties on us. For example, the FTC uses its consumer protection authority to initiate enforcement actions against companies whose inadequate data security programs may expose consumers to fraud, identity theft and privacy intrusions, including the security programs of entities subject to the HIPAA regulations. Other state data privacy and security laws also may be applicable to certain data held by our facilities of residents of such states, such as the California Consumer Privacy Act of 2018, as well as other similar laws that are selected to go into effect in the future (for example, the Virginia Consumer Data Protection Act and the Colorado Privacy Act).

Corporate Practice of Medicine and Fee-Splitting

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

Facility Licensure, Certification, and Accreditation

All of our facilities must comply with various federal, state and local licensing and certification regulations and undergo periodic inspection by licensing agencies to certify compliance with such regulations. The initial and continued licensure of our facilities and certification to participate in government healthcare programs depends upon many factors including various state licensure regulations relating to quality of care, environment of care, equipment, services, staff training, personnel and the existence of adequate policies, procedures and controls. Federal, state and local agencies survey our facilities on a regular basis to determine whether the facilities are in compliance with regulatory operating and health standards and conditions for participating in government healthcare programs.

Most of our general acute care hospitals and IRFs maintain accreditation from private entities, such as The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities ("***CARF***"). The Joint Commission accredits a broad variety of healthcare organizations, including hospitals and behavioral health organizations. CARF accredits behavioral health organizations providing mental health and alcohol and drug use and addiction services, rehabilitation services, as well as opiate treatment programs, and other types of healthcare programs. These accreditation programs are intended generally to improve the quality, safety, outcomes and value of healthcare services provided by accredited facilities. Certain federal and state licensing agencies as well as many government and private healthcare payment programs require that providers be accredited as a condition of licensure, certification or participation. Accreditation is typically granted for a specified period, ranging from one to three years, and renewals of accreditation generally require completion of a renewal application and an on-site renewal survey.

The Controlled Substances Act and Drug Enforcement Administration ("***DEA***") regulations require every person who dispenses controlled substances to be registered with the DEA at each principal place of business or professional practice where the person dispenses controlled substances, subject to limited exceptions. Each hospital or clinic must hold a DEA registration at each location and may be subject to similar state registration requirements. In addition, our facilities are subject to a variety of federal and state statutes and regulations that govern operational issues related to pharmaceuticals and controlled substances, such as those related to packaging, storing, and dispensing of pharmaceutical drugs, inventory control and recordkeeping requirements for controlled substances, and other standards intended to prevent diversion of controlled substances. The DEA, the DOJ, HHS, and state boards of pharmacy have broad enforcement powers, may conduct audits and investigations and can impose substantial fines and other penalties, including revocation of registration.

Certificates of Need

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

Not-for-Profit Hospital Conversion Legislation

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

Environmental Regulation

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

Compliance Program

We maintain a company-wide ethics and compliance program designed to ensure that we maintain high standards of ethical conduct in the operation of our business and to meet or exceed applicable federal guidance and industry standards. We continually implement written policies and procedures for all of our employees to promote compliance with all applicable laws, regulations and Company policies and to encourage a "culture of compliance" within the Company and its facilities. The organizational structure of our ethics and compliance program includes oversight by our Board of Directors and compliance committees at the Company and facility levels. We have compliance officers and personnel at the Company level and at our facilities. Other features of our compliance program include initial and periodic ethics and compliance training, systems for identifying and tracking compliance issues (including databases and hotlines for employees to report, without fear of retaliation, any suspected legal or ethical violations), regular auditing and monitoring of compliance issues, including coding audits and reviews of our financial relationships with physicians, and prompt review and resolution of identified issues.

Our compliance program also oversees the implementation and monitoring of the standards set forth by HIPAA for privacy. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and oversight at the Company level.

Risk Management and Insurance

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("***SIR***") and deductible levels. At December 31, 2021, our SIR for professional liability claims is $15 million per claim at the majority of our acute care hospitals. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico and Pennsylvania. We have a $25,000 deductible for professional liability at each of our IRFs. At December 31, 2021, our deductible for workers' compensation claims at each of our acute care hospitals was $1 million per claim in all states in which we operate except for Montana and Washington. We participate in state-specific programs for our workers' compensation claims arising in these states. There is no deductible for workers' compensation claims at our IRFs. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

We also maintain directors' and officers', property, some professional liability and other types of insurance coverage with unrelated commercial carriers. Our directors' and officers' liability insurance coverage for current officers and directors is a program that protects us as well as the individual director or officer. We maintain property insurance through unrelated commercial insurance companies.

We operate a captive insurance company under the name Point of Life Indemnity, Ltd. This captive insurance company, which is licensed by the Cayman Islands Monetary Authority and is a wholly-owned subsidiary of LifePoint, issues malpractice indemnity policies to some subsidiaries employing physicians and advanced practice providers.

Item 1A. ***Risk Factors.***

Any of the following risks could materially and adversely affect our business, financial condition or results of operations. In addition, the risks described below are not the only risks that we face. The following information should be read in conjunction with "Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Report. Additional risks and uncertainties not currently known to us or those that we currently view to be immaterial could also materially and adversely affect our business, financial condition or results of operations.

Risk Factor Summary

The following is a summary of the principal risks that could adversely affect our business, operations and financial results.

COVID-19 and Other Potential Pandemic Risks

- The COVID-19 global pandemic continues to affect our operations, business and financial condition, and our liquidity could be negatively impacted, particularly if the U.S. economy remains unstable for a significant amount of time.
- There can be no assurance as to the total amount of financial assistance or types of assistance we seek or receive under existing or future stimulus legislations, or that the terms of provider relief funding or other programs will not change in ways that affect our funding or eligibility to participate.
- The emergence and effects related to a pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations and financial condition.

Business and Operational Risks

- The implementation of the Kindred Transaction may have an adverse effect on our business, financial condition and results of operations, and we may not realize the anticipated benefits of the Kindred Transaction within the timeframe expected or at all.
- Our revenues will decline if federal or state programs reduce our Medicare or Medicaid payments.
- Uncertainty regarding the Affordable Care Act or future healthcare reform may adversely affect our business, financial condition and results of operations.
- Changes to Medicaid supplemental payment programs may materially and adversely affect our revenues and results of operations.
- Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may limit our revenues and profitability.
- We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations, or it could diminish the anticipated value of the acquired facility.
- If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.
- We are subject to risks associated with outsourcing functions to third parties, including risks associated with the protection of patient data.
- We conduct a significant portion of our operations through joint ventures. We cannot provide assurances that relationships with our joint venture partners will remain strong, which could negatively affect our joint ventures, affiliations and other strategic alliances as well as our overall business.
- Deterioration in the collectability of "patient due" accounts could adversely affect our revenues and results of operations.
- Other hospitals and inpatient and outpatient facilities provide services similar to those which we offer. In addition, physicians and other healthcare practitioners provide services in their offices that could be provided in our facilities. These factors increase the level of competition we face and may therefore adversely affect our revenues and results of operations.
- We may have difficulty acquiring or divesting facilities on favorable terms. Furthermore, our business could be negatively affected if acquisitions or divestitures are not successfully completed or if contingent liabilities materialize in connection with such transactions.
- If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results could be negatively impacted.
- Under the 2021 Master Lease (defined below), a default with respect to one facility could cause a default under all of the facilities subject to the 2021 Master Lease, which would have a material adverse effect on our business, results of operations and financial condition.
- Because many of the facilities we operate are subject to long-term leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises.
- Many of the non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies intended to generate organic growth and improve operating results at our facilities.

Credit and Liquidity Risks

- Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments.
- Our debt agreements contain restrictions that will limit our flexibility in operating our business.
- Repayment of our debt is dependent on cash flow generated by our subsidiaries.
- Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.
- We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.
- Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.
- Discontinuation, reform or replacement of LIBOR may adversely affect our results of operations.
- We may not be able to generate sufficient cash flow through operations or successfully access other capital resources to fund all of our capital expenditure programs and commitments.
- Our ability to utilize our net operating loss carryforwards ("***NOLs***") may be limited, and we may not be able to utilize our NOLs as a result of recent U.S. federal tax reform legislation.

Human Capital Risks

- Factors related to our employment of physicians could affect our financial performance.
- Our operations and ability to deliver healthcare services efficiently may be adversely affected by competition for staffing, the shortage of experienced physicians, nurses and other healthcare professionals, and vaccine mandates.
- Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and subject to the terms of collective bargaining agreements.
- We are dependent on our executive management team and the loss of the services of one or more of our executive management team could have a material adverse effect on our business.

Regulatory and Legal Risks

- We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may reduce our revenues and profitability.
- We may be subjected to actions brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the False Claims Act's "qui tam" or "whistleblower" provisions.
- We will be subject to liabilities because of malpractice and related legal claims brought against our facilities or healthcare providers associated with, or employed by, our facilities or affiliated entities. If we become subject to these claims, we could be required to pay significant damages, which may not be covered by insurance.
- As a result of reviews of claims to Medicare and Medicaid for our services, we may experience delayed payments or incur additional costs and may be required to repay amounts already paid to us.
- Controls designed to reduce inpatient services may reduce our revenues.
- If we do not manage admissions in the IRFs that we operate or manage in compliance with a 60% threshold, reimbursement for services rendered by us in these facilities will be based upon less favorable rates.
- Certificate of need laws and regulations regarding licenses, ownership and operation may impair our future expansion in some states. In states without certificate of need laws, competing providers of healthcare services are able to expand and construct facilities without the need for significant regulatory approval.
- Failure to implement and use certified health information technology in an effective and timely manner could adversely affect our operations and result in reduced Medicare and Medicaid reimbursement and government enforcement actions.
- The industry emphasis on value-based purchasing and bundled payment arrangements may negatively affect our revenues.
- The implementation of participation and quality measurement requirements under the MACRA's Merit-Based Incentive Payment System may affect our revenues.
- If current or future laws or regulations force us or cause us to restructure our arrangements with physicians and other providers, we may incur additional costs, lose contracts and suffer a reduction in net revenue under existing contracts, and we may need to refinance our debt or obtain consent from our lenders.

Data Security and Privacy Risks

- A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.
- If access to our information systems or those provided by our third-party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

COVID-19 and Other Potential Pandemic Risks

The COVID-19 global pandemic continues to affect our operations, business and financial condition, and our liquidity could be negatively impacted, particularly if the U.S. economy remains unstable for a significant amount of time.

The COVID-19 global pandemic continues to affect our facilities, employees, patients, communities, business operations and financial performance, as well as the U.S. economy and financial markets. Although vaccines have been developed and are being distributed in the U.S., the length and severity of the COVID-19 pandemic continues to evolve and much of its impact remains unknown and difficult to predict because many of the driving factors are beyond our control, including the vaccination rates in the communities we serve, the number and severity of the variants of the virus that emerge, and the effectiveness of the vaccines against the virus and those variants.

Although we continue to take precautions to ensure we can continue providing quality care and safeguard the health and well-being of patients, employees, providers, volunteers and visitors in each community we serve, exposure to COVID-19 and variants of the virus has increased the cost of operating our facilities, has increased the length of patient stays, and has led to increased risks to doctors and nurses, which has caused staffing shortages and required us to utilize temporary healthcare practitioners and may further reduce our operating capacity. Additionally, the reluctance of some employees and providers to comply with federal and state vaccine mandates has further contributed to staffing shortages at our facilities. If our facilities fail to comply with the federal vaccine mandate they could potentially be subject to the imposition of civil monetary penalties, reduced reimbursement, and termination from participation in the Medicare and Medicaid programs. Certain of our facilities have experienced staffing shortages, and, if our facilities continue to treat an increased number of COVID-19 patients, they could become overwhelmed by excessive demand, potentially preventing them from treating all patients who seek care. We also have experienced supply chain disruptions during the pandemic, including shortages and delays, as well as price increases in equipment, inventory, pharmaceuticals and medical supplies, particularly personal protective equipment (or PPE). Any staffing, equipment, inventory, pharmaceutical and medical supplies shortages may impact our ability to see, admit and treat patients.

The willingness and ability of patients to seek healthcare services also has been impacted by restrictive measures, like travel bans and restrictions, social distancing, vaccine mandates and quarantine guidelines, which have negatively impacted the volume of procedures performed at our facilities more generally, as well as the volume of emergency room and physician office visits unrelated to COVID-19. Furthermore, in response to the COVID-19 pandemic, regulatory barriers to telehealth services have been reduced to expand the availability of remote care. As patients become more comfortable with remote care, which generally receives a lower reimbursement for services, our revenues may be adversely impacted, particularly if CMS and other third-party payers make the increased availability of telehealth services and remote care permanent.

Broad economic factors resulting from the COVID-19 pandemic, including increased unemployment rates, increased inflation rates and reduced consumer spending, could also negatively affect our payer mix, increase the relative proportion of lower margin services we provide and reduce patient volumes, as well as diminish our ability to collect outstanding receivables. See "—Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may limit our revenues and profitability." Business closings and layoffs in the communities in which we operate may lead to increases in the uninsured, underinsured and Medicaid populations and adversely affect demand for our services, as well as the ability of patients and other payers to pay for services as rendered. Any increase in the amount or deterioration in the collectability of patient accounts receivable will adversely affect our cash flows and results of operations, requiring an increased level of working capital. If general economic conditions continue to deteriorate or remain uncertain for an extended period of time, our liquidity and ability to repay our outstanding debt may be harmed.

In addition, our results and financial condition may be further adversely affected by future federal or state laws, regulations, orders, or other governmental or regulatory actions addressing the COVID-19 pandemic or the U.S. healthcare system, which, if adopted, could result in direct or indirect restrictions to our business, financial condition, results of operations and cash flow. We may also be subject to lawsuits from patients, employees and others exposed to COVID-19 and variants of the virus at our facilities, or from other third-parties or family members who are exposed due to contact with patients, employees, or others exposed at our facilities. Such actions may involve large demands, as well as substantial defense costs. Our professional and general liability insurance may not cover all claims against us.

The foregoing and other continued disruptions to our business as a result of the COVID-19 pandemic have had and are likely to continue to have a material adverse effect on our business and could have a material adverse effect on our results of operations, financial condition, cash flows and our ability to service our debt. Furthermore, the COVID-19 pandemic (including governmental responses, broad economic impacts and market disruptions) has heightened the materiality of certain other risk factors described herein.

There can be no assurance as to the total amount of financial assistance or types of assistance we seek or receive under existing or future stimulus legislations, or that the terms of provider relief funding or other programs will not change in ways that affect our funding or eligibility to participate.

We received and may seek other funds that are made available to us and our facilities under the CARES Act and other existing or future stimulus legislation, if any. There can be no assurance that the terms of provider relief funding or other programs under the CARES Act and other existing stimulus legislation or future stimulus legislation, if any, will not change in ways that affect our funding or eligibility to participate, or that changes to the terms of such programs will not result in government recoupment of funds that were initially released to us as grants. Additionally, although the federal government may consider additional stimulus and relief efforts, such efforts may be drafted or implemented in ways that restrict, limit or otherwise negatively impact our ability to access these funds. As a result, we cannot predict the manner in which existing or future stimulus funds will be allocated or administered, and we cannot assure you that we will be able to access future stimulus funds in a timely manner or at all. For additional information regarding the CARES Act and related stimulus legislation, and our participation in programs under the CARES Act and related stimulus legislation, if any, see "Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19."

In addition, there have been frequent clarifications and revisions to the guidance available regarding the accounting treatment of funds that have been received by us and our facilities under the CARES Act and other COVID-19 stimulus legislation. These changes and lack of clarity require us to apply professional judgment and make certain estimates and assumptions with respect to the presentation, amount and timing of our recognition of stimulus received under the CARES Act. For additional information regarding the CARES Act and related financial impact, refer to Note 3 to the consolidated financial statements included elsewhere in this Report.

The emergence and effects related to a pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations and financial condition.

As evidenced by the COVID-19 pandemic, the occurrence of a pandemic, epidemic, outbreak of an infectious disease or other public health crisis in an area in which we operate could adversely affect our operations and financial condition. In reaction to such a crisis or the fear of exposure to infection, patients might cancel elective procedures or fail to seek needed care at our facilities, which could result in reduced patient volumes and operating revenues, potentially over an extended period of time. Furthermore, a pandemic, epidemic or outbreak might adversely affect our operations by causing a temporary shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. Additionally, such a crisis could diminish the public trust in healthcare facilities, especially hospitals that fail to accurately or timely diagnose, or are treating (or have treated) patients affected by infectious diseases, and negatively affect the reputation at our facilities.

Although we have disaster plans in place and operate pursuant to infectious disease protocols, the extent to which the potential emergence of a pandemic, epidemic or outbreak would impact our business and operations is difficult to predict and would depend on many factors beyond our control, including the speed of the contagion, the development and implementation of effective preventative measures and possible treatments, the scope of governmental and other restrictions on travel and other activities, and public reactions to these factors.

Business and Operational Risks

The implementation of the Kindred Transaction may have an adverse effect on our business, financial condition and results of operations, and we may not realize the anticipated benefits of the Kindred Transaction within the timeframe expected or at all.

Uncertainty about the effect of the Kindred Transaction on our employees, patients, local communities, business partners and other parties may have an adverse effect on our business, financial condition and results of operation, and we may not realize the anticipated benefits of the Kindred Transaction within the timeframe expected or at all. These risks to our business include the following, all of which could be exacerbated by a delay in realizing the benefits of the Kindred Transaction:

- our ability to attract, retain, and motivate current and prospective employees may be adversely impacted;
- the attention of our management and employees may be diverted due to activities related to the Kindred Transaction;
- we may be subject to increased regulatory oversight as a result of the Kindred Transaction;
- we may be subject to legal proceedings relating to the Kindred Transaction; and
- we may experience delays, difficulties or complications with the integration of Kindred's rehabilitation and behavioral health businesses, including expanded joint venture relationships, into our healthcare network.

There can be no assurance that we will realize the anticipated benefits of the Kindred Transaction within the timeframe expected or at all. In addition, we have incurred, and will continue to incur, significant costs, expenses and fees for professional services and other transaction costs in connection with the Kindred Transaction. These fees and costs will generally be payable by us and may relate to activities that we would not have undertaken other than to complete the Kindred Transaction.

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

For the years ended December 31, 2021, 2020 and 2019, approximately 56.1%, 55.7% and 55.2% of our revenues, respectively, related to patients participating in Medicare and Medicaid programs, collectively. Numerous factors could materially decrease, or delay timing of, Medicare and Medicaid payments to our facilities. These factors include statutory and regulatory changes, administrative rulings and determinations concerning patient and provider eligibility and requirements for utilization review. Furthermore, the Affordable Care Act and related federal laws provide for material scheduled reductions in the growth rate of Medicare and Medicaid program spending, including reductions in market basket updates and Medicare and Medicaid DSH funding. Additionally, a number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures or reform their Medicaid programs, including enrolling Medicaid recipients in managed care programs or converting to modified block grant funded programs. States may also impose additional taxes on hospitals to help finance the state's Medicaid programs.

Uncertainty regarding the Affordable Care Act or future healthcare reform may adversely affect our business, financial condition and results of operations.

The Affordable Care Act dramatically altered the U.S. healthcare system, and we have expended substantial cost and effort to prepare for and comply with the Affordable Care Act. The net effect of the Affordable Care Act on our business continues to be subject to a number of variables, including the law's complexity, its changing and often incomplete implementation of regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. Additionally, the Affordable Care Act has been the subject of numerous legal challenges and legislative efforts to delay, defund or repeal the implementation or amend significant provisions of the Affordable Care Act. Although the U.S. Supreme Court rejected the most recent challenge to the constitutionality of the Affordable Care Act, we cannot predict the outcome of other lawsuits that are still pending in lower courts regarding the implementation of various aspects of the Affordable Care Act and whether the U.S. Supreme Court will decide to hear additional cases related to the Affordable Care Act in the future. We also cannot predict the impact that the current or future Presidential administrations and Congresses will have on the implementation and enforcement of the provisions of the Affordable Care Act or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

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

MSPs are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and UPL payments. Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating these patients. The total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law. Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars.

The Affordable Care Act called for significant reductions in Medicaid DSH funding to account for decreases in uncompensated care anticipated under the health insurance coverage expansion. Subsequent changes in the law have delayed the implementation of these reductions until FFY 2024. Reductions in Medicaid DSH payments may take place without increases in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

UPL programs have expanded in recent years and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs. We cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease.

Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may limit our revenues and profitability.

The amounts we receive for services provided to patients are determined by a number of factors, including the payer mix of our patients and the reimbursement methodologies and rates utilized by our payers. We have seen shifts of patients from commercial and private insurance to Medicare and Medicaid programs and from "traditional" fee-for-service Medicare and Medicaid programs to "managed" Medicare and Medicaid programs. Reimbursement rates generally are lower for (i) Medicare and Medicaid beneficiaries than they are for patients whose care is covered by commercial and private insurance and (ii) managed Medicare and Medicaid beneficiaries than they are for traditional Medicare and Medicaid beneficiaries. Broad economic factors resulting from the COVID-19 pandemic, including inflationary pressures, supply chain disruptions, labor shortages, increased unemployment and underemployment rates and reduced consumer spending and confidence, may impact our revenue mix. We also experience demographic pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs. Our revenues and results of operations may be adversely affected by these shifts.

In addition, our revenues from negotiated rates with HMOs, PPOs, insurance companies, employers and other private payers may decline based on renegotiations and the respective bargaining power of the parties. Also, consolidation among private payers may increase their bargaining power over fee structures. As a result, payers increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk related to paying for care provided. These changes include moving away from a percent of charge payment structure to a fixed payment for an episode of care, which typically reduces our payment rate and limits our ability to raise prices going forward. Furthermore, low-cost plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices, restrict or exclude our facilities or impose significantly higher cost sharing obligations for care provided by our facilities if they are classified in a disfavored tier. In addition, other healthcare providers, including some with greater financial resources, greater geographic coverage or a wider range of services, may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care plans to contract with us. As payments are reduced, if we are excluded from more payer networks or if the scope of services covered by payers is limited, there could be a material adverse effect on our revenues and results of operations.

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

We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations or it could diminish the anticipated value of the acquired facility.

We may be unable to timely and effectively integrate facilities that we acquire with our ongoing operations. Many of the facilities we have acquired had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced delays in improving the operating margins or effectively integrating the operations of our acquired facilities, and we may experience such delays in implementing operating procedures and systems in newly or future acquired facilities. Integrating an acquired facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel. Additionally, we may experience delays in reimbursement from governmental and third-party payers as a result of the change of ownership of our acquired facilities.

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

Facilities we have acquired or facilities we acquire in the future, may have unknown or contingent liabilities for historical activities or conditions, including liabilities for failure to comply with laws and regulations, retroactive payment adjustments or recoupments from payer audits, medical and general professional malpractice liabilities, unfunded pension liabilities, workers' compensation or other employee-related liabilities, previous tax or environmental liabilities, regulatory and compliance related liabilities, and unacceptable business or accounting practices. Although we endeavor to obtain contractual indemnification from sellers covering these matters in connection with some acquisitions, we have not obtained contractual indemnifications in connection with all of them, and any indemnification obtained from sellers may be insufficient to cover material claims or liabilities for past activities of acquired businesses and the sellers may have insufficient funds to satisfy any claims or liabilities for which we may otherwise be entitled to be reimbursed.

We typically retain and rely on existing local management teams at newly acquired facilities to implement changes to operating procedures and systems. Integrating local management teams can involve cultural and systems challenges that may demand a disproportionate share of our resources and senior management's attention, and we may experience turnover of providers and other key personnel. Our acquisitions have become, and may continue to become larger, and may occur in communities with competing facilities. As a result, the issues surrounding integration may become more complex, expensive and time-consuming and may have a greater impact on our financial performance when we experience delays or difficulties.

If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.

As of December 31, 2021, we had approximately $3.9 billion of goodwill and other intangible assets and approximately $3.3 billion of long-lived assets, net of accumulated depreciation. We expect to recover the carrying values of both our goodwill and long-lived assets through our future cash flows. We evaluate the carrying value of our goodwill at least annually, based on our fair value, to determine whether it is impaired. We evaluate our long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows. If the carrying value of our goodwill or our long-lived assets is impaired, we may incur a material non-cash charge to earnings.

We are subject to risks associated with outsourcing functions to third parties, including risks associated with the protection of patient data.

We outsource selected business functions to third parties, including electronic health record software and data hosting, revenue cycle management, patient access, billing, cash collections, payment compliance and support services, project implementation, supply chain management, payroll system services and parts of cybersecurity. We take steps to monitor and regulate the performance of the independent third parties to whom we delegate selected functions. Arrangements with third-party service providers may make our operations vulnerable if vendors fail to satisfy their obligations to us as a result of their performance, changes in their own operations, financial condition, or other matters outside of our control. We may also face legal, financial or reputational harm for the actions or omissions of such providers, including for violations of HIPAA and other privacy and security laws applicable to healthcare providers and the Cures Act information blocking regulations, and we may not have effective recourse against the providers for those harms. While we evaluate the information security programs and defenses of such third parties, we cannot be certain that our evaluations will identify all or any potential information security weaknesses, or that such third parties' information security protocols are or will be sufficient to withstand or adequately respond to a cyber-attack or other information security incident. The expanding role of third-party providers may also require changes to our existing operations and the adoption of new procedures and processes for retaining and managing these providers, as well as redistributing responsibilities as needed. Effective management, development and implementation of our outsourcing strategies are important to our business and strategy. If there are delays or difficulties in enhancing business processes or our third-party providers do not perform as anticipated, we may not fully realize on a timely basis the anticipated economic and other benefits of the outsourcing projects or other relationships we enter into with key vendors, which could result in substantial costs, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us. Terminating, transitioning or renegotiating arrangements with key vendors or failure to renegotiate on favorable terms could result in additional costs and a risk of operational delays, potential errors and possible control issues as a result of the termination or during the transition or renegotiation phase.

We conduct a significant portion of our operations through joint ventures. We cannot provide assurances that relationships with our joint venture partners will remain strong, which could negatively affect our joint ventures, affiliations and other strategic alliances as well as our overall business.

We are a party to a number of joint ventures, affiliations and other strategic alliances as part of our business strategy, including joint venture relationships transferred to us in connection with the Kindred Transaction. We expect to enter into similar transactions in the future, including joint ventures where we may have a noncontrolling interest. Any changes in our relationships with our joint venture partners could disrupt ongoing business, negatively affect cash flow and distract management and other key personnel. In the event of a material disagreement with any of our joint venture partners or the breach of any of our joint venture agreements, a joint venture may be subject to dissolution, unwinding or purchase of either party's interest, which could have a material adverse effect on our revenues and results of operations or result in reputational harm.

As a general matter, our joint venture partners may have investment and operational goals that are not consistent with our company-wide objectives, including the timing, terms and strategies for future growth and development opportunities, and we could reach an impasse on certain decisions, which may hinder our ability to pursue preferred strategies for growth and development, could require significant resources and attention from management and key employees to resolve and could have an adverse effect on our operations, cash flow and revenue growth. In addition, our joint venture relationships with not-for-profit partners and the agreements that govern these relationships are structured based on current provisions of the Internal Revenue Code of 1986, as amended (the "***Code***") (and the Treasury Regulations thereunder), published rulings by the Internal Revenue Service ("***IRS***"), as well as case law relevant to joint ventures between for-profit and not-for-profit entities. Material changes in these legal authorities could adversely affect our relationships with not-for-profit partners and related joint venture arrangements.

Furthermore, joint ventures in which we have a noncontrolling equity interest and noncontrolling investments inherently involve a lesser degree of control over business operations, thereby potentially increasing the financial, legal, operational and compliance risks associated with the joint venture or minority investment. We may be dependent on joint venture partners or management who may have business interests, strategies or goals that are inconsistent with ours. Business decisions or other acts or omissions of the joint venture partner or management may adversely affect the value of our investment, result in litigation or regulatory action against us, result in reputational harm to us or adversely affect the value of our investment or partnership. To the extent another party makes decisions that negatively impact the joint venture or internal control issues arise within the joint venture, we may have to take responsive or other actions or we may be subject to penalties, fines or other related actions for these activities.

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

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

If we experience growth in self-pay volume and revenue, including increased acuity levels for uninsured patients and increases in co-payments and deductibles for insured patients, our revenues and results of operations could be adversely affected. Although we have experienced a reduction in uninsured patients since 2014 as a result of the Affordable Care Act and the expansion of state Medicaid programs, we are unable to predict whether that trend will continue in light of the repeal of the penalties associated with the individual mandate, the cessation of the cost sharing reduction payments to insurers, the decision by some states not to expand their Medicaid programs, and the business closings and layoffs that have and may continue to occur as a result of the COVID-19 pandemic. In addition, the risk of collection from insured patients (and the amounts due) has increased, and will likely continue to increase, as a result of more individuals being enrolled in insurance plans with high deductibles and high co-payments, including those purchased on the Exchanges. Furthermore, our ability to improve co-insurance collections and collections from self-pay patients may be limited by legislative developments, such as federal and state legislation designed to reduce "surprise billing," or by other regulatory or investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

An increase in the proportion of our accounts receivable being comprised of uninsured accounts and a deterioration in the collectability of these both insured and uninsured accounts could adversely affect our results of operations and revenues. Even if the Affordable Care Act remains implemented in its current form, we may continue to experience bad debts and be required to provide uninsured discounts and charity care for patients who choose not to purchase coverage, are undocumented immigrants who are not permitted to enroll in the Exchanges or government healthcare programs or live in states that do not expand or maintain the expansion of their Medicaid programs.

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

Competition among hospitals and other healthcare service providers, including inpatient and outpatient facilities, has intensified in recent years. We also have acquired, and may continue to acquire, larger facilities in more concentrated population centers, which experience greater competition for healthcare services. We compete with other facilities, including larger tertiary and quaternary care centers located in metropolitan areas. Although the facilities with which we compete may be a significant distance away from our facilities, patients in our markets may migrate on their own to, may be referred by local providers to, or may be required by their health plan to travel to these facilities. Furthermore, some of the facilities with which we compete may offer more or different services than those available at our facilities, may have more advanced equipment or technology or may have a medical staff that is perceived to be better qualified. We also compete with facilities and health systems that are implementing physician and other provider alignment strategies, such as employing providers, acquiring physician practice groups and participating in ACOs or other clinical integration models, which may impact our competitive position. Also, many of the facilities that compete with our facilities are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions and are eligible to participate in the 340B Program. These facilities, in most instances, are also exempt from paying sales, property and income taxes and have the ability to issue tax-exempt bonds for financing.

Quality of care, value-based purchasing, and price transparency have also become significant trends and competitive factors in the healthcare industry. CMS makes public the performance data relating to multiple quality measures that facilities submit in connection with their Medicare payment. CMS also requires every Medicare participating hospital to establish and update annually a public online listing of the hospital's standard charges for items and services and has issued regulations that significantly increase hospital charge reporting requirements. If the publicly-available performance and charge data become a primary factor in where patients choose to receive care, and if competing facilities have lower charges or better results than our facilities on those measures, our revenues and/or patient volumes could decline.

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

We may have difficulty acquiring or divesting facilities on favorable terms. Furthermore, our business could be negatively affected if acquisitions or divestitures are not successfully completed or if contingent liabilities materialize in connection with such transactions.

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

The cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired facility's results of operations, allocation of purchase price, effects of subsequent legislation and limitations on rate increases. As part of our acquisition strategy, we may commit to making significant capital improvements at acquired facilities. Such improvements may be difficult to achieve in the anticipated timeframe, if at all, due to a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions.

Our ability to engage in certain acquisitions in several states may be limited due to exclusivity, non-competition and non-solicitation provisions that we have agreed to in connection with our joint ventures and previous acquisitions and divestiture transactions. Additionally, certain acquisitions may require the consent of and collaboration with our joint venture partners based upon the applicable governing documents. If we cannot obtain the cooperation of our joint venture partners in certain instances, we may not be able to pursue these opportunities.

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

In recent years, the legislatures and attorneys general of several states have sought to exercise more active oversight authority regarding sales of facilities by tax-exempt entities. For example, as a condition to approving an acquisition involving a non-profit hospital, the state attorney general of a state in which an acquisition takes place may require us to maintain specific service lines or provide charity care at certain minimum levels for set periods of time after closing of the acquisition, regardless of profitability. Additionally, the federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive, and antitrust enforcement in the healthcare industry is currently a priority of the FTC. This heightened scrutiny may increase the cost and difficulty, or prevent the completion, of transactions in the future. Our failure to acquire facilities consistent with our growth plans could prevent us from increasing our revenues.

We regularly evaluate the potential disposition of assets and facilities that may no longer help us attain our objectives. When we decide to sell assets or facilities, we may encounter difficulties in finding buyers or alternative exit strategies on acceptable terms or in a timely manner, which could delay the achievement of our strategic objectives. Additionally, the terms of our Master Lease Agreement, dated December 23, 2021, entered into with certain affiliates of Medical Properties Trust, Inc. (the "***2021 Master Lease***") pursuant to sale leaseback transactions may make it more difficult to dispose of certain facilities. We may also dispose of assets or a facility at a price, or on terms, less desirable than we anticipated. In addition, we may experience greater dis-synergies than expected. After reaching an agreement with a buyer for the disposition of assets or a facility, we will be subject to satisfaction of pre-closing conditions as well as to necessary regulatory and governmental approvals on acceptable terms, which, if not satisfied or obtained, may prevent us from completing the transaction. Dispositions may also involve continued financial involvement in the divested facilities, such as through continuing equity ownership, guarantees, indemnities, transition service agreements or other financial and commercial obligations, and inability to avoid retention of certain regulatory and compliance risks. There can be no assurance that the anticipated benefits of our future divestiture strategies will be realized. Furthermore, we may be exposed to contingent liabilities in connection with completed divestitures. Finally, certain acquisition agreements and joint venture arrangements contain covenants that restrict our ability to dispose of certain facilities without first seeking consent of a joint venture partner or other third parties, which may affect our ability to take advantage of business opportunities that may be in our interest. If we do not realize the anticipated benefits of such divestitures, if contingent liabilities related to such divestitures materialize or if we are unable to divest certain properties on favorable terms or at all, this could have a material adverse effect on our results of operations.

If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results could be negatively impacted.

We have initiated a multi-year business initiative to standardize certain processes, policies and systems throughout our facilities, including migrating our multiple IT platforms to a smaller number of enterprise-wide systems solutions. If we do not allocate and effectively manage the resources necessary to build and sustain the proper IT infrastructure and implement standardized systems, or if we fail to achieve the expected benefits from this initiative, it may impact our ability to operate profitably and efficiently, as well as comply in a timely manner with changing regulatory requirements and with the requests of patients, payers and business partners. The failure to transition to these systems on time, or anticipate necessary readiness and training needs, could lead to business disruption and loss of revenue. In addition, the operating results of newly acquired facilities could be impacted if such facilities are not integrated on a timely basis into our new systems. The actions we take to resolve compliance or regulatory issues within acquired facilities may affect our revenue or results of operations.

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

Under the 2021 Master Lease, a default with respect to one facility could cause a default under all of the facilities subject to the 2021 Master Lease, which could have a material adverse effect on our business, results of operations and financial condition.

Upon certain defaults under the 2021 Master Lease, even if such default relates to one facility, the lessor(s) may terminate the 2021 Master Lease in its entirety with respect to all of the facilities governed by the 2021 Master Lease. Under the 2021 Master Lease, we are subject to financial covenants based on certain fixed charges. The failure to meet or obtain a waiver of such covenants or otherwise cure such non-compliance with such financial covenants in the 2021 Master Lease in the future could result in an event of default.

Other events that could trigger a default under the 2021 Master Lease if not cured within the time periods required by the 2021 Master Lease include, without limitation, (i) failure to pay rent or other amounts due under the 2021 Master Lease, (ii) failure to comply with the non-financial covenants under the 2021 Master Lease, (iii) the bankruptcy of any facility lessee under the 2021 Master Lease or the guarantor of the facility lessees under the 2021 Master Lease, (iv) termination of any licenses necessary for operation of a facility or required for certification under Medicare or Medicaid, (v) a change of control (as defined in the 2021 Master Lease) in violation of the 2021 Master Lease and (vi) a default under any material documents between any lessee of the facilities and any lessor of any facility. A default under the 2021 Master Lease that results in a termination of the 2021 Master Lease would cause us to lose the ability to operate all of the facilities subject to the 2021 Master Lease and to incur substantial costs in restoring the premises, which could have a material adverse effect on our business, results of operations and financial condition.

If the 2021 Master Lease is terminated prior to its expiration because of a default and the lessor exercises its rights thereunder, in addition to losing the ability to operate our facilities, we may be liable for (i) damages and charges such as continued lease payments through the end of the lease term (or such shorter period as provided in the 2021 Master Lease or by law) and (ii) maintenance costs for the leased property. Upon termination of the 2021 Master Lease, we will be obligated to restore the applicable premises to its original condition and repair all damage caused by the installation or removal of our personal property, ordinary wear and tear excepted. We also have restoration obligations with respect to certain casualty and condemnation events. In addition, upon termination of the 2021 Master Lease, the lessor will have the option to purchase all of the applicable lessee's personal property at fair market value.

Because many of the facilities we operate are subject to long-term leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises.

The rights to use many of our facilities are based upon long-term leases, including the 2021 Master Lease. Pursuant to the terms of these leases, we are required to pay all rent due and comply with all other lessee obligations. As of December 31, 2021, the remaining term of these leases (including renewal options) generally ranged from less than one year up to 74 years. A pledge of our interest in some of these leases may also require the consent of the respective lessor and its lenders. As a result, we may not be able to sell, assign, transfer or convey our interest in certain facilities subject to such leases in the future absent consent of such third parties even if such transactions may be in our best interest. Most of the leases require that, upon the expiration or termination of the leases, we must surrender any improvements to the land to lessor. In addition, some of our leases include early termination provisions. We are typically responsible for all taxes, insurance, assessments and maintenance obligations under the leases. The leases also generally require the lessee to either reconstruct or restore the premises to its original condition following a casualty and to apply in a specified manner any proceeds received in connection therewith. In some leases the lessor has the option to purchase some or all of the assets owned by us and used in connection with the operation of the applicable facility. Accordingly, failure to comply with the terms of such leases, the invalidity of or default or termination under such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises, which could have a material adverse effect on our business, results of operations and financial condition.

Many of the non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies intended to generate organic growth and improve operating results at our facilities.

Many of the non-urban communities in which we operate continue to face challenging economic conditions, including high levels of unemployment and unfavorable demographic trends, which may impede our business strategies intended to generate organic growth and improve operating results at our facilities. These challenging economic conditions have been further exacerbated by the impact of the COVID-19 pandemic. The economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of large employers, especially manufacturing or similar facilities. These employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our facilities for care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or similar facilities located in or near many of the non-urban communities in which our facilities primarily operate, could cause affected employees to move elsewhere for employment or lose insurance coverage that was otherwise available to them.

When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to (i) defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for facilities, or (ii) purchase a high-deductible insurance plan or no insurance at all, which increases a facility's dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms.

Additionally, non-urban communities are experiencing a much slower rate of growth, if any, as compared to more concentrated population centers. As a result, we may experience payer mix pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs.

Credit and Liquidity Risks

Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments.

We are a highly leveraged company. As of December 31, 2021, we had total outstanding debt of approximately $6.3 billion, excluding finance lease obligations and unamortized debt issuance costs and premiums. Our substantial indebtedness could have important consequences for the Lenders and Holders of our indebtedness. For example, it could:

- limit our ability to borrow money for our working capital, capital expenditures, debt service requirements, strategic initiatives or other purposes;
- make it more difficult for us to satisfy our obligations with respect to our indebtedness and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the agreements governing our indebtedness;
- require us to dedicate a substantial portion of our cash flow from operations to the payment of interest and the repayment of our indebtedness, thereby reducing funds available to us for other purposes;
- limit our flexibility in planning for, or reacting to, changes in our operations or business;
- make us more highly leveraged than some of our competitors, which may place us at a competitive disadvantage;
- make us more vulnerable to downturns in our business, our industry or the economy;
- restrict us from making strategic acquisitions, engaging in development activities, introducing new technologies or exploiting business opportunities;
- cause us to make non-strategic divestitures;
- limit, along with the financial and other restrictive covenants in our indebtedness, among other things, our ability to borrow additional funds or dispose of assets;
- prevent us from raising the funds necessary to repurchase all notes tendered to us upon the occurrence of certain changes of control, which failure to repurchase would constitute an event of default under the Indentures governing the Notes; or
- expose us to the risk of increased interest rates, as certain of our borrowings, including borrowings under the ABL Facility and the Term Loan Facility, are at variable rates of interest.

In addition, the Indentures and the Credit Agreements contain restrictive covenants that limit or will limit our ability to engage in activities that may be in our long-term best interest. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of substantially all of our existing and future indebtedness.

Our debt agreements contain restrictions that will limit our flexibility in operating our business.

The Indentures and the Credit Agreements contain, and any other existing or future indebtedness of ours would likely contain, a number of covenants that will impose significant operating and financial restrictions on us, including restrictions on our and our subsidiaries ability to, among other things:

- incur additional debt, guarantee indebtedness or issue certain preferred shares;
- pay dividends on or make distributions in respect of, or repurchase or redeem, our capital stock or make other restricted payments;
- prepay, redeem or repurchase certain debt;
- make loans or certain investments;
- sell certain assets;
- create liens on certain assets;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates;
- alter the businesses we conduct;
- enter into agreements restricting our subsidiaries' ability to pay dividends; and
- designate our subsidiaries as unrestricted subsidiaries.

As a result of these covenants, we will be limited in the manner in which we conduct our business, and we may be unable to engage in favorable business activities or finance future operations or capital needs.

In addition, the ABL Facility requires us to maintain a minimum fixed charge coverage ratio at any time when the average availability is less than the greater of $65 million and 10% of the lesser of the aggregate amount of revolving facility commitments and the borrowing base at such time. In that event, we must satisfy a minimum fixed charge ratio of 1.0 to 1.0. At December 31, 2021, we were in compliance with this financial maintenance covenant.

A failure to comply with the covenants under the Indentures, the Credit Agreements or any of our other future indebtedness could result in an event of default, which, if not cured or waived, could have a material adverse effect on our business, financial condition and results of operations. In the event of any such default, the Lenders thereunder:

- will not be required to lend any additional amounts to us;
- could elect to declare all borrowings outstanding, together with accrued and unpaid interest and fees, to be due and payable and terminate all commitments to extend further credit;
- could require us to apply all of our available cash to repay these borrowings; or
- could effectively prevent us from making debt service payments on the Notes (due to a cash sweep feature under the ABL Facility).

Such actions by the Lenders could cause cross defaults under our other indebtedness. If we were unable to repay those amounts, the Lenders and Holders under the ABL Facility, the Term Loan Facility, the 6.75% Secured Notes and the 4.375% Secured Notes could proceed against the collateral granted to them to secure the ABL Facility, the Term Loan Facility or the 6.75% Secured Notes and the 4.375% Secured Notes, respectively. If any of our outstanding indebtedness under the ABL Facility, the Term Loan Facility, Notes or any of our other existing or future indebtedness were to be accelerated, there can be no assurance that our assets would be sufficient to repay such indebtedness in full.

Repayment of our debt is dependent on cash flow generated by our subsidiaries.

Repayment of our indebtedness, including the ABL Facility, the Term Loan Facility and the Notes, is dependent on the generation of cash flow by our subsidiaries and their ability to make such cash available to us, by dividend, debt repayment or otherwise. Unless they are guarantors of the indebtedness, our subsidiaries do not have any obligation to pay amounts due on such indebtedness or to make funds available for that purpose. Our subsidiaries may not be able to, or may not be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each subsidiary is a distinct legal entity and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries. While our debt agreements will limit the ability of our restricted subsidiaries to incur consensual restrictions on their ability to pay dividends or make other intercompany payments to us, these limitations are subject to certain qualifications and exceptions. In the event that we do not receive distributions from our subsidiaries, we may be unable to make required principal and interest payments on our indebtedness. In the event we require restructuring or refinancing, we cannot assure you that we will be able to restructure or refinance any of our debt on commercially reasonable terms or at all.

Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.

We and our subsidiaries may be able to incur substantial indebtedness in the future. Although the terms of the Credit Agreements and the Indentures contain restrictions on our and our subsidiaries' ability to incur additional indebtedness, these restrictions are subject to a number of important qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. As of December 31, 2021, we had $598 million available for additional borrowing under the ABL Facility (after giving effect to any letters of credit issued thereunder (which were approximately $50 million as of December 31, 2021)), all of which would be secured. In addition to the Notes and our borrowings under the Credit Agreements, the covenants under any other existing or future debt instruments could allow us to incur a significant amount of additional indebtedness and, subject to certain limitations, such additional indebtedness could be secured. The more leveraged we become, the more we, and in turn our security holders, will be exposed to certain risks described above under "—Our debt agreements contain restrictions that will limit our flexibility in operating our business."

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.

Our ability to pay principal and interest and to satisfy our other debt obligations will depend upon, among other things:

- our future financial and operating performance (including the realization of any cost savings described herein), which will be affected by prevailing economic, industry and competitive conditions and financial, business, legislative, regulatory and other factors, many of which are beyond our control; and
- our future ability to borrow under the ABL Facility, the availability of which depends on, among other things, our complying with the covenants in the credit agreement governing the ABL Facility.

We cannot assure you that our business will generate cash flow from operations, or that we will be able to draw under the ABL Facility or otherwise, in an amount sufficient to fund our liquidity needs, including the payment of principal and interest on the ABL Facility, the Term Loan Facility and the Notes.

If our cash flows and capital resources are insufficient to service our indebtedness, we may be forced to reduce or delay capital expenditures, sell assets, seek additional capital or restructure or refinance our indebtedness, including the Notes and any indebtedness under the Credit Agreements. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. In addition, the terms of existing or future debt agreements, including the ABL Facility, the Term Loan Facility, the Indentures, may restrict us from adopting some of these alternatives. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to dispose of material assets or operations to meet our debt service and other obligations. We may not be able to consummate those dispositions for fair market value or at all. Furthermore, any proceeds that we could realize from any such dispositions may not be adequate to meet our debt service obligations then due. The Sponsor and its affiliates have no continuing obligation to provide us with debt or equity financing. Our inability to generate sufficient cash flow to satisfy our debt obligations, or to refinance our indebtedness on commercially reasonable terms or at all, could result in a material adverse effect on our business, results of operations and financial condition and could negatively impact our ability to satisfy our obligations under our indebtedness.

If we cannot make scheduled payments on our indebtedness, we will be in default, and the Lenders under the Term Loan Facility and the Holders of the Notes could declare all outstanding principal and interest to be due and payable, the Lenders under the ABL Facility could terminate their commitments to loan money, our secured lenders (including the Lenders under the ABL Facility and the Holders of the Notes) could foreclose against the assets securing their loans and the Notes and we could be forced into bankruptcy or liquidation.

Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. Assuming the revolving credit facility is fully drawn, each 1% change in assumed blended interest rates would result in an approximately $40 million change in aggregate annual interest expense on indebtedness under the ABL Facility and the Term Loan Facility. To manage this risk, we entered into an interest rate swap agreement on December 21, 2018 with Citibank, N.A. as counterparty (the "***Interest Rate Swap***"). The terms of the Interest Rate Swap required us to pay a fixed rate of 2.63% on a notional amount of $1.1 billion and, in exchange, we received one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and terminated on February 19, 2022.

Discontinuation and replacement of LIBOR may adversely affect our results of operations.

The U.K. Financial Conduct Authority announced in 2017 that it intends to phase out LIBOR by the end of 2023. Changes to LIBOR or any other benchmark rate may impact credit markets. In accordance with recommendations from the Alternative Reference Rates Committee ("***ARRC***"), U.S.-dollar LIBOR is expected to be replaced with the Secured Overnight Financing Rate ("***SOFR***"), a new index calculated by reference to short-term repurchase agreements for U.S. Treasury securities. Although there have been a few issuances utilizing SOFR or the Sterling Over Night Index Average, an alternative reference rate that is based on transactions, it is unknown whether SOFR or any of the other alternative reference rates will attain market acceptance as replacements for LIBOR. There is currently no definitive successor reference rate to LIBOR and various industry organizations are still working to develop workable transition mechanisms.

Borrowings under our Term Loan Facility and ABL Facility bear interest at rates based on LIBOR. The administrative agent for those facilities may approve a comparable or successor rate with respect to LIBOR or, if not feasible, another accommodation as reasonably determined by the agent. The replacement of LIBOR with a comparable or successor rate could cause the amount of interest payable on our Term Loan Facility and ABL Facility to be different than expected.

Until a successor rate is more firmly determined, we cannot implement the transition away from LIBOR for our Term Loan Facility and ABL Facility. As such, we are unable to predict the effect of any changes to LIBOR, the establishment and success of any alternative reference rates, or any other reforms to LIBOR or any replacement of LIBOR that may be enacted in the U.S. or elsewhere.

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

We require substantial capital resources to fund our growth strategy and ongoing capital expenditure programs, including capital expenditure programs for renovation, expansion and construction at our facilities and the addition of equipment and technology at our facilities. We often commit to significant capital expenditures well in advance of the time these expenditures will be made. Our cash flows and available capital resources may be insufficient to fund our capital expenditure programs and commitments, and we may be forced to reduce or delay planned and required capital expenditures. Additionally, we may experience delays or impediments in satisfying the schedule for capital expenditure commitments because of a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions, adverse weather conditions, shortages of labor or materials or other unforeseen problems or delays. The failure to satisfy our capital expenditure commitment obligations could also damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities, lessors or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions.

At December 31, 2021, we estimated our total remaining capital expenditure commitments to be approximately $738 million. The majority of this amount represents long-term commitments that are computed as a percentage of revenues. The failure to satisfy our capital expenditure commitment obligations could damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities, lessors or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions. As a result, if our cash flows and available capital resources are not sufficient to fund all of our anticipated capital expenditures, it may be necessary for us to give priority to contractual capital expenditure commitment obligations over other elective capital expenditure programs.

Our ability to utilize our NOLs may be limited, and we may not be able to utilize our NOLs as a result of recent U.S. federal tax reform legislation.

As of December 31, 2021, we had federal NOLs of approximately $31 million and state and local NOLs of approximately $3.2 billion that expire at various dates between 2022 and 2039 or have an indefinite carryforward period. To the extent available and not otherwise utilized, we intend to use any NOLs to reduce the applicable federal and state corporate income tax liability associated with our operations. However, our ability to utilize our NOLs is based on the extent to which we generate future taxable income and on prevailing corporate income tax rates, and we cannot provide any assurance as to when and to what extent we will generate sufficient future taxable income to realize our deferred tax assets, whether in whole or in part. Furthermore, the utilization of our NOLs may become subject to an annual limitation under Section 382 of the Code (and similar state provisions) in the event of certain cumulative changes in the ownership interest of significant shareholders in excess of 50 percent over a three-year period. This could limit the amount of NOLs that can be utilized annually to offset taxable income. The amount of the annual limitation is determined based on the value of a company immediately prior to the ownership change. Subsequent ownership changes may further affect the limitation in future years. For these reasons, our ability to utilize our NOLs may be limited.

Human Capital Risks

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

Our subsidiaries employ a large number of physicians. Physician employment by health systems and healthcare facilities, where permissible, is a trend in the industry and has become more common as a result of actual and potential reductions in payment amounts for physician services and increasing operating costs to physicians. Employed physicians generally present more direct risks to us than those presented by independent members of our hospitals' medical staffs, such as risks of unsuccessful physician integration, challenges associated with physician practice management and compliance risks arising from the increased billing and coding activities associated with the employment of physicians, the possibility of legal claims under federal and state employment law, and governmental scrutiny of physician employment arrangements. Employed physicians also require us to incur additional expenses, such as increased salary and benefit costs, medical malpractice expense and rent expense. Payments received by us for services provided by our employed physicians, the physicians to whom our facilities have provided recruitment assistance, and the physician members of our medical staffs could be adversely affected as physician payment methodologies move toward pay-for-performance as hospital payment models are doing. The combination of payment cuts, potential liabilities and increased expenses could have an adverse effect on our results of operations.

Our operations and ability to deliver healthcare services efficiently may be adversely affected by competition for staffing, the shortage of experienced physicians, nurses and other healthcare professionals, and vaccine mandates.

The success of our business operations and the efficiency with which we deliver healthcare services depends on the number and quality of our physicians and other healthcare providers such as nurses, pharmacists and lab technicians, and management and other non-physician personnel responsible for the day-to-day operations of each of our facilities. Our ability to recruit and retain quality providers and personnel in turn depends on several factors, including the actual and perceived quality of services furnished by our facilities, our ability to meet demands for new technology, our ability to identify and communicate with providers who want to practice in our communities and our ability to provide competitive financial compensation packages. In some markets, the availability of nurses and other medical support personnel has been a significant operating issue to healthcare providers, including at certain of our facilities. The COVID-19 pandemic has exacerbated workforce competition and shortages, both of which may continue beyond the duration of the pandemic. This may result in personnel turnover, require us to enhance wages and benefits to recruit and retain management, nurses and other medical support personnel, recruit personnel from foreign countries, and hire more expensive temporary or contract personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified physicians, nurses and other medical support staff, and management and non-physician personnel, or to control our labor costs could have a material adverse effect on our revenues or results of operations.

Federal and state laws and regulations may impact our ability to hire and retain and increase our costs of employing qualified physicians, nurses and other medical support personnel. For example, a significant portion of the providers serving our facilities are native to countries other than the U.S. Our ability to recruit such providers and their ability and willingness to remain and work in the U.S. are impacted by immigration laws and regulations. Changes in immigration or naturalization laws, regulations, or procedures may adversely affect our ability to hire or retain providers and may adversely affect our costs of doing business or our ability to deliver services in our communities. In addition, the states in which we operate have adopted or could adopt mandatory nurse staffing ratios, or could increase mandatory nurse staffing ratios. State-mandated nurse staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. Also, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the federal physician self-referral law (commonly referred to as the Stark law), the Anti-kickback Statute, state anti-kickback and self-referral statutes, and related regulations. The Stark law requires, among other things, that recruitment assistance can only be provided to physicians who meet certain geographic and practice requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit physicians currently in practice in the community beyond recruitment costs actually incurred by them. All arrangements with physicians must also be fair market value and commercially reasonable.

Additionally, on November 5, 2021, CMS issued a health and safety regulation (the "***CMS Mandate***") requiring certain covered facilities (including hospitals, ambulatory surgery centers, and long-term care facilities that are Medicare and Medicaid certified providers) to ensure all staff who work in the covered facility and who provide care, treatment or other services for the facility and/or its patients are fully vaccinated against COVID-19. The application of the CMS Mandate could adversely impact the availability of staff to provide services at certain of our facilities. Additional vaccine and testing mandates may also be announced by state-run OSHA programs or state and local officials in jurisdictions in which we operate our business and which could adversely impact the availability of staff to provide services at certain of our facilities. The unavailability of such staff, or our inability to control labor costs, could have a material, adverse effect on our capacity, growth prospects and results of operations.

In addition to these legal requirements, there is competition from other communities and facilities for these providers, and this competition continues after the provider is practicing in one of our communities. For example, integrated ACOs and other kinds of "narrow" provider networks or organizations may exclude our providers from their plans' networks of healthcare providers. These contracting networks often organize hospitals, providers and ancillary healthcare providers into exclusive networks involving fewer healthcare providers. If our affiliated providers are excluded from such networks, we may have difficulty recruiting new providers or retaining existing providers.

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

Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and subject to the terms of collective bargaining agreements.

Increased or ongoing labor union activity could adversely affect our labor costs or otherwise adversely impact us. Several of our facilities, including those in which we have a non-controlling interest, have unionized employees. When a new collective bargaining agreement with a union must be negotiated, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur, and our operations could be disrupted or our labor costs increased as a result of these disruptions. Our labor costs also could increase significantly if a substantial number of other employees at our facilities unionize. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained.

The terms of the collective bargaining agreements also set forth certain requirements related to the respective facility's employment practices, seniority, hours of work, overtime, holidays, use and redemption of paid time off, extended illness bank, vacation scheduling, compensation, pay practice, health and non-health benefits, leaves of absence, grievance procedures, disability accommodations and the facility's drug and alcohol policies. If these facilities fail to fulfill any of these requirements, it could result in discussions with union representatives or the filing of a grievance that could be costly and time-consuming for those facilities. Furthermore, the terms of the collective bargaining agreements constrain our flexibility with respect to these and other employee issues. The inability to negotiate future collective bargaining agreements on favorable terms with these employees or with other unionized employees could have a material adverse effect on our business, results of operations and financial condition.

We are dependent on our executive management team and the loss of the services of one or more of our executive management team could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our executive management team. In addition, we depend on the ability of our executive officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our executive management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial and results of operations. If we were to lose the services of one or more members of our executive management team, we could experience a significant disruption in our operations and failure of the affected facilities to adhere to their respective business plans.

Regulatory and Legal Risks

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

All participants in the healthcare industry are required to comply with numerous overlapping laws and regulations at the federal, state and local government levels. These laws and regulations require that healthcare facilities and providers meet various requirements, including those relating to relationships with referral sources, the adequacy and quality of medical care, inpatient admission criteria, privacy and security of health information, standards for equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, the use and storage of pharmaceuticals and controlled substances, compliance with building codes and *environmental* protection, among other matters. Many of the laws and regulations applicable to the healthcare industry are complex and may be violated inadvertently, and there are numerous enforcement authorities, including CMS, the OIG, the DOJ, state attorneys general, and contracted auditors, as well as private plaintiffs.

There are also heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. Recent enforcement actions have focused on, among other things, financial arrangements between hospitals and providers, billing for services without adequately documenting the medical necessity for such services and billing for services outside the coverage guidelines for such services. Hospital services and certain other ancillary services that our facilities provide, such as physical therapy services, continue to be focal areas of the OIG and other governmental fraud and abuse programs, as described in the OIG Work Plan. Dealing with investigations can be time and resource consuming and can divert management's attention from the business. Any such investigation or settlement could increase our costs or otherwise have an adverse effect on our business. In addition, because of the potential for large monetary exposure under the False Claims Act, which provides for treble damages and substantial civil monetary penalties for each separate false claim or statement, healthcare providers often resolve allegations without admissions of liability for significant and material amounts to avoid the uncertainty of damages and penalties that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree, settlement agreement or corporate integrity agreement. These additional requirements can result in significant additional and ongoing expenditures. Given the significant size of actual and potential settlements, it is expected that the government will continue to devote substantial resources to investigating healthcare facility and provider compliance with the healthcare payment rules and fraud and abuse laws. Certain of our facilities have received inquiries and subpoenas from various governmental agencies regarding these matters, and we are also subject to various claims and lawsuits relating to these and other matters.

The laws and regulations with which we must comply continually change. In the future, different interpretations or enforcement of these laws and regulations could subject our business practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws and regulations, many of these laws and regulations are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable laws and regulations. If we fail to comply with applicable laws and regulations, we could suffer substantial civil or criminal penalties, including the loss of our licenses to operate our facilities or loss of our ability to participate in the Medicare, Medicaid and other governmental programs.

Additionally, we are subject to a variety of different federal, state and local employment and wage and hour laws. While we strive to comply with those laws, if we fail to do so, we may be subject to lawsuits by governmental authorities or private plaintiffs. In addition, the IRS and/or state taxing authorities may successfully challenge positions taken on our tax returns.

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

Finally, we communicate with patients, with prior consent, through short message service ("***SMS***") text messages. While we obtain consent from these individuals to send text messages and limit the content of those messages, federal or state regulatory authorities or private litigants may claim that the notices and disclosures we provide, form of consents we obtain, or our SMS texting practices are not adequate or violate applicable law. In addition, we must ensure that our SMS texting practices comply with regulations and agency guidance under the Telephone Consumer Protection Act (the "***TCPA***"), a federal statute that protects consumers from unwanted telephone calls, faxes and text messages, HIPAA, and all applicable state data privacy and security laws and regulations. While we strive to adhere to strict policies and procedures that comply with the TCPA, the Federal Communications Commission, as the agency that implements and enforces the TCPA, may disagree with our interpretation of the TCPA and impose penalties and other consequences for noncompliance. Determination by a court or regulatory agency that our SMS texting practices violate the TCPA could subject us to civil penalties and could require us to change some portions of our business. Even an unsuccessful challenge by patients or regulatory authorities of our activities could result in adverse publicity and could require a costly response from and defense by us.

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

The False Claims Act prohibits healthcare facilities and providers, as well as other entities or individuals from, among other things, knowingly submitting false claims for payment to the federal government, or knowingly causing the submission of such claims. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are generally entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. We are required to provide information to our employees and certain contractors about state and federal false claims laws and whistleblower provisions and protections. Defendants found to be liable under the False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus substantial civil monetary penalties, that are subject to annual inflation adjustments, for each separate false claim.

There are many potential bases for liability under the False Claims Act, including reckless or intentional acts or omissions. The government has used the False Claims Act to prosecute Medicare and other government healthcare program violations such as coding errors, billing for services not provided, submitting false cost reports, falsely certifying meaningful use of certified health information technology, and providing care that is not medically necessary or that is substandard in quality. The Affordable Care Act also (i) created potential False Claims Act liability for failing to report and repay identified overpayments within sixty (60) days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later, and (ii) provided that claims submitted in connection with patient referrals that result from violations of the Anti-kickback Statute constitute false claims for the purposes of the False Claims Act. Violations of the Stark law can result in False Claims Act liability, as well. In addition, a number of states have adopted their own false claims and whistleblower provisions whereby a private party may file a civil lawsuit in state court.

Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws, many of these laws are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable fraud and abuse laws.

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

We will be subject to medical malpractice lawsuits and other legal actions arising out of the operations of our facilities and the activities of our employed or affiliated providers. As a matter of policy, we typically notify patients of any potential harms they may have suffered at our facilities, regardless of whether such notifications are required by law and notwithstanding our uncertainty as to the severity of such harms or whether they even took place. This may lead to class actions or other multi-plaintiff lawsuits or whistleblower reports. These actions may involve large claims and significant defense costs and, if we or our facilities are found liable, any judgments against us may be material. Furthermore, some states in which we operate do not impose caps on non-economic malpractice damages and, even in the states that have imposed caps on such damages, litigants may seek recoveries under alternative theories of liability that might not be subject to such caps. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement whether or not we believe we are liable. Amounts we pay to settle any of these matters also may be material.

Although we maintain professional and general liability insurance with unrelated commercial insurance carriers, each individual plaintiff's claim is generally subject to a SIR insurance program administered in-house by our risk department with assistance from our insurance brokers. Any successful claim against us that is within our SIR amounts could have an adverse effect on our results of operations or liquidity. Some of these claims could exceed the scope of the excess coverage in effect, or coverage of particular claims could be denied, and any amounts not covered by insurance could be material.

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

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

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare and Medicaid for payment for our services. These post-payment reviews may increase as a result of government cost-containment initiatives, including, without limitation, enhanced medical necessity reviews for patients admitted as inpatients to general acute care hospitals for certain procedures and audits of claims under the RAC programs to detect overpayments not identified through existing claims review mechanisms. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those claims most likely to contain overpayments, such as incorrectly coded services, short stays, incorrect payment amounts, non-covered services and duplicate payments. The claims review strategies used by the RACs generally include a review of high dollar claims, including, for example, inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals.

In addition, CMS and the states use UPICs to perform post-payment audits of claims and identify Medicare and Medicaid overpayments. Third party audits or investigations of Medicare or Medicaid claims could result in increases or decreases in operating revenues to be recognized in periods subsequent to when the related services were performed, which may have a material adverse effect on our results of operations.

Controls designed to reduce inpatient services may reduce our revenues.

Over the last several years, payers have instituted policies and procedures to reduce or limit the use of inpatient services. Controls imposed by Medicare, Medicaid, and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for payment are properly filed. In the hospital context, these provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by QIOs, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of the MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. QIOs may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider that is in substantial noncompliance with quality standards be excluded from participation in the Medicare program.

Utilization review is also a requirement of most non-governmental managed care organizations and other third-party payers. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Additionally, in some states in which we operate, commercial third-party payers and Medicaid managed care plans have instituted policies that retroactively limit or deny patient coverage for emergency department and certain other services provided at hospitals or services provided at other inpatient facilities if the payers believe the services could have been provided in less expensive settings. For example, such payers are increasingly seeking to pay relatively low "triage fees" for patients seen in emergency departments when the payers retrospectively determine the patients' treatment did not qualify as an emergency service. Significant limits on the scope of services reimbursed or on the amounts paid for such services could have a material adverse effect on our revenues and results of operations.

If we do not manage admissions in the IRFs that we operate or manage in compliance with a 60% threshold, reimbursement for services rendered by us in these facilities will be based upon less favorable rates.

IRFs and ARUs are subject to a Medicare requirement that 60% or more of the patients admitted to the facilities have one or more specific conditions in order to qualify for reimbursement under the IRF PPS. If that compliance threshold is not maintained, the IRFs and ARUs will be reimbursed by Medicare at IPPS rates applicable to acute care hospitals. That likely would lead to reduced revenue in the IRFs and ARUs that we operate or manage and also may lead customers of IRFs and ARUs to attempt to renegotiate the terms of their contracts or terminate their contracts. Our inability to appropriately manage admissions in our IRFs and ARUs in compliance with applicable thresholds could have a material adverse effect on our business, financial position, results of operations, and liquidity.

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

Some states require prior approval for the purchase, construction and expansion of healthcare facilities, based on the state's determination of need for additional or expanded healthcare facilities or services. Certain states in which we operate facilities require a certificate of need for the purchase, construction or expansion of hospital facilities, capital expenditures exceeding a prescribed amount, changes in bed capacity or services, or for other hospital-related activities. We may not be able to obtain certificates of need required for expansion activities or to effectively compete with competing healthcare providers in the future. In addition, all of the states in which we operate facilities require hospitals, other healthcare facilities, and most healthcare providers to maintain one or more licenses. If we fail to obtain any required certificate of need or license, our ability to operate or expand operations in those states could be impaired.

In the states in which we operate that do not require certificates of need for the purchase, construction and expansion of hospital facilities, competing healthcare facilities face lower regulatory barriers to entry and expansion. If competing healthcare entities are able to purchase, construct or expand healthcare facilities without the need for regulatory approval, we may face decreased market share and revenues in those markets.

Failure to implement and use certified health information technology in an effective and timely manner could adversely affect our operations and result in reduced Medicare and Medicaid reimbursement and government enforcement actions.

The federal government has adopted laws and regulations intended to promote the adoption of health information technology, advance the interoperability of medical record systems, and support the access, exchange, and use of electronic health information. For example, under the Medicare Promoting Interoperability Programs (formerly the Medicare EHR Incentive Program), eligible hospitals, critical access hospitals and eligible professionals that do not successfully demonstrate meaningful use of certified electronic health record technologies every year (absent a hardship exception) may be subject to a downward payment adjustment under Medicare. In addition, health information technology that is certified by CMS is subject to an annual certification process. While we generally have no control over whether the health information technology we have implemented will continue to maintain CMS certification, we routinely monitor and evaluate our health information technology for compliance with the applicable CMS certification standards. Failure of our health information technology to maintain CMS certification could result in reduced Medicare and Medicaid reimbursement. Also, the Cures Act and its implementing regulations impose regulatory obligations, including new Medicare conditions of participation on hospitals and critical access hospitals, related to the access and exchange of electronic health information and prohibit information blocking, which includes any practice that is unreasonable and likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information, by healthcare providers and certain other entities, unless required by law or otherwise permitted by an exception in the applicable regulations. Failure to comply with these requirements could subject us to financial penalties or other disincentives or reputational damage. Complying with these and future initiatives related to healthcare technology and interoperability may also require us to change our operations or incur additional costs related to investments in information technology and EHR system software upgrades, and our payers may not adequately reimburse us for these costs and investments.

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

There is a trend in the healthcare industry toward value-based purchasing of healthcare services and bundled payment arrangements. Value-based purchasing programs include both public reporting of quality data and payment limitations tied to the incidence of preventable adverse events or the quality and efficiency of care provided by facilities. For example, Medicare, Medicaid and many large commercial payers may require facilities to report certain quality data to receive full payment updates or avoid payment reductions. They may also impose payment reductions in connection with HACs and excessive readmissions for certain conditions designated by HHS. Our revenue may be negatively impacted by the application of one or more of these measures. Bundled payment arrangements generally set target payment amounts for all healthcare services provided to patients during particular episodes of care. They are intended to create incentives for physicians, hospitals and other providers to work together to provide higher quality and more coordinated care at a lower cost. We currently participate in a few ACOs as well as a number of bundled payment programs, and we expect value-based purchasing programs, including programs that condition payment on patient outcome measures, to become more common and to involve a higher percentage of payment amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively affect our revenues.

The implementation of participation and quality measurement requirements under the MACRA's Merit-Based Incentive Payment System may affect our revenues.

Under MACRA, CMS updates payment rates for physician and practitioner services on an annual basis, and implements the QPP that rewards value and outcomes through participation in MIPS or an APM program. MIPS measures provider performance under four categories: quality, improvement activities, promoting interoperability and cost, and annually establishes a point threshold for each category and overall performance. The results of the measurement are used to establish a positive, negative, or neutral payment adjustment for the physician or practitioner for claims that are submitted two years after the applicable MIPS measurement period. The MIPS adjustment has a more significant impact on payment for physician and practitioner services than the annual inflationary update to the Medicare PFS.

Physicians participate in MIPS unless they are participants of specific forms of APM, are newly enrolled in Medicare, or see a low volume of Medicare patients (i.e., no more than 200 Medicare Part B patients in a calendar year, 200 covered professional services to Medicare Part B patients, or $90,000 in charges for Medicare Part B professional services). Groups or eligible clinicians who choose not to participate and fall within specified circumstances may request an exception through a hardship application and incur no MIPS impact on Medicare payments. CMS permits hardship applications, including, in 2020 and 2021, hardships based on circumstances arising from COVID related operational issues, through which clinicians can request reweighing of any or all performance categories if they encounter an extreme and uncontrollable circumstance or a public health emergency. MIPS eligible clinicians or Group Practices were subject to a payment adjustment on a sliding scale of minus to plus 7% per claim in CY 2021 (based on CY 2019 performance) and are subject to a sliding scale payment adjustment of minus to plus 9% per claim in CY 2022 and beyond. In addition, MIPS eligible clinicians with exceptional performance may receive up to 10% bonus payment from $500 million specifically allocated for this purpose. MIPS is a budget neutral program, and, as a result, any upward payment adjustments that are made for highly performing clinicians are offset by downward payment adjustments for others. Providers participating in an APM may be eligible for more advantageous adjustments under MIPS (or avoid any negative adjustment) and receive a 5% bonus. At this time, we have limited participation in APMs.

If an eligible clinician has not been satisfactorily participating in MIPS (and is not qualified to participate in an APM), his or her claims for Medicare Part B services are likely to be subject to negative payment adjustments in CY 2021 (which was based on CY 2019 performance) and CY 2022 (which was based on CY 2020 performance). For participating eligible clinicians that meet or exceed the MIPS threshold or APM requirements, claims for payment are likely to be subject to positive adjustments as well as a share of an additional pool of bonus payments. At this time, and as CMS continues to modify MIPS payment policies, it is unclear how MIPS will impact our overall physician payments under the Medicare program. If we have not timely and effectively implemented policies and procedures, quality programs and appropriate clinician contracting to ensure compliance with MACRA and other QPP requirements, we would experience a negative effect on future revenues related to Medicare Part B claims.

MACRA requires that CMS publish each eligible clinician's MIPS score and performance category scores on its Physician Compare website. Publishing of MIPS scores could have an adverse reputational effect on us if our employed physicians have low scores or scores that are lower than those of the other clinicians in the relevant communities.

If current or future laws or regulations force us or cause us to restructure our arrangements with physicians and other providers, we may incur additional costs, lose contracts and suffer a reduction in net revenue under existing contracts, and we may need to refinance our debt or obtain consent from our lenders.

A number of laws bear on our relationships with our physicians and other providers. There is a risk that state authorities in some jurisdictions may find that our contractual relationships with our physicians violate laws prohibiting the corporate practice of medicine and fee-splitting. These laws generally prohibit the practice of medicine by lay entities or persons and are intended to prevent unlicensed persons or entities from interfering with or inappropriately influencing the physician's professional judgment. They may also prevent the sharing of professional services income with non-professional or business interests. In states that have enacted corporate practice of medicine and fee-splitting prohibitions, we believe that we have structured our physician contracts in an effort to remain compliant with such laws. A regulatory agency, however, could still make a determination that our arrangements constitute a corporate practice of medicine or fee splitting violation. A review or action by regulatory authorities or the courts could force us to terminate or modify our contractual relationships with physicians and affiliated medical groups or revise them in a manner that could be materially adverse to our business.

In addition, we have also entered into a number of joint venture arrangements with physicians and other potential sources of referrals (e.g., hospitals and hospital operators) that are subject to state and federal fraud and abuse laws, including the Anti-kickback Statute and False Claims Act. See "—We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may reduce our revenues and profitability." To the extent applicable, regulatory agencies may view these transactions as prohibited arrangements that must be restructured, or discontinued, or for which we could be subject to other significant penalties, including debarment, suspension or exclusion from state and federal government healthcare programs. Although compliance programs can mitigate the risk of investigation and prosecution for violations of these laws, the risks cannot be entirely eliminated. Any action against us for violation of these laws, even if we successfully defend against it, could cause us to incur significant legal expenses and loss of revenue from those joint ventures and divert our management's attention from the operation of our business.

Data Security and Privacy Risks

A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

We rely extensively on our information systems and certain systems operated by us and third-parties to manage clinical, financial and employee data, communicate with our patients, payers, vendors and other third parties and summarize and analyze operating results. These systems are at risk from cybersecurity attacks, ransomware attacks, denial-of-service attacks, and other intrusions, including attempts to gain unauthorized access to and theft of our confidential data, misuse, corruption or destruction of confidential data and damage, disruptions or shutdowns of these systems due to viruses, malware, ransomware, malicious code, employee error or malfeasance, and other electronic security breaches. Our systems, which transmit and store sensitive and confidential data, including personally identifiable information ("***PII***") and other PHI of our patients, employees and others, and our proprietary and confidential business performance and other data, will continue to be a target for attempts to gain unauthorized access and data theft due to the valuable nature of the information they contain, as well as at risk for accidental exposure. In addition, certain third-party medical devices and equipment are used at our facilities, and may be vulnerable to cybersecurity attacks or other breaches which could negatively impact our systems or our patients.

Cybersecurity breaches and other unauthorized access to our data can sometimes be difficult to discern, and any delays in detection may lead to increased harm. Such attacks or breaches are common in the healthcare sector and could result in the compromise of health information or other data subject to protection by HIPAA and other laws and regulations or disrupt our IT systems or business. There can be no assurance that we will not be subject to material cyber-attacks or security breaches in the future, or that the preventive actions we take to reduce the risk of such incidents and protect our IT and data will be sufficient. We continue to develop our cybersecurity practices and controls to protect our systems. However, regardless of the nature, extent and timing of our actions, these measures may not prevent security breaches. If our services are subject to cyber-attacks that impair or deny the ability of patients to access our services, current and potential patients may become unwilling to provide us the information necessary for them to become users of our services or may curtail or stop using our services. As cyber-threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures and to investigate and remediate any information security vulnerabilities. As we are subjected to cyber-attacks and possible security breaches in the future, this could have an adverse impact on our business, reputation, financial condition and results of operations, as well as expose us to class action lawsuits and regulatory investigation, action, and penalties. We also cannot be sure that our existing insurance coverage will continue to be available on acceptable terms or will be available in sufficient amounts to cover one or more large claims related to a security breach, or that the insurer will not deny coverage as to any future claim.

The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. If, in spite of our security and compliance efforts we or any of our business associates were to experience a breach, loss, or other compromise of PHI or PII, such event could disrupt our operations, result in increased data protection costs, damage our reputation, or result in regulatory penalties, legal claims and civil or criminal liability under HIPAA and other state and federal laws, which could have a material adverse effect on our results of operations.

If access to our information systems or those provided by our third party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

Our business depends heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and to develop new systems in order to keep pace with continuing changes in information processing technology. In addition to our own systems, we rely on multiple third-party providers of financial, clinical, supply chain, patient accounting and network information services and, as a result, we face operational challenges in maintaining multiple provider platforms and facilitating the interface of such systems with one another. The third-party providers may not have appropriate controls to protect confidential information. We do not control the information systems of third-party providers, and in some cases we may have difficulty accessing information archived on third-party systems, which could subject us to liability for failure to respond to legal, regulatory or payer obligations or information requests. Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, flood, hurricane, telecommunications failure, terrorist attack or other catastrophic event. If these systems fail or are interrupted, if our access to these systems is limited in the future or if providers develop systems more appropriate for more urban healthcare markets and not suited for our facilities, our operations could suffer.

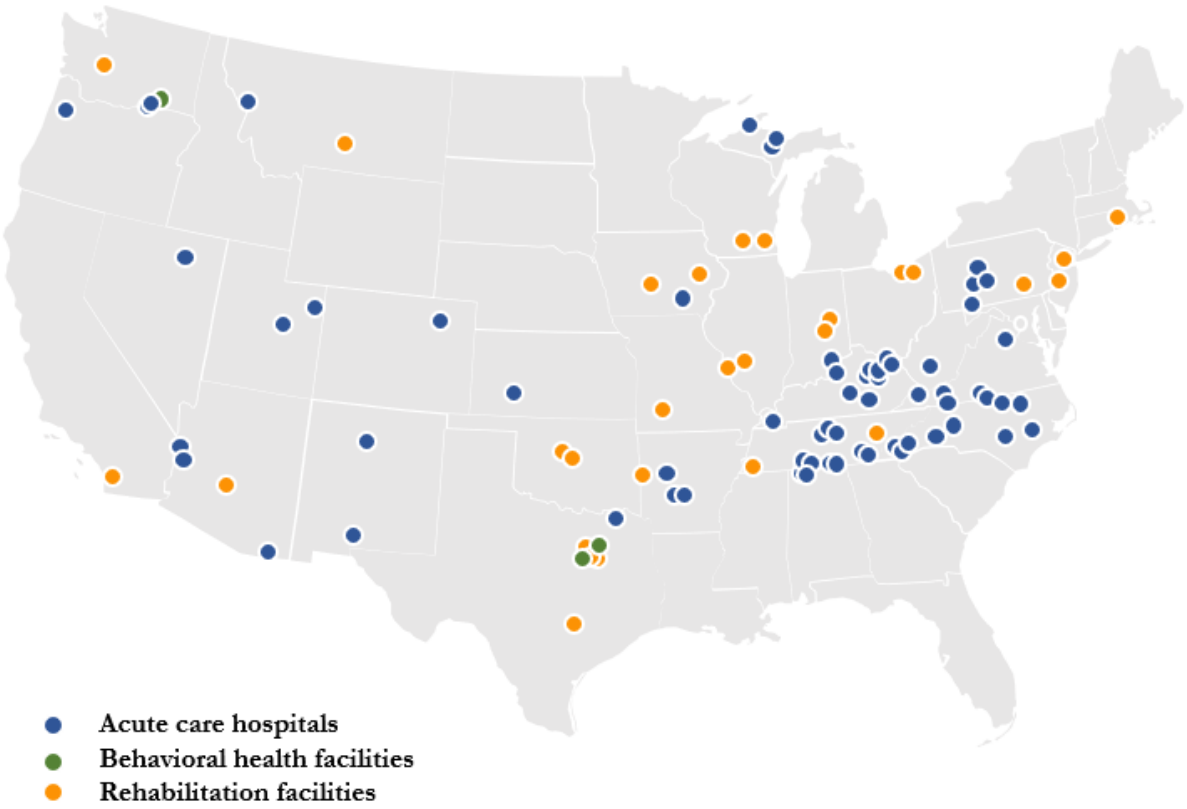
We intend to expand our operations, including by acquiring more facilities, which will require us to integrate and transition certain existing information systems. In addition, as new information systems are developed in the future, we will need to integrate them into our existing systems. Evolving industry and regulatory standards, such as the HITECH Act, HIPAA and EHR meaningful use regulations, also may require changes to our information systems in the future. System conversions are costly, time consuming and disruptive for providers, staff and, in some cases, patients. If such conversions occurred on a large scale or if we are unable to properly integrate other information systems or expand or update our current information systems, the costs and disruptions could have a material adverse effect on our revenues or results of operations.

Item 2. ***Properties.***

The following tables and map present certain information with respect to our consolidated facilities as of December 31, 2021:

Service Line	Facilities	Licensed Beds	States
Acute Care	65	8,637	21
Inpatient Rehabilitation [(a)]	28	1,447	17
Behavioral Health	3	128	2
	96	10,212	

(a) Excludes one non-consolidated IRF.



Facilities

Facility Name	City	Service Line	Licensed Beds
Alabama			
North Alabama Medical Center	Florence	Acute Care	263
Shoals Hospital	Muscle Shoals	Acute Care	198
Arizona			
Canyon Vista Medical Center	Sierra Vista	Acute Care	100
Dignity Health East Valley Rehabilitation Hospital	Chandler	Inpatient Rehabilitation	50
Havasu Regional Medical Center	Lake Havasu City	Acute Care	171
Valley View Medical Center	Fort Mohave	Acute Care	84
Arkansas			
Mercy Rehabilitation Hospital Fort Smith	Ft. Smith	Inpatient Rehabilitation	50
National Park Medical Center	Hot Springs	Acute Care	163
Saline Memorial Hospital	Benton	Acute Care	177
St. Mary's Regional Medical Center	Russellville	Acute Care	170

Facility Name	City	Service Line	Licensed Beds
California			
Palomar Health Rehabilitation Institute	Escondido	Inpatient Rehabilitation	52
Colorado			
Colorado Plains Medical Center	Fort Morgan	Acute Care	50
Illinois			
Anderson Rehabilitation Institute	Edwardsville	Inpatient Rehabilitation	34
Indiana			
Clark Memorial Hospital	Jeffersonville	Acute Care	236
Community Rehabilitation Hospital	Indianapolis	Inpatient Rehabilitation	60
Community Rehabilitation Hospital South	Greenwood	Inpatient Rehabilitation	44
Scott Memorial Hospital	Scottsburg	Acute Care	25
Iowa			
Mercy Iowa City Rehabilitation Hospital	Coralville	Inpatient Rehabilitation	40
MercyOne Clive Rehabilitation Hospital	Clive	Inpatient Rehabilitation	50
Ottumwa Regional Health Center	Ottumwa	Acute Care	217
Kansas			
Western Plains Medical Complex	Dodge City	Acute Care	99
Kentucky			
Bluegrass Community Hospital	Versailles	Acute Care	25
Bourbon Community Hospital	Paris	Acute Care	58
Clark Regional Medical Center	Winchester	Acute Care	79
Fleming County Hospital	Flemingsburg	Acute Care	25
Georgetown Community Hospital	Georgetown	Acute Care	75
Jackson Purchase Medical Center	Mayfield	Acute Care	107
Lake Cumberland Regional Hospital	Somerset	Acute Care	295
Meadowview Regional Medical Center	Maysville	Acute Care	100
Spring View Hospital	Lebanon	Acute Care	75
Michigan			
UP Health System - Bell	Ishpeming	Acute Care	25
UP Health System - Marquette	Marquette	Acute Care	222
UP Health System - Portage	Hancock	Acute Care	96
Missouri			
Mercy Rehabilitation Hospital Springfield	Springfield	Inpatient Rehabilitation	60
Mercy Rehabilitation Hospital St. Louis	Chesterfield	Inpatient Rehabilitation	90
Montana			
Community Medical Center	Missoula	Acute Care	151
The Rehabilitation Hospital of Montana	Billings	Inpatient Rehabilitation	34
Nevada			
Northeastern Nevada Regional Hospital	Elko	Acute Care	75
New Jersey			
Atlantic Rehabilitation Institute	Madison	Inpatient Rehabilitation	38
New Mexico			
Los Alamos Medical Center	Los Alamos	Acute Care	47
Memorial Medical Center of Las Cruces	Las Cruces	Acute Care	199
North Carolina			
Central Carolina Hospital	Sanford	Acute Care	137
Frye Regional Medical Center	Hickory	Acute Care	355
Harris Regional Hospital	Sylva	Acute Care	86
Haywood Regional Medical Center	Clyde	Acute Care	154
Maria Parham Medical Center	Henderson	Acute Care	205
Person Memorial Hospital	Roxboro	Acute Care	98
Rutherford Regional Medical Center	Rutherfordton	Acute Care	143
Swain County Hospital	Bryson City	Acute Care	48
Wilson Medical Center	Wilson	Acute Care	384

Facility Name	City	Service Line	Licensed Beds
Ohio			
University Hospitals Avon Rehabilitation Hospital	Avon	Inpatient Rehabilitation	50
University Hospitals Rehabilitation Hospital	Beachwood	Inpatient Rehabilitation	50
Oklahoma			
Mercy Rehabilitation Hospital Oklahoma City	Oklahoma City	Inpatient Rehabilitation	66
Mercy Rehabilitation Hospital Oklahoma City South	Oklahoma City	Inpatient Rehabilitation	36
Oregon			
Willamette Valley Medical Center	McMinnville	Acute Care	60
Pennsylvania			
Conemaugh Memorial Medical Center	Johnstown	Acute Care	539
Lancaster Rehabilitation Hospital	Lancaster	Inpatient Rehabilitation	59
Meyersdale Medical Center	Meyersdale	Acute Care	20
Miners Medical Center	Hastings	Acute Care	25
Nason Medical Center	Roaring Spring	Acute Care	45
St. Mary Rehabilitation Hospital	Langhorne	Inpatient Rehabilitation	50
Rhode Island			
Rehabilitation Hospital of Rhode Island	North Smithfield	Inpatient Rehabilitation	82
Tennessee			
Baptist Memorial Rehabilitation Hospital	Germantown	Inpatient Rehabilitation	53
Knoxville Rehabilitation Hospital	Knoxville	Inpatient Rehabilitation	57
Riverview Regional Medical Center	Carthage	Acute Care	35
Southern Tennessee Regional Health System - Lawrenceburg	Lawrenceburg	Acute Care	99
Southern Tennessee Regional Health System - Pulaski	Pulaski	Acute Care	95
Southern Tennessee Regional Health System - Sewanee	Sewanee	Acute Care	46
Southern Tennessee Regional Health System - Winchester	Winchester	Acute Care	152
Starr Regional Medical Center - Athens	Athens	Acute Care	190
Starr Regional Medical Center - Etowah	Etowah	Acute Care	88
Sumner Regional Medical Center	Gallatin	Acute Care	167
Trousdale Medical Center	Hartsville	Acute Care	25
Texas			
Central Texas Rehabilitation Hospital	Austin	Inpatient Rehabilitation	50
Paris Regional Medical Center	Paris	Acute Care	154
Texas Rehabilitation Hospital of Arlington	Arlington	Inpatient Rehabilitation	40
Texas Rehabilitation Hospital of Fort Worth	Fort Worth	Inpatient Rehabilitation	66
Texas Rehabilitation Hospital of Keller	Keller	Inpatient Rehabilitation	36
WellBridge Healthcare Greater Dallas	Plano	Behavioral Health	48
WellBridge Healthcare Fort Worth	Fort Worth	Behavioral Health	48
Utah			
Ashley Regional Medical Center	Vernal	Acute Care	39
Castleview Hospital	Price	Acute Care	39
Virginia			
Clinch Valley Medical Center	Richlands	Acute Care	175
Fauquier Health	Warrenton	Acute Care	210
Sovah Health - Danville	Danville	Acute Care	250
Sovah Health - Martinsville	Martinsville	Acute Care	220
Twin County Regional Hospital	Galax	Acute Care	141
Wythe County Community Hospital	Wytheville	Acute Care	100
Washington			
CHI Franciscan Rehabilitation Hospital	Tacoma	Inpatient Rehabilitation	60
Lourdes Health - Medical Center	Pasco	Acute Care	95
Lourdes Health - Counseling Center	Pasco	Behavioral Health	32
Trios Health - Southridge Hospital	Kennewick	Acute Care	74
Trios Health - Women's and Children's Hospital	Kennewick	Acute Care	37

Facility Name	City	Service Line	Licensed Beds
West Virginia			
Raleigh General Hospital	Beckley	Acute Care	300
Wisconsin			
Pro Health Rehabilitation Hospital of Wisconsin	Waukesha	Inpatient Rehabilitation	40
UW Health Rehabilitation Hospital	Madison	Inpatient Rehabilitation	50
			10,212

We own or lease and operate medical office buildings, clinics and other ancillary properties in conjunction with many of our hospitals. These medical office buildings and clinics are primarily occupied by physicians who practice at our hospitals. Additionally, we lease office space in Brentwood, Tennessee and Louisville, Kentucky for our HSC. All of our facilities are suitable for their respective uses and are generally adequate for our present needs.

Item 3. ***Legal Proceedings.***

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

Except as discussed under "Legal Proceedings and General Liability Claims" in Note 14 to our accompanying consolidated financial statements included elsewhere in this Report, we are currently not a party to any pending proceedings, which, in management's opinion would have a material adverse effect on our business, financial condition or results of operations.

Item 4. ***Mine Safety Disclosures*****.**

Not applicable.

PART II

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

All of our equity securities are held by Holdings, an indirect subsidiary of the Parent. As of December 31, 2021, our Sponsor and certain co-investors beneficially owned approximately 97.0% of the capital units of the Parent with the remaining approximate 3.0% owned by our current or former directors, members of management and employees, and/or our affiliates. Because our equity securities are privately held, there is no established public trading market for our equity securities.

Equity Compensation Plan Information

Refer to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by the Parent to our employees and directors.

Recent Sales of Unregistered Securities

There have been no recent sales of unregistered equity securities of the Company within the period covered by this Report.

Item 6. [Reserved.]

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

The following is management's discussion and analysis of our financial condition and results of operations for the years ended December 31, 2021 and December 31, 2020. We recommend that you read this discussion together with our accompanying consolidated financial statements and related notes included elsewhere in this Report.

Management's discussion and analysis of our financial condition and results of operations as of and for the year ended December 31, 2019 has been omitted as permitted by Instruction 1 to Item 303(a) of Regulation S-K. Refer to "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations for the Years Ended December 31, 2020 and 2019" in our Annual Report for the year ended December 31, 2020 for management's discussion and analysis of changes in financial condition and results of operations as of and for the year ended December 31, 2019.

Overview

We are a leading provider of healthcare serving patients, clinicians, communities and partner organizations across the healthcare continuum. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a growing diversified healthcare delivery network comprised of 65 community hospital campuses, 28 IRFs, three behavioral health facilities, and additional sites of care that include ARUs, outpatient centers and post-acute care facilities. As of December 31, 2021, we operated 96 healthcare facilities in 29 states throughout the U.S. with approximately 10,000 licensed beds and approximately 50,000 dedicated employees.

We seek to fulfill our mission of Making Communities Healthier® by (1) delivering high quality patient care, (2) supporting our physicians, (3) creating excellent workplaces for our employees, (4) taking a leadership role in our communities and (5) ensuring fiscal responsibility. We strive to create places where people choose to come for healthcare, physicians want to practice and employees want to work.

We generated revenues of $8,937 million and $8,122 million for the years ended December 31, 2021 and 2020, respectively. For the years ended December 31, 2021 and 2020, approximately 56.1% and 55.7% of our revenues, respectively, related to patients participating in Medicare and Medicaid programs, collectively. Payments made to our facilities pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payers, together with certain limited services provided to Medicare recipients, to generate an operating profit. The healthcare industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payers. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our facilities.

Developments, Trends and Operating Environment

Kindred Transaction

On June 18, 2021, we entered into a definitive agreement (the "***Kindred Purchase Agreement***") for us and/or one or more affiliated assignees to acquire, directly or indirectly, Kindred Healthcare, a leading specialty hospital company that operates facilities providing post-acute care, rehabilitation services and behavioral health services throughout the U.S. On November 30, 2021, our affiliate Knight Health assumed from us and we assigned to Knight Health our rights and obligations under the Kindred Purchase Agreement in respect of the purchase of all of the issued and outstanding equity interests of the Knight and the Blocker Sellers and the payment of the purchase price for such equity interests. The Kindred Transaction closed on December 23, 2021. Upon the closing of the Kindred Transaction, a new healthcare company was established operating under the name ScionHealth, which is separate from LifePoint. For additional information regarding the Kindred Transaction, see "Item 1. Business—Our Background— Kindred Transaction" included elsewhere in this report.

Divestitures

Entry into Agreement to Sell Colorado Plains Medical Center and Western Plains Medical Complex

On January 31, 2022, we entered into a definitive agreement with an unrelated third-party to sell Colorado Plains Medical Center, located in Fort Morgan, Colorado, and Western Plains Medical Complex, located in Dodge City, Kansas. We expect the transaction to close in the second quarter of 2022. The results of operations of Colorado Plains Medical Center and Western Plains Medical Complex remain included in the classification of "same-facility" in the forthcoming discussion and analysis of our results of operations for the years ended December 31, 2021 and 2020.

Providence Health and KershawHealth

Effective August 1, 2021, we sold Providence Health, comprised of two hospital campuses located in Columbia, South Carolina, and KershawHealth, located in Camden, South Carolina, to an unrelated third-party. We excluded Providence Health and KershawHealth from the classification of "same-facility" in the forthcoming discussion and analysis of our results of operations for the years ended December 31, 2021 and 2020.

Capital Medical Center

Effective April 1, 2021, we sold our majority ownership interest in Capital Medical Center. We excluded Capital Medical Center from the classification of "same-facility" in the forthcoming discussion and analysis of our results of operations for the years ended December 31, 2021 and 2020.

For additional information regarding our recent divestitures, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Impact of COVID-19

Our internal COVID-19 taskforce, which was established during the early stages of the pandemic, continues to meet regularly. Additionally, in November 2020, we established a COVID-19 vaccine team to help facilitate the successful distribution and administration of vaccines across our markets. This team continues to meet regularly to discuss the latest vaccine developments and keep a pulse on potential barriers our facilities may encounter as they work to increase vaccination rates locally.

The number and severity of COVID-19 variants, including the Delta and Omicron variants, continue as a concerning threat for the national healthcare system, including our hospitals and the communities we serve. The rapid spread of the Delta and Omicron variants through largely unvaccinated populations has resulted in a sharp rise in COVID-19 cases across the country. This activity and the threat of other COVID-19 variants has further emphasized the need for our hospitals and providers to continue endorsing COVID-19 vaccination as the primary means for protection.

Our top priorities continue to be protecting our patients, supporting our people, being leaders in our communities, and managing our financial health. We have put in place a number of protocols to protect our patients, providers, employees, volunteers and visitors.

Our evaluation of the measures taken across our health system in response to COVID-19 is ongoing and additional updates to our policies, procedures and operations could occur as best practices continue to evolve. Furthermore, our facilities are located across a wide geographic range of communities, which may require us to modify measures we take at specific facilities based on local conditions, including the severity of COVID-19 and any variants of the virus in the community served by a facility and changes in state and local executive orders that may restrict certain services or activities.

Additionally, although we recently have repaid or declined funds that are available to us and our facilities under the CARES Act and related stimulus legislation, we cannot predict if we will need to seek such funds in the future, and we cannot assure you that we will be able to access such funds in a timely manner or at all.

For additional information about the risks presented by the COVID-19 pandemic, our responses to the pandemic and the resources available to healthcare providers, refer to "Part I, Item 1A. Risk Factors" included in this Report.

Legislative and Regulatory Developments in Response to COVID-19

CARES Act, Other Stimulus Legislation and Regulatory Developments

Numerous recent legislative and regulatory actions have been taken in an attempt to provide businesses, including healthcare providers, with relief from the negative impacts of the COVID-19 pandemic. For additional information about the CARES Act and other stimulus legislation and regulatory developments related to the COVID-19 pandemic, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" and to Note 3 to our consolidated financial statements included elsewhere in this Report.

Stimulus Payments

With respect to payments being made to providers from the Emergency Fund, beginning April 10, 2020, the Public Health and Social Services Emergency Fund distributed approximately $50 billion to hospitals based on their 2018 net patient revenue. Additionally, since that time, the Emergency Fund has distributed more than $80 billion to a number of different types of healthcare providers, including participants in state Medicaid/CHIP programs, providers in areas particularly impacted by the COVID-19 outbreak, rural providers (including hospitals and rural health clinics), skilled nursing facilities, dentists, providers of services with lower shares of Medicare reimbursement or who predominantly serve Medicaid beneficiaries, and providers requesting reimbursement for the treatment of uninsured patients.

For the years ended December 31, 2021 and 2020, we recognized $17 million and $646 million, respectively, of stimulus payments as other income under the caption "Government stimulus income" in our accompanying consolidated statements of operations included elsewhere in this Report.

For additional information about stimulus payments, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" included in this Report.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, HHS had also expanded the CMS Accelerated and Advance Payment Program to a broader group of Medicare Part A and Part B providers. Under the expanded Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period.

Through December 31, 2020, we received a total of $991 million of Medicare advance payments under the Accelerated and Advance Payment Program, of which $370 million and $621 million are included under the captions "Current portion of Medicare advance payments" and "Long-term portion of Medicare advance payments", respectively, in our accompanying consolidated balance sheet at December 31, 2020 included elsewhere in this Report. During the year end December 31, 2021, we fully repaid all Medicare advance payments, and we do not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program.

For additional information about the repayment of these accelerated/advance payments refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" included in this Report.

CARES Act Tax Provisions

The CARES Act also provides for certain federal income tax changes, including an increase in the interest expense tax deduction limitation, the deferral of the employer portion of Social Security payroll taxes, refundable payroll tax credits, employee retention tax credits, net operating loss carryback periods, alternative minimum tax credit refunds and bonus depreciation of qualified improvement property. During the year ended December 31, 2020, we deferred cash payments of approximately $84 million related to Social Security payroll tax payments. During the year ended December 31, 2021, we fully repaid all previously deferred Social Security payroll taxes.

The federal income tax changes brought about by the CARES Act are complex and further guidance is expected. We may change our provision for income taxes and our deferred income taxes as our understanding of the CARES Act tax provisions evolves due to additional U.S. Department of Treasury guidance. Any such adjustments could materially impact our provision for income taxes and, as a result, our financial results in the relevant periods.

Healthcare Reform Efforts

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The net effect of the Affordable Care Act, as currently adopted, on our business continues to be subject to a number of variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. On June 17, 2021, the U.S. Supreme Court issued its decision in litigation that had been brought by a number of states against the federal government alleging that, in light of the repeal of the penalties associated with the individual mandate, the Affordable Care Act was unconstitutional. In its decision, the Court held that the states and other plaintiffs did not have standing to challenge the Affordable Care Act and ordered the case to be dismissed. While the U.S. Supreme Court rejected this most recent challenge to the Affordable Care Act, we cannot predict the outcome of other lawsuits that are still pending in lower courts regarding the implementation of various aspects of the Affordable Care Act and whether the U.S. Supreme Court will decide to hear future cases. Additionally, we cannot predict the impact that the current or future Presidential administrations and Congresses will have on the implementation and enforcement of the provisions of the Affordable Care Act or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

Refer to "Part I, Item 1. Business—Healthcare Reform" included in this Report for more information about the Affordable Care Act.

Competitive and Structural Environment

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

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

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

In addition to competitive concerns, many of our communities are experiencing slow growth, and in some cases, population losses. We believe this trend has occurred mainly as a result of challenging economic conditions in the non-urban communities where our facilities primarily operate, which are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves. In addition, other economic factors, including, the recent economic downturn resulting from the COVID-19 pandemic and, potentially, self-rationing of healthcare services, have made it more difficult to increase the number of patients who seek care at many of our facilities.

Regulatory Environment

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

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

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

In light of the provisions of the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

Revenue Sources

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

Medicare and Medicaid Reimbursement

Revenues from governmental payers, such as Medicare and Medicaid, are controlled by complex rules and regulations that stipulate the amount a healthcare provider is paid for providing healthcare services. We must comply with these rules and regulations to continue to be eligible to participate in the Medicare and Medicaid programs. These rules and regulations are subject to frequent changes as a result of legislative and administrative action and annual payment adjustments on both the federal and the state levels. In addition, Medicare payment methodologies have been, and are expected to continue to be, revised significantly based on cost containment and policy considerations.

For more information about Medicare and Medicaid reimbursement matters, refer to “Part I, Item 1. Business—Sources of Revenue” included in this Report.

Physician & Non-Physician Practitioner Services

We employ an increasing number of physicians and non-physician practitioners, such as physician assistants and nurse practitioners, in our hospital markets. Medicare pays us for services provided by our employed physicians and non-physician practitioners under the PFS system. MACRA, which was adopted in 2015, significantly changed how CMS determines the annual updates to the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased annually by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the Bipartisan Budget Act of 2018, were increased by 0.25% for CY 2019. PFS payment rates are scheduled to remain at their CY 2019 levels through CY 2025. In addition, MACRA also established the QPP for incentivizing physician and practitioner care that meets certain value, quality, cost, and performance criteria, and, beginning in CY 2019, amounts paid to physicians and practitioners under the PFS are subject to adjustment through the QPP and participation in either MIPS or an APM. For more information, refer to "Part I, Item 1. Business—Sources of Revenue—Medicare Physician Fee Schedule" included in this Report.

HMOs, PPOs and Other Private Insurers

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

Self-pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities have experienced in prior years, which included increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. We cannot predict how administrative or judicial interpretations, legislative actions or any other modifications to the Affordable Care Act that may be implemented or adopted, such as the cessation of cost sharing reduction payments or the repeal of the individual mandate, may impact our self-pay revenues.

Surprise Billing Regulations

On December 21, 2020, Congress adopted legislation that is intended to limit the "surprise" medical bills that are often received by individuals receiving emergency and certain other services (such as anesthesia services) from out-of-network providers. Effective as of January 1, 2022, the No Surprises Act prohibits, among other things, out-of-network providers from balance billing patients for emergency care services that are provided by out-of-network facilities or at in-network facilities by out-of-network providers. The No Surprises Act also generally prohibits out-of-network providers from billing patients for non-emergency medical treatment unless the provider first notifies the patient of the provider's network status and estimated charges and the patient agrees to be financially liable for the additional amounts. Violations of the No Surprises Act are punishable by civil monetary penalties of up to $10,000, and the No Surprises Act may be enforced by both the state and federal governments. We cannot predict how the No Surprises Act will be implemented or enforced. We also cannot predict the amounts that will be received by our facilities and our employed providers for out-of-network services, whether the No Surprises Act will impact the in-network payment rates that are offered by third-party payers and the willingness of those payers to enter into participation agreements with us and our facilities in the future, or the costs we will incur in complying with the requirements of the No Surprises Act. For more information, see "Business—Sources of Revenues—Surprise Medical Billing" included elsewhere in this Report —Item 1.

Price Transparency

Transparency in healthcare pricing has become a focal point for CMS, Congress, and many state legislatures. For example, effective as of January 1, 2021, hospitals generally are required to post their standard charges prominently on a publicly available website. Although we continue to evaluate, and are taking proactive steps in response to, the legislative and regulatory developments regarding price transparency, we cannot predict how existing regulations will be implemented or interpreted or whether any other requirements will be imposed on providers and health plans. We also cannot predict what affect the public disclosure of hospitals' or insurance providers' negotiated rates will have on our future negotiations with payers or the effect that the disclosure of pricing information by healthcare providers and health plans will have on our patient volumes and revenues. For more information, see "Business—Sources of Revenues—Price Transparency" included elsewhere in this Report—Item 1.

Results of Operations

Certain Definitions

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

Adjusted EBITDA. EBITDA adjusted to exclude unusual items and other adjustments required or permitted in calculating debt covenant compliance under the Indentures governing the Notes and/or the Credit Agreements. We believe that this inclusion of supplementary adjustments to EBITDA applied in presenting Adjusted EBITDA are appropriate to provide additional information to investors about the impact of certain non-cash items, unusual items that we do not expect to continue or at the same level in the future and other items.

Admissions. The total number of patients admitted to our facilities for inpatient treatment.

Case mix index. Refers to the acuity or severity of illness of an average patient at our acute care facilities.

Consolidated. Consolidated information includes the results of all facility operations and corporate overhead costs, including the results of our recent acquisitions and divestitures during the applicable periods.

EBITDA. Earnings before interest, taxes, depreciation and amortization.

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

Outpatient factor. The sum of gross inpatient revenue and gross outpatient revenue divided by gross inpatient revenue.

Patient days. The total number of days of care provided to patients admitted to our facilities for inpatient treatment.

Pro forma same-facility. Pro forma same-facility information includes the results of the same facilities operated during the entire years ended December 31, 2021 and 2020, as if the Kindred Transaction had occurred on January 1 for each of the years then ended. Pro forma same-facility information excludes the results of the Artemis Business, as well as new facilities opened and divestitures completed during 2021 and 2020.

Summary

The following table summarizes our consolidated results of operations for the years ended December 31, 2021 and 2020 (dollars in millions):

	Years Ended December 31,			
	2021		2020	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 8,937	100.0 %	$ 8,122	100.0 %
Salaries and benefits	4,176	46.7	3,877	47.7
Supplies	1,505	16.8	1,418	17.5
Other operating expenses, net	2,245	25.1	2,190	27.0
Government stimulus income	(17)	(0.2)	(646)	(8.0)
Depreciation and amortization	345	3.9	378	4.7
Interest expense, net	466	5.2	528	6.5
Transaction-related costs	86	1.0	132	1.6
Other non-operating losses, net	19	0.2	4	-
	8,825	98.7	7,881	97.0
Income before income taxes	112	1.3	241	3.0
Benefit from income taxes	(27)	(0.3)	(64)	(0.8)
Net income	139	1.6	305	3.8
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(9)	(0.1)	(22)	(0.3)
Net income attributable to LifePoint Health, Inc.	$ 130	1.5 %	$ 283	3.5 %

Revenues

The following table summarizes our key revenue metrics on a consolidated basis for the years ended December 31, 2021 and 2020:

	Years Ended December 31,		Increase	% Increase
	2021	2020	(Decrease)	(Decrease)
Number of facilities (at end of period) (a)	96	88		
Revenues (in millions)	$ 8,937	$ 8,122	$ 815	10.0 %
Patient days	1,524,403	1,504,852	19,551	1.3 %
Admissions	284,918	299,254	(14,336)	(4.8)%
Equivalent admissions	734,730	744,917	(10,187)	(1.4)%
Revenues per equivalent admission	$ 12,164	$ 10,903	$ 1,261	11.6 %
Case mix index (b)	1.49	1.45	0.04	2.8 %
Total surgeries (b)	380,293	357,389	22,904	6.4 %
Emergency department visits (b)	1,606,668	1,570,558	36,110	2.3 %

(a) Excludes one non-consolidated IRF.
(b) Metric attributable to acute care facility operations only.

For the year ended December 31, 2021, our consolidated revenues increased $815 million, or 10.0%, to $8,937 million compared to $8,122 million for the prior year. The increase in our revenues was primarily attributable to improvements in both commercial and government pricing, most notably the modification of the Commonwealth of Kentucky implemented Medicaid Hospital Rate Improvement Program, which is discussed further in Note 1 to our accompanying consolidated financial statements included elsewhere in this Report, as well as overall improvements in surgical volumes during the year ended December 31, 2021 compared to the prior year. Our revenues and patient volumes for the year ended December 30, 2020 were lower as a result of the deferral of certain non-urgent and elective procedures, as well as nationwide shelter-in-place and safer-at-home orders issued in response to the COVID-19 pandemic. The increase in our consolidated revenues was partially offset by hospital divestitures completed during the second and third quarters of 2021.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2021 and 2020 (dollars in millions):

	Years Ended December 31,			
	2021		2020	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,368	37.7 %	$ 3,134	38.6 %
Medicaid	1,645	18.4	1,392	17.1
HMOs, PPOs and other private insurers	3,691	41.3	3,382	41.6
Self-pay	55	0.6	55	0.7
Other	156	1.8	137	1.7
Revenue from contracts with customers	8,915	99.8	8,100	99.7
Rental income	22	0.2	22	0.3
Revenues	$ 8,937	100.0 %	$ 8,122	100.0 %

Salaries and Benefits

For the year ended December 31, 2021, our consolidated salaries and benefits expense was $4,176 million, or 46.7% of revenues, compared to $3,877 million, or 47.7% of revenues, for the prior year. The increase in our salaries and benefits expense was partially attributable to the increase in revenues during the year ended December 31, 2021 compared to the prior year, in addition to $112 million of accelerated stock-based compensation expense recognized in connection with the sale of the Parent, including the Company and its subsidiaries, by certain affiliates of the Parent in the second quarter of 2021. For additional information regarding our accounting for stock-based compensation, refer to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report. Our salaries and benefits expenses were higher as a percentage of revenues during the year ended December 31, 2020 as a result of the decrease in revenues associated with the COVID-19 pandemic.

Supplies

For the year ended December 31, 2021, our consolidated supplies expense was $1,505 million, or 16.8% of revenues, compared to $1,418 million, or 17.5% of revenues, for the prior year. The increase in our supplies expense was primarily attributable to the increase in revenues during the year ended December 31, 2021 compared to the same period last year, as well as an increase in the overall level of acuity of services provided during the year ended December 31, 2021 compared to the same period last year.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the year ended December 31, 2021, our consolidated other operating expenses were $2,245 million, or 25.1% of revenues, compared to $2,190 million, or 27.0% of revenues, for the prior year. The increase in our other operating expenses was primarily attributable to the increase in revenues during the year ended December 31, 2021 compared to the same period last year, in addition to increased provider taxes associated with certain of our Medicaid reimbursement programs, and the transition of certain personnel-related costs, previously included in salaries and benefits, to a third-party contracted services model for certain revenue cycle and environmental service functions. Our other operating expenses were higher as a percentage of revenues during the year ended December 31, 2020 as a result of the decrease in revenues associated with the COVID-19 pandemic.

Government Stimulus Income

As a result of the adverse impact of the COVID-19 pandemic on our business, we received stimulus payments from the Emergency Fund established under the CARES Act. For the years ended December 31, 2021 and 2020, we recognized $17 million and $646 million, respectively, of stimulus payments as other income. For additional information regarding the CARES Act and related financial impact, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Depreciation and Amortization

For the year ended December 31, 2021, our consolidated depreciation and amortization expense was $345 million, or 3.9% of revenues, compared to $378 million, or 4.7% of revenues, for the prior year. The decrease in our depreciation expense was primarily attributable to the discontinuation of depreciation expense related to the property and equipment of our recently divested hospitals.

Interest Expense, Net

For the year ended December 31, 2021, our consolidated interest expense was $466 million, or 5.2% of revenues, compared to $528 million, or 6.5% of revenues, for the prior year. The decrease in our interest expense was primarily attributable to the non-cash changes in the estimated fair value of our Interest Rate Swap recognized through interest expense during the years ended December 31, 2021 and 2020. Additionally, we completed various debt refinancing activities during 2020, which resulted in a lower weighted average borrowing rate for the year ended December 31, 2021 compared to the same period last year. For a further discussion of our debt and corresponding interest expense, refer to Notes 4 and 11 to our accompanying consolidated financial statements included elsewhere in this Report.

Transaction-Related Costs

For the year ended December 31, 2021, we recognized $86 million of transaction and advisory related expenses, primarily in connection with the Kindred Transaction and other business development activities. For the year ended December 31, 2020, we recognized $115 million of debt transaction costs associated with the various debt financing activities completed during 2020, as well as $17 million of transaction and advisory related expenses associated with our business development activities. For additional information regarding our business development activities and debt transactions, refer to Notes 2 and 4, respectively, to our accompanying consolidated financial statements included elsewhere in this Report.

Other Non-Operating Losses, Net

For the year ended December 31, 2021, we recognized a net other non-operating loss of $19 million, primarily comprised of net gains and losses recognized in connection with our recent hospital divestitures, as well as other miscellaneous disposals of property and equipment. For the year ended December 31, 2020, we recognized a net other non-operating loss $4 million, primarily related to non-cash changes in the estimated fair value of certain contingent liabilities and miscellaneous disposals of property and equipment.

Income Taxes

For the years ended December 31, 2021 and 2020, we recognized a benefit from income taxes of $27 million and $64 million, respectively. For a further discussion of our income taxes, refer to Note 6 to our accompanying consolidated financial statements included elsewhere in this Report.

Non-GAAP Measures

Supplemental Results of Operations on a Pro Forma Same-Facility Basis

The following table summarizes our key supplemental results of operations for the years ended December 31, 2021 and 2020 on a pro forma same-facility basis as if the Kindred Transaction had occurred on January 1 for each of the years then ended. GAAP does not allow for such a combination of results of operations; however, we believe this information is useful in evaluating our financial performance.

	Years Ended December 31,		Increase	% Increase
	2021	2020	(Decrease)	(Decrease)
Number of facilities (at end of period) (a)	86	86		
Revenues (in millions)	$ 8,191	$ 7,297	$ 894	12.3 %
Patient days	1,538,547	1,493,717	44,830	3.0 %
Admissions	253,776	257,346	(3,570)	(1.4)%
Equivalent admissions	627,571	614,841	12,730	2.1 %
Revenues per equivalent admission	$ 13,052	$ 11,868	$ 1,184	10.0 %
Case mix index (b)	1.49	1.45	0.04	2.8 %
Total surgeries (b)	310,099	283,556	26,543	9.4 %
Emergency department visits (b)	1,258,218	1,187,884	70,334	5.9 %

(a) Excludes one non-consolidated IRF.
(b) Metric attributable to acute care facility operations only.

For the year ended December 31, 2021, our pro forma same-facility revenues increased $894 million, or 12.3%, compared to the prior year. The increase in our pro forma same-facility revenues was primarily attributable to improvements in both commercial and government pricing, most notably the modification of the Commonwealth of Kentucky implemented Medicaid Hospital Rate Improvement Program, as well as overall improvements in patient volumes during the year ended December 31, 2021 compared to the prior year. Our revenues and patient volumes for the year ended December 30, 2020 were lower as a result of the deferral of certain non-urgent and elective procedures, as well as nationwide shelter-in-place and safer-at-home orders issued in response to the COVID-19 pandemic.

EBITDA and Adjusted EBITDA

The following table presents a reconciliation of net income to EBITDA and Adjusted EBITDA prepared in accordance with the calculations set forth in the Indentures and the Credit Agreements for the years ended December 31, 2021 and December 31, 2020 (in millions):

	Years Ended December 31,	
	2021	**2020**
Net income (a)	$ 139	$ 305
Interest expense, net	466	528
Income taxes	(27)	(64)
Depreciation and amortization	345	378
EBITDA	923	1,147
Transaction-related costs (b)	86	132
Stock-based compensation (c)	117	5
Facility lease expense (d)	(74)	(80)
One-time costs, non-cash and non-recurring items (e)	75	53
Subtotal	1,127	1,257
Pro forma run rate adjustments (f)	206	127
Adjusted EBITDA	$ 1,333	$ 1,384

(a) Included in net income for the years ended December 31, 2021 and 2020 is $17 million and $646 million, respectively, of stimulus payments recognized as other income. For additional information regarding the CARES Act and related stimulus programs, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

(b) Represents the exclusion of certain transaction-related expenses, including costs associated with the Kindred Transaction and other business development activities occurring during 2021 and 2020, as well as costs associated with our various debt financing activities completed during 2020. For additional information regarding our business development activities and debt transactions, refer to Notes 2 and 4, respectively, to our accompanying consolidated financial statements included elsewhere in this Report.

(c) Represents the exclusion of stock-based compensation expense, including expense associated with the accelerated vesting of profits units recognized in connection with a 2021 transaction involving the Parent. For additional information regarding our accounting for stock-based compensation, refer to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report.

(d) Represents cash interest expense in connection with certain finance leases. Pursuant to the terms of our financial covenants contained in our debt agreements, we are required to consider cash interest expense on facility-related finance leases within the definition of Adjusted EBITDA.

(e) Represents the exclusion of certain one-time costs, non-cash and non-recurring items, including non-recurring incremental operating expenses associated with the COVID-19 pandemic, the elimination of EBITDA associated with facilities that have been divested, differences between cash payments and reported rent expense for facility operating leases, gains and losses related to hospital divestitures and other disposals of property and equipment, and other non-operational items.

(f) Represents the estimated pro forma EBITDA impact attributable to various strategic initiatives in accordance with our debt agreements. Such items primarily consist of (i) the net estimated pro forma EBITDA impact attributable to the businesses transferred in connection with the Kindred Transaction, including incremental corporate overhead costs, which has also been included for the year ended December 31, 2020 for comparative purposes; (ii) unrealized cost savings related to conversions of the revenue cycle management function in certain of our facilities and other initiatives; (iii) new or expanded service lines, newly constructed facilities and other strategic investments; and (iv) the pro forma impact of our recent divestitures.

Leverage

The following table illustrates our indebtedness and certain leverage ratios prepared in accordance with the calculations set forth in the Indentures and the Credit Agreements as of and for the year ended December 31, 2021 (dollars in millions):

	December 31, 2021
Cash and cash equivalents	$ 853
ABL Facility	$ -
Term Loan Facility	3,215
6.75% Secured Notes	600
4.375% Secured Notes	600
Total Secured Debt (a)	$ 4,415
Net Secured Debt (a)	$ 3,562
9.75% Unsecured Notes	$ 1,425
5.375% Unsecured Notes	500
Total Debt (a)	$ 6,340
Net Debt (a)	$ 5,487
Adjusted EBITDA	$ 1,333
Total Secured Debt (a) / Adjusted EBITDA	3.31x
Net Secured Debt (a) / Adjusted EBITDA	2.67x
Total Debt (a) / Adjusted EBITDA	4.76x
Net Debt (a) / Adjusted EBITDA	4.12x

(a) Excludes finance lease obligations, which are not considered indebtedness for purposes of calculating the ratios set forth in the Indentures and the Credit Agreements, as well as unamortized debt issuance costs and premium.

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash generated by operations and borrowings under the ABL Facility. Our primary uses of cash are working capital requirements, debt service requirements and capital expenditures. Based on our current level of operations and available cash, we believe our cash flows from operations, combined with availability under the ABL Facility, will provide sufficient liquidity to fund our current obligations, projected working capital requirements, debt service requirements and capital spending requirements over the next twelve months. We cannot assure you, however, that our business will generate sufficient cash flows from operations or that future borrowings will be available to us under the ABL Facility, which is subject to a borrowing base, in an amount sufficient to enable us to pay principal and interest on the ABL Facility, the Term Loan Facility and the Notes, or to fund other liquidity needs. Our ability to do so depends on prevailing economic conditions, many of which are beyond our control. In addition, upon the occurrence of certain events, such as a change of control, we could be required to repay or refinance our indebtedness. We cannot assure you that we will be able to refinance any of our indebtedness on commercially reasonable terms or at all. Any future acquisitions, joint ventures or other similar transactions will likely require additional capital, and there can be no assurance that any such capital will be available to us on acceptable terms or at all. Any refinancing of our indebtedness could be at higher interest rates and may require us to comply with more onerous covenants that could further restrict our business operations. See "Item 1A, Risk Factors—Credit and Liquidity Risks" included elsewhere in this Report.

The following table presents summarized cash flow information for the years ended December 31, 2021 and 2020 (in millions):

	2021	2020
Net cash (used in) provided by operating activities	$ (590)	$ 1,920
Net cash used in investing activities	(1,034)	(120)
Net cash (used in) provided by financing activities	(176)	105
Change in cash and cash equivalents	$ (1,800)	$ 1,905

Operating Activities

When adjusted to exclude the impact of Medicare advance payments and deferred payroll taxes in connection with the CARES Act, our net cash provided by operating activities for the years ended December 31, 2021 and 2020 was $485 million and $845 million, respectively. The decrease in our net cash provided by operating activities was primarily attributable to changes in net working capital, partially offset by lower cash payments for interest during the year ended December 31, 2021 compared to the prior year. Additionally, our net cash provided by operating activities for the year ended December 31, 2020 included $646 million of stimulus payments recognized as other income compared with only $17 million for the year ended December 31, 2021.

Investing Activities

We invested $274 million and $170 million in purchases of property and equipment for the years ended December 31, 2021 and 2020, respectively. Refer to "—Capital Expenditures" below for further information.

In connection with the Kindred Transaction, we transferred cash of $946 million to ScionHealth and received cash of $71 million associated with the Knight Transferred Business, resulting in a net cash outflow of $875 million for the year ended December 31, 2021. Additionally, during the year ended December 31, 2021, we received cash proceeds of $119 million in connection with our recent divestitures. For a further discussion of the Kindred Transaction and our recent divestitures, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

During the year ended December 31, 2020, we sold a portion of our ownership interest in In-Home Healthcare Partnership to a wholly-owned subsidiary of LHC Group, Inc. for cash proceeds of approximately $24 million, in addition to proceeds from various other investing activities.

Financing Activities

Our net cash used in financing activities for the year ended December 31, 2021 includes a $93 million cash distribution to the Parent to partially fund the repurchase of certain previously issued Units and capital units, primarily held by certain of our former employees, as well as certain of our current employees, executives, and directors, in addition to distributions to certain joint venture partners, and payments made under finance lease arrangements.

Our net cash provided by financing activities for the year ended December 31, 2020 consisted of proceeds from the offering of our 6.75% Secured Notes, 4.375% Secured Notes, and 5.375% Unsecured Notes, in addition to the issuances of the Incremental Term Loan, partially offset by payments made in connection with the redemption and discharge of our 8.25% Secured Notes and 11.5% Unsecured Notes, and prepayments of our Term Loan Facility. For a further discussion of our recent debt transactions, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Capital Expenditures

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

The following table summarizes our capital expenditures as a percentage of revenues and as a percentage of depreciation expense for the years ended December 31, 2021 and 2020 (dollars in millions):

	2021		2020	
	Amount	% of Revenues	Amount	% of Revenues
Capital expenditures	$ 274	3.1 %	$ 170	2.1 %
Depreciation expense	$ 344		$ 376	
Ratio of capital expenditures to depreciation expense	79.7 %		45.2 %	

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

Capital Resources

ABL Facility

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we entered into the ABL Facility in an aggregate principal amount of up to $800 million with a maturity of five years. For further information regarding the ABL Facility, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

Term Loan Facility

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we entered into the Term Loan Facility with an original aggregate principal amount of $3,550 million with a maturity of seven years and we repaid in full our Prior Term Facility. The Term Loan Facility was amended in connection with a refinancing transaction during the first quarter of 2020. For further information regarding the Term Loan Facility, including certain restrictive covenants and the refinancing transactions, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

6.75% Secured Notes

On April 13, 2020, we issued the 6.75% Secured Notes in an aggregate principal amount of $600 million with a maturity of five years. For further information regarding the 6.75% Secured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

4.375% Secured Notes

On February 13, 2020, we issued the 4.375% Secured Notes in an aggregate principal amount of $600 million with a maturity of seven years. For further information regarding the 4.375% Secured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

9.75% Unsecured Notes

On November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, we issued the 9.75% Unsecured Notes in an aggregate principal amount of $1,425 million with a maturity of eight years. For further information regarding the 9.75% Unsecured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

5.375% Unsecured Notes

On December 4, 2020, we issued the 5.375% Unsecured Notes in an aggregate principal amount of $500 million with a maturity of eight years. For further information regarding the 5.375% Unsecured Notes, including certain restrictive covenants, refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report.

We monitor the capital markets and our capital structure and make changes from time to time, with the goal of maintaining financial flexibility, preserving or improving liquidity and/or achieving cost efficiency. From time to time, we may elect to repurchase amounts of our outstanding debt for cash through open market repurchases or privately negotiated transactions with certain of our debt holders, although there is no assurance we will do so.

Liquidity and Capital Resources Outlook

We continue to have ongoing capital commitments in connection with several of our facilities. At December 31, 2021, we estimated our total remaining capital expenditure commitments to be approximately $738 million. The majority of this amount represents long-term commitments that are computed as a percentage of revenues. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the ABL Facility.

Our business strategy contemplates the selective acquisition of additional hospitals and other healthcare service providers, and we regularly review potential acquisitions. These acquisitions may, however, require additional financing. Our primary sources of liquidity are cash flows provided by our operations and our borrowings available under the ABL Facility. We believe that our internally generated cash flows and borrowing availability under the ABL Facility will be adequate to service existing debt, finance internal growth and fund capital expenditures and small to mid-size hospital acquisitions over the next twelve months and into the foreseeable future prior to maturity dates of our outstanding debt. Certain larger hospital acquisitions may, however, require additional financing.

Inflation

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

Contractual Obligations and Material Cash Requirements

We have certain material contractual obligations which are recorded as liabilities in our consolidated financial statements, primarily including:

- long-term debt obligations (refer to "—Capital Resources" above and to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report); and
- finance and operating lease obligations (refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report).

Additionally, we have certain other material cash requirements related to items that are not recognized as liabilities in our consolidated financial statements, primarily including:

- capital expenditure commitments (refer to "—Capital Expenditures" above and to Note 14 to our accompanying consolidated financial statements included elsewhere in this Report);
- shared centralized resource model arrangements with various third-parties to provide certain nonclinical business functions to us, including payroll, supply chain management and revenue cycle management;
- information technology services, including, but not limited to, financial, clinical, patient accounting and other information services;
- diagnostic imaging equipment maintenance and bio-medical services; and
- other minimum commitments to purchase miscellaneous goods or services under non-cancelable contracts.

Off-Balance Sheet Arrangements

We had letters of credit outstanding of approximately $50 million as of December 31, 2021, primarily related to the self-insured retention level of our general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements.

Adoption of Recently Issued Accounting Standards

None.

Critical Accounting Estimates

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

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

Our critical accounting estimates include the following areas:

- Accounting for CARES Act stimulus payments;
- Revenue recognition and accounts receivable;
- Goodwill impairment analysis;
- Accounting for income taxes; and
- Reserves for self-insurance claims.

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

Accounting for CARES Act Stimulus Payments

For the years ended December 31, 2021 and 2020, we recognized $17 million and $646 million, respectively, of stimulus payments as other income under the caption "Government stimulus income" in our accompanying consolidated statements of operations included elsewhere in this Report. Payments made by the Emergency Fund and the ARP rural program to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, filing attestations acknowledging receipt of payments, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients, not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse, and submitting such reports as may be required by HHS regarding the provider's compliance with the terms and conditions of the Emergency Fund. Healthcare providers that received more than $10,000 from the Emergency Fund between April 10, 2020 through June 30, 2020, also referred to as the First Payment Received Period, were required to submit a report on their use of those funds no later than September 30, 2021. We successfully submitted the required reports for all of our providers that received and retained payments from the Emergency Fund during First Payment Received Period prior to the deadline. However, we will be required to submit additional reports in the future for payments that were received and retained by our providers from the Emergency Fund after the end of the First Payment Received Period. The reporting requirements and guidance from HHS related to the Emergency Fund have been subject to frequent clarifications and revision, and there can be no assurance that we will not be required to submit additional reports or provide additional information related to the payments we receive from the Emergency Fund in the future. In addition, HHS has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the OIG of HHS, will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

We have accounted for the stimulus payments received as a government grant related to income in a manner consistent with International Accounting Standards 20, "Accounting for Government Grants and Disclosure of Government Assistance" ("***IAS 20***"). In accordance with IAS 20, government grants are recognized either as other income or a reduction to a related expense when there is reasonable assurance that the grant will be received, and the entity will comply with any conditions attached to the grant. There is currently limited, and sometimes changing, guidance available regarding the accounting treatment of funds that have been received by us and our facilities under the CARES Act and the related stimulus legislation. This lack of guidance requires us to apply professional judgement and make certain estimates and assumptions with respect to the presentation, amount and timing of our recognition of stimulus received under the CARES Act. For additional information regarding the CARES Act and related financial impact, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" and Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Revenue Recognition and Accounts Receivable

We recognize revenues in the period in which performance obligations are satisfied. Generally, we bill patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. Amounts we receive for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, HMOs, PPOs and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in our financial statements are recorded at the net consideration to which we expect to be entitled to receive in exchange for providing patient care.

Approximately 98.0%, 98.0% and 98.2% of our patient revenues recognized during the years ended December 31, 2021, 2020 and 2019, respectively, related to discounted charges, which were comprised of the following sources (as a percentage of our revenues):

	2021	2020	2019
Medicare	37.7 %	38.6 %	38.1 %
Medicaid	18.4 %	17.1 %	17.1 %
HMOs, PPOs and other private insurers	41.3 %	41.6 %	42.3 %
Self-pay	0.6 %	0.7 %	0.7 %

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

We monitor our processes for calculating contractual allowances through:

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

Medicare and Medicaid

The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e. gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under the Medicaid program's prospective reimbursement systems, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates.

Discounts for retrospectively cost-based revenues are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under these programs are subject to adjustment based on administrative review and audit by third-party intermediaries, which can take several years to resolve completely.

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

HMOs, PPOs and Other Private Insurers

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

The process of determining the allowance requires us to estimate the amount expected to be received based on payer contract provisions, historical collection data as well as other factors and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts for managed care plans would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third-party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. We evaluate these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. We estimate the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that we utilize include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that we expect to collect. Because we provide care to patients regardless of their ability to pay, we have determined that the differences between the amounts we bill based on gross or discounted charges and the amounts we expect to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and we account for this variable consideration in accordance with the provisions of ASC 606. Self-pay accounts receivable are written off after collection efforts have been followed in accordance with our policies.

Goodwill Impairment Analysis

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired businesses. Our goodwill included in our consolidated balance sheet as of December 31, 2021 was $3.9 billion. Refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report for a detailed roll forward of changes in our goodwill during the years ended December 31, 2021 and 2020.

In accordance with ASC 350, "Intangibles — Goodwill and Other" ("***ASC 350***") goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. Prior to the LifePoint/RCCH Merger, we historically determined that each of our hospitals represented a reporting unit in accordance with ASC 280, "Segment Reporting" ("***ASC 280***") and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on our management team and business operations, we re-evaluated our reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that our consolidated business comprises a single reporting unit for goodwill impairment testing purposes. There were no changes in our determination of reporting units for the years ended December 31, 2021 and 2020. For the annual impairment evaluation, we determine fair value using a discounted cash flow ("***DCF***") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing our assumptions. The cash flows employed in the DCF analysis are based on our most recent financial budgets and business plans and, when applicable, various growth rates for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the respective reporting unit.

If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. Refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report for further discussion of the results of our annual goodwill impairment evaluation procedures.

Accounting for Income Taxes

Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or subsequently increase or decrease this allowance, we must include an adjustment as part of the income tax provision in our results of operations. Our deferred tax asset balances in our consolidated balance sheets were $504 million and $537 million as of December 31, 2021 and 2020, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $197 million and $360 million as of December 31, 2021 and 2020, respectively.

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

The first step in determining the deferred tax asset valuation allowance is identifying reporting jurisdictions where we have a history of tax and operating losses or are projected to have losses in future periods as a result of changes in operational performance. We then determine if a valuation allowance should be established against the deferred tax assets for that reporting jurisdiction. The second step is to determine the amount of the valuation allowance. We will generally establish a valuation allowance equal to the net deferred tax asset (deferred tax assets less deferred tax liabilities) related to the jurisdiction identified in step one of the analysis. In certain cases, we may not reduce the valuation allowance by the amount of the deferred tax liabilities depending on the nature and timing of future taxable income attributable to deferred tax liabilities.

In assessing tax contingencies, we apply the provisions of ASC 740, “Income Taxes”. We apply the recognition threshold and measurement of a tax position taken or expected to be taken in a tax return and follow the guidance on various matters such as derecognition, interest, penalties and disclosure. We classify interest and penalties as a component of income tax expense. During each reporting period, we assess the facts and circumstances related to recorded tax contingencies. If tax contingencies are no longer deemed probable based upon new facts and circumstances, the contingency is reflected as a reduction of the provision for income taxes in the current period.

Our deferred tax assets exceeded our deferred tax labilities by $158 million as of December 31, 2021, excluding the impact of valuation allowances. Historically, we have not produced federal taxable income, and in connection with the LifePoint/RCCH Merger, we became highly leveraged. As such, we believe it is likely that a significant component of our deferred tax assets will not be realized and thus have established a valuation allowance against these deferred tax assets as of December 31, 2021. In addition, we have subsidiaries with a history of tax losses in certain state jurisdictions, and, based upon those historical tax losses, we have assumed that the subsidiaries would not be profitable in the future for those states’ tax purposes. If our assertion regarding the future profitability of those subsidiaries would have been different, then our deferred tax assets would be understated by the amount of the state valuation allowance of $146 million at December 31, 2021. During the year ended December 31, 2021, we reduced our valuation allowance by $163 million as a result of the transfers and utilization of certain net deferred tax assets and liabilities between us and ScionHealth.

Reserves for Self-Insurance Claims

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers’ compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers’ compensation claims exceeding SIR and deductible levels. At December 31, 2021, our SIR for professional liability claims is $15 million per claim at the majority of our acute care hospitals. Additionally, we participate in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico and Pennsylvania. We have a $25,000 deductible for professional liability at each of our IRFs. At December 31, 2021, our deductible for workers’ compensation claims at each of our acute care hospitals was $1 million per claim in all states in which we operate except for Montana and Washington. We participate in state-specific programs for our workers’ compensation claims arising in these states. There is no deductible for workers’ compensation claims at our IRFs. Our SIR and deductible levels are evaluated annually as a part of our insurance program’s renewal process.

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

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

Our reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. Our reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. We have discounted our reserves for self-insured claims to their present value using a discount rate of 1.6% at December 31, 2021, 1.7% at December 31, 2020, and 1.9% at December 31, 2019. We select a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

The following table provides information regarding our reserves for self-insured claims at December 31, 2021 and 2020 (in millions):

	2021	2020
Undiscounted	$ 308	$ 301
Discounted (as reported)	$ 295	$ 287

As of December 31, 2021 and 2020, we estimated less than 1% of our reserves for self-insured claims represent reserves for settled and unpaid claims. Our average lag time between the settlement and payment of a self-insured claim ranges from 1 to 2 weeks.

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

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

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

Ultimately, from an actuarial standpoint, the sensitivity in the estimates of reserves for self-insured claims is reflected in the various actuarial confidence levels. Our best estimate of our reserves for self-insured claims utilizes an actuarial central estimate, which employs a statistical confidence level that approximates 50%. Higher statistical confidence levels, while not representative of our best estimate, reflect reasonably likely outcomes upon the ultimate resolution of related claims. Using a higher statistical confidence level would increase the estimated reserves for self-insured claims. At a 75% statistical confidence level, our estimated reserve would increase by $27 million. Changes in our estimates of reserves for self-insured claims are non-cash charges and accordingly, do not impact our liquidity or capital resources.

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of our quarterly and semi-annual actuarial calculations resulted in changes to our reserves for self-insured claims for prior years. For the years ended December 31, 2021 and 2019 our related self-insured claims expense increased by $13 million and $7 million, respectively, compared to the prior year and for the year ended December 31, 2020 it decreased by $4 million compared to the prior year.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk.***

Market Risk

Market risk is defined as the risk of loss resulting from changes in market prices as a result of changes in interest rates, credit and liquidity or general economic conditions. Our principal market risks in the ordinary course of business are credit risk, liquidity risk and interest rate risk. We currently do not have direct exposure to either market risk from trading activities or foreign currency exchange rate risk.

Credit Risk

We define credit risk as the risk that amounts payable by uninsured patients and remaining patient responsibility amounts (deductibles and co-payments) for patient accounts where the primary insurance carrier has paid the amounts covered by the applicable agreements will not be paid. The provision for doubtful accounts relates primarily to amounts due directly from patients. While we have experienced a reduction in uninsured patients, the risk of collection from insured patients and the amounts due, may increase as more individuals are enrolled in insurance plans with larger deductibles and/or co-payments, including those purchased on insurance exchanges.

Liquidity Risk

We define liquidity risk as the risk that we will not meet our payment obligations in a timely manner or the risk that market conditions or institution-specific events may reduce our ability to raise funds from market counterparties. An adverse institution-specific event such as a major loss that causes a perceived or actual deterioration in our financial condition or an adverse systemic event could affect our funding liquidity.

Interest Rate Risk

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. To manage this risk, we entered into an Interest Rate Swap. The terms of the Interest Rate Swap require us to pay a fixed rate of 2.63% on a notional amount of $1.1 billion and, in exchange, we receive one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and terminated on February 19, 2022.

As of December 31, 2021, we had total outstanding debt of approximately $6.3 billion, excluding finance lease obligations and unamortized debt issuance costs and premium, of which approximately $2.1 billion, or 33.3%, was subject to variable rates of interest after giving effect to our Interest Rate Swap, and approximately $3.2 billion, or 50.7%, was subject to variable rates of interest prior to giving effect to our Interest Rate Swap. If the interest rate on our variable rate long-term debt outstanding as of December 31, 2021, prior to giving effect to our Interest Rate Swap, were to increase by 100 basis points during any annual period, our cash flows would be negatively impacted by approximately $32 million.

Item 8. ***Financial Statements and Supplementary Data.***

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

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

None.

Item 9A. ***Controls and Procedures.***

The information that would be required to be disclosed under Part II, Item 9A of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a**)** of each of the Indentures.

Item 9B. ***Other Information.***

None.

Item 9C. ***Disclosure Regarding Foreign Jurisdictions that Prevent Inspections.***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance*.**

The following table provides information regarding our executive officers and the members of our Board of Directors (ages as of April 5, 2022):

Name	Age	Position(s)
David M. Dill	53	President, Chief Executive Officer, Director and Chairman
Michael S. Coggin	52	Executive Vice President and Chief Financial Officer
Victor E. Giovanetti	58	Executive Vice President, Hospital Operations
Jennifer C. Peters	51	Executive Vice President, General Counsel
Terry W. Terrill, Jr.	55	Executive Vice President, Administration
Jason Zachariah	44	President, Integrated Operations
Matthew H. Nord	42	Director
Norman Brownstein	78	Director
Nell Buhlman	55	Director
Christine Cahill	27	Director
Christopher J. Christie	59	Director
Maxwell David	31	Director
Michael P. Haley	71	Director
Holly McMullan	45	Director
Daniel Morissette	56	Director
Eric L. Press	56	Director
G. Rodney Wolford	75	Director

David M. Dill became our Chief Executive Officer upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Dill served in various roles at Legacy LifePoint as President since January 2011 and as Chief Operating Officer since April 2009. Mr. Dill served as Executive Vice President from February 2008 to January 2011. Mr. Dill joined Legacy LifePoint in July 2007 as Chief Financial Officer and continued to serve in that role until April 2009. From March 2006 until Mr. Dill joined Legacy LifePoint, he served as executive vice president of Fresenius Medical Care North America and as chief executive officer of one of two U.S. divisions of Fresenius Medical Care Services, a wholly owned subsidiary of Fresenius Medical Care AG & Co. KGaA. Mr. Dill previously served as executive vice president, chief financial officer and treasurer of Renal Care Group, Inc., a publicly-traded dialysis services company, from November 2003 until Renal Care Group was acquired by Fresenius Medical Care in March 2006. From 1996 to November 2003, Mr. Dill served in various finance and accounting roles with Renal Care Group, Inc. Mr. Dill served as a member of the board of directors of Psychiatric Solutions, Inc., a behavioral health services company, from 2005 until 2010.

Michael S. Coggin became our Executive Vice President and Chief Financial Officer upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Coggin served in various roles at Legacy LifePoint as Executive Vice President, Chief Financial Officer and Chief Accounting Officer, since September 2016. From December 2008 until September 2016, Mr. Coggin served as Senior Vice President and Chief Accounting Officer of Legacy LifePoint. From September 2007 until December 2008, Mr. Coggin served as chief financial officer of Specialty Care Services Group, a multi-service line healthcare provider primarily focused on providing perfusion and auto-transfusion services to hospitals. Mr. Coggin was a senior vice president in the finance, accounting and internal audit groups of Renal Care Group, Inc. from April 2004 until its acquisition by Fresenius Medical Care AG & Co. KGaA in March 2006. Following the acquisition, Mr. Coggin provided finance and accounting oversight for business units within the East Division of Fresenius. Prior to that time, Mr. Coggin was an audit manager at KPMG Peat Marwick in Nashville, Tennessee.

Victor E. Giovanetti became our Executive Vice President, Hospital Operations upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Mr. Giovanetti served as President of Legacy LifePoint's Eastern Group since January 2017. From July 2015 to January 2017, Mr. Giovanetti served as President of Legacy LifePoint's Western Group. Mr. Giovanetti joined Legacy LifePoint in July 2013 as Chief Operating Officer of Legacy LifePoint's Eastern Group. Mr. Giovanetti has more than 25 years of management experience in operations, financial, clinical and strategic aspects of healthcare administration. Prior to joining the Company, his positions included president of HCA Lewis-Gale Regional Health System in Roanoke, Virginia, chief executive officer and chief operating officer of Southern Hills Medical Center in Nashville, Tennessee, and various management roles with HCA, Symbion and other healthcare organizations in Georgia.

Jennifer C. Peters became our Executive Vice President and General Counsel upon consummation of the LifePoint/RCCH Merger. Prior to the consummation of the LifePoint/RCCH Merger, Ms. Peters served as Legacy LifePoint's General Counsel since April 2017 and Corporate Secretary since June 2017. Prior to that, Ms. Peters served as senior vice president and chief operations counsel of Legacy LifePoint, where she was responsible for overseeing the Company's operations lawyers and contract management team to ensure consistent legal guidance across all operational units. Prior to joining Legacy LifePoint in November 2013, Ms. Peters served as general counsel, secretary and chief compliance officer for Simplex Healthcare from October 2010 through November 2013. Ms. Peters has also served as vice president and associate general counsel at Community Health Systems. In addition, Ms. Peters has experience as a hospital administrator.

Terry W. "Sonny" Terrill, Jr. joined the Company in April 2019 as Executive Vice President, Human Resources. Mr. Terrill is responsible for providing leadership in developing and executing human resources strategies in support of the overall business plan and strategic direction of the organization. Mr. Terrill has three decades of HR experience, including executive coaching, full-cycle talent management and management of large-scale system and organizational integration. Before joining the Company, he served in a number of leadership roles, most recently as executive vice president, chief human resources officer for BrightSpring Health from August 2017 to March 2019 and human resources officer for CIGNA- HealthSpring from May 2005 to August 2017. He is also a Six Sigma Black Belt.

Jason Zachariah became our President, Integrated Services upon consummation of the Kindred Transaction in December 2021. Prior to the consummation of the Kindred Transaction, Mr. Zachariah served as President and Chief Operating Officer of Kindred Healthcare since December 2020, and as Chief Operating Officer of Kindred Healthcare since January 2020. Mr. Zachariah also served at Kindred Rehabilitation Services as President from August 2016 to January 2020, and as Chief Operating Officer, Kindred Hospital Rehabilitation Services, from July 2013 to August 2016. From May 2006 to July 2013, he served in various roles in Kindred's Hospital Division, including Chief Operating Officer/Executive Director of the California/Arizona district. From 2003 until Mr. Zachariah joined Kindred Healthcare, he served as a Senior Sales Representative at GlaxoSmithKline Pharma GmbH.

Matthew H. Nord is Partner and Co-Head of Private Equity at Apollo Global Management, where he oversees the firm's private equity strategy and has led numerous investments across technology, healthcare and business services. Mr. Nord currently serves on the board of directors of TD Synnex, ADT, Intrado Corporation, LifePoint Health, ScionHealth, and the Rock and Roll Hall of Fame Foundation. Prior to joining Apollo in 2003, Mr. Nord was a member of the Investment Banking division of Salomon Smith Barney Inc. Mr. Nord graduated summa cum laude from the University of Pennsylvania's Wharton School of Business with a B.S. in Economics. Mr. Nord also serves on the Montefiore Health System Board of Trustees and on the Board of Advisors of the University of Pennsylvania's Stuart Weitzman School of Design.

Norman Brownstein became our Director in April 2016. Mr. Brownstein is the founding member and chairman of the board of the law firm of Brownstein Hyatt Farber Schreck, LLP. Mr. Brownstein is nationally recognized for his extensive experience in real estate law, commercial transactions and public policy advocacy, which spans the economic spectrum, extending to telecommunications, financial services, agriculture, tax and healthcare interests. Mr. Brownstein's firm is one of the leading lobbying firms in the U.S. Mr. Brownstein serves on the board of directors of National Jewish Health and the Simon Wiesenthal Center, and during the past five years has also served as a director of Ardent Healthcare Services. Mr. Brownstein received a B.S. from the University of Colorado and a J.D. from the University of Colorado Law School.

Nell Buhlman became our Director in March 2022**.** Ms. Buhlman is the President and Chief Operating Officer of Press Ganey, overseeing enterprise growth strategy, client management, marketing, health policy, and educational, advisory & consulting services. Since joining Press Ganey in 2010, Ms. Buhlman has also served as the company's Chief Strategy Officer, Senior Vice President for Clinical and Analytic Solutions, and Vice President for Product Strategy. Ms. Buhlman is a Board Member for the Hospital for Consumptives of Maryland (Eudowood Foundation), serves on the Parent Advisory Council for the Greater Baltimore Medical Center, and is an Executive in Residence for the Johns Hopkins Carey Business School. She also serves as a trustee for the WPW Foundation, a charitable organization that provides grants to nonprofits serving vulnerable women and children. Ms. Buhlman holds a Bachelor of Arts degree from Connecticut College and an MBA from Johns Hopkins Carey Business School.

Christine Cahill became our Director in March 2022. Ms. Cahill is an Associate in Apollo Global Management's Private Equity business, having joined in 2018. Prior to that time, Ms. Cahill was a member of the Investment Banking Division of Goldman Sachs. Ms. Cahill serves on the board of directors of Lune Holdings (parent of Kem One). Ms. Cahill graduated from Harvard University with a B.A. in Economics.

Christopher J. Christie became our Director in December 2018. Mr. Christie served two terms as Governor of New Jersey from 2010 to 2018. Prior to that, Mr. Christie served as U.S. Attorney for the District of New Jersey from 2002 to 2008. During his governorship, Mr. Christie chaired the President's Commission on Combating Drug Addiction and the Opioid Crisis in 2017. He currently serves as a legal and political commentator for ABC News. Mr. Christie is a graduate of the University of Delaware and Seton Hall University School of Law.

Maxwell David became our Director in December 2018. Mr. David is a Principal in Apollo Global Management's Private Equity business, having joined in 2014. Prior to that time, Mr. David was a member of the Investment Banking division of Bank of America Merrill Lynch. Mr. David serves on the board of directors of ScionHealth, 25m Health and Camaro Parent, LLC (parent of CareerBuilder). Mr. David graduated cum laude from Dartmouth College.

Michael P. Haley became our Director in December 2018. Prior to that time, Mr. Haley served as a director of Legacy LifePoint since 2005 and as chair of its Audit Committee since 2016. Mr. Haley is also a member of the board of directors of American National Bankshares, Inc., a bank holding company. From 2005 until April 2018, Mr. Haley served as a director of Ply Gem Holdings, Inc., a producer of window, door and siding products for the residential construction industry. Mr. Haley served as an advisor to Fenway Partners, LLC, a private equity investment firm, from April 2006 to June 2015, and was a managing director of its affiliate, Fenway Resources, from 2008 to June 2015. Mr. Haley's previous executive leadership experience includes service as executive chairman of Coach America, a transportation services operator, and as chairman, president and chief executive officer of MW Manufacturers, Inc., a subsidiary of Ply Gem Industries, Inc. In addition, Mr. Haley has served on the Board of Trustees of Roanoke College (Virginia) since 2010 and previously served on the board of the Martinsville-Henry County United Way and as chairman of the board of trustees of Memorial Hospital of Martinsville and of the Martinsville-Henry County Economic Development Corporation.

Holly McMullan became our Director in December 2018. Ms. McMullan is a Partner in Apollo Global Management's Client and Product Solutions group, where she is responsible for fundraising efforts for Apollo's private equity and capital markets businesses, having joined in 2008. Prior to that time, Ms. McMullan was a Senior Vice President at Pequot Capital Management and was previously a member of Guggenheim Advisors, Bear Stearns, and Robertson Opportunity Capital. She currently serves on the following advisory boards: 30 % Coalition, McCombs Advisory Council, New York for McCombs (Chair) and the Hicks Muse Private Equity Research Center at the University of Texas at Austin. Ms. McMullan holds an M.B.A. with a concentration in Finance from the McCombs School of Business at the University of Texas at Austin and a B.A. (honors) in International Business from Sheffield Hallam University, Sheffield, UK.

Daniel Morissette became our Director in April 2016. Mr. Morissette serves as Senior Executive Vice President and Chief Financial Officer for Common Spirit Health and served as Senior Executive Vice President/Chief Financial Officer for Dignity Health since February 2016. Previously, Mr. Morissette served as the Chief Financial Officer for Stanford Health Care. Mr. Morissette has over 25 years of experience in healthcare, consulting and international business development. During the past five years, Mr. Morissette served as a director for Optum360. Mr. Morissette received a B.S. from DePaul University and an M.B.A. from The University of Chicago, Booth School of Business.

Eric L. Press has been our Director since December 2015. Mr. Press is a Partner in Apollo Global Management's Private Equity business, having joined in 1998. In his time with Apollo, he has been involved in many of the firm's investments in basic industrials, metals, lodging/gaming/leisure and financial services. Prior to joining Apollo, Mr. Press worked at the law firm of Wachtell, Lipton, Rosen & Katz, specializing in mergers, acquisitions, restructurings and related financing transactions. Prior thereto, Mr. Press was a consultant with The Boston Consulting Group, a management consulting firm focused on corporate strategy. Mr. Press serves on the boards of directors of ScionHealth, ADT Inc, Lottomatica S.p.A. (f/k/a Gamenet Group S.p.A.) and Apollo Commercial Real Estate Finance, Inc. He previously served on the boards of directors of Eagle LM5 Holdings Inc., Caesars Entertainment Corporation, Princimar Chemical Holdings, LLC, and PlayAGS, Inc. He graduated magna cum laude from Harvard College, with an A.B. in economics, and Yale Law School, where he was a Senior Editor of the Yale Law Journal.

G. Rodney Wolford became our Director in April 2016. Mr. Wolford has over 40 years of wide-ranging experience in the healthcare industry, having served in leadership roles with healthcare providers, suppliers, consulting firms, associations and insurers. Redirecting his professional time from active executive leadership, he now focuses his professional time on multiple boards of directors and rural community economic development. Among his many executive positions, Mr. Wolford served as chief executive officer of Alliant Healthcare (now Norton Healthcare) in Louisville, KY, Sterling Diagnostic, a worldwide manufacturer of x-ray film, Forhealth Technologies, the inventor of the first robot dedicated to hospital IV production, and a senior executive of Blue Cross Tennessee. Mr. Wolford currently serves on the boards of Atlanta based D4C Brands, a pediatric dentistry company, and Liberate Medical, which develops electronic stimulation for ventilator patients, and as a fund manager of Bluegrass Angel Funds III and IV. During the past five years, Mr. Wolford has also served as a director of Haven Behavioral, Laboratory Supply Company and VetCor.

Code of Ethics

Our Board expects its members, as well as our officers and employees, to act ethically at all times and to acknowledge in writing their adherence to the policies comprising our Code of Conduct, which is known as "Common Ground," and, as applicable, our Code of Ethics for Senior Financial Officers and Chief Executive Officer.

Board Structure

The Board consists of 13 directors (with one current vacancy). The Board has the following standing committees: audit; compensation; nominating and governance; compliance; quality; and executive. In addition, the board of directors of the Parent company also has a compensation committee that administers equity-based compensation plans in which our managers, officers, employees, consultants and directors participate. Apollo has the power to control us and our affairs and policies, including the designation of a majority of the members of our Board and the appointment of management.

Committees of our Board of Directors

The Board has adopted written charters for each of the following standing committees:

Audit Committee

The current members of our audit committee are Messrs. Morissette, Haley and Wolford. Mr. Morissette is the chairman of our audit committee. The principal duties and responsibilities of our audit committee are to assist the Board in overseeing:

- the integrity of our financial statements;
- the independent auditor's qualifications, independence and performance;
- the performance of our internal audit function; and
- our compliance with certain legal, ethical and regulatory requirements.

The audit committee has the authority to conduct or authorize investigations into or studies of matters within its scope of responsibilities. It also has the authority to retain and determine funding for independent legal, accounting or other advisors (without seeking Board approval) as it determines necessary or appropriate to carry out its duties and responsibilities.

Our Board has determined that each of Messrs. Morissette and Wolford is an "audit committee financial expert" within the meaning of applicable SEC regulations.

Compensation Committee

The current members of our compensation committee are Messrs. Nord and Press. Mr. Press is the chair of our compensation committee. The principal duties and responsibilities of our compensation committee are as follows:

- approving the non-equity-based compensation of our officers, directors and key employees;
- administering our non-equity-based compensation plans; and
- making recommendations to the Parent for the equity-based compensation of the Parent and its subsidiaries' officers, directors and employees.

Nominating and Governance Committee

The current members of our nominating and governance committee are Messrs. Christie and Press. Mr. Press is the chair of our nominating and governance committee. The principal duties and responsibilities of our nominating and governance committee are as follows:

- to assist the Board in identifying individuals qualified to serve as members of the Board and/or its committees; and
- other duties and responsibilities that our Board may delegate to the nominating and governance committee.

Compliance Committee

The current members of our compliance committee are Messrs. Morissette and Wolford. Mr. Wolford is the chair of our compliance committee. The compliance committee is responsible for overseeing our legal and regulatory compliance program, including certain healthcare and regulatory compliance matters that affect us and our business operations.

Quality Committee

The current members of our quality committee are Messrs. Brownstein, David, Dill, Haley and Ms. McMullan. Mr. Dill is the chair of our quality committee. The quality committee is responsible for monitoring and evaluating the adequacy and effectiveness of our quality of care and patient safety programs and initiatives.

Executive Committee

The current members of our executive committee are Messrs. David, Nord and Press. Mr. Nord is the chair of our executive committee. The principal duties and responsibilities of our executive committee are as follows:

- to advise and counsel the Chief Executive Officer regarding company matters; and
- to take such actions as are necessary due to their urgent or highly confidential nature, or where convening the Board is impracticable, subject to certain limitations.

Item 11. ***Executive Compensation.***

The information that would be required to be disclosed under Part III, Item 11 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

The information that would be required to be disclosed under Part III, Item 12 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

Executive Compensation

Employment Agreements

In connection with the consummation of the LifePoint/RCCH Merger, we entered into an employment agreement with each of Messrs. Dill, Coggin and Giovanetti and Ms. Peters. We also entered into an employment agreement with Mr. Terrill effective April 8, 2019. Following the consummation of the Kindred Transaction, we assumed an employment agreement with Jason Zachariah.

Each applicable executive's employment agreement contains an indefinite term of employment, other than Mr. Zachariah's, which contains a rolling one-year employment term. Each employment agreement established the applicable executive's annual base salary at the time (the annual base salary in the employment agreements for each of Messrs. Dill, Coggin, Giovanetti, Terrill and Zachariah and Ms. Peters is currently set at $1,500,000, $700,000, $750,000, $525,000, $750,000 and $600,000, respectively), and his or her eligibility to receive an annual bonus with the target bonus for each fiscal year determined annually by our board of directors or our compensation committee. Pursuant to his or her respective employment agreement, Mr. Dill's target bonus is at least 150% of base salary, and each of Messrs. Coggin's, Giovanetti's, Zachariah's and Terrill's and Ms. Peters' target bonus is at least 100% of base salary with a maximum of 200% of base salary except that the agreement for Mr. Zachariah does not specify a maximum bonus percentage. The actual bonus payable to each applicable executive is based upon the level of achievement of annual Company and individual performance objectives, as determined by the board of directors or our compensation committee. In connection with the COVID-19 pandemic, the Company reduced each of Messrs. Dill's, Coggin's, Giovanetti's, Jay's and Terrill's and Ms. Peters' annual base salaries by 30%, effective April 11, 2020 through May 31, 2020.

In the event of the executive's termination without cause (other than due to death or disability) or resignation for good reason, the executive shall be entitled to receive: (i) unpaid prior year's bonus; (ii) if the termination occurs after the second quarter of a fiscal year (or at any time for Mr. Zachariah), a pro rata bonus for the year of termination based upon achievement of performance criteria; (iii) a severance payment equal to 1.5x (or, for Mr. Dill, 2x) the sum of the executive's annual base salary and target bonus, payable in substantially equal installments for 18 months (or, for Mr. Dill, 24 months) following termination (or payable in a lump sum for Mr. Zachariah); provided, that, for all the executives other than Mr. Zachariah or Mr. Terrill, in the event that the Company terminates the executive's employment without cause (other than due to death or disability) or resignation for good reason following a change in control, then the severance payment shall equal 3x the sum of the executive's annual base salary and target bonus, to be paid as a lump sum following termination and (iv) up to 12 months of health benefits continuation (or, for Mr. Zachariah, 18 months).

Each applicable executive is subject to a (i) 12-month post-termination non-competition covenant relating to competitors of the Company, (ii) 12-month post-termination non-solicitation covenant in respect of our employees, consultants, clients, customers and similar business relationships of the Company and (iii) perpetual confidentiality and non-disparagement covenants.

Retention Bonus and Severance Payments

In connection with the consummation of the LifePoint/RCCH Merger, we paid retention bonuses and severance payments to certain former Legacy LifePoint or RCCH executives and other employees. The aggregate amount for such payments made during the year ended December 31, 2019 are included within merger and acquisition costs on our consolidated statement of operations and are discussed in Note 2, "Business Development Update" to our accompanying consolidated financial statements included elsewhere in this Report.

Nonqualified Deferred Compensation

After freezing the LifePoint Hospitals Deferred Compensation Plan and RCCH HealthCare Partners Deferred Compensation Plan at the end of 2020, the Company established a new nonqualified deferred compensation plan effective January 1, 2021 in which certain Company executives and employees participate. Also, certain former Kindred executives and employees, including Mr. Zachariah, who are now Company executives and employees, participate in a separate nonqualified deferred compensation plan that replicates the former Kindred Deferred Compensation Plan. Plan participants may defer a portion of their salary and bonuses. Currently, the Company does not make any matching or other contributions to the nonqualified deferred compensation plans. The timing and form of payments are based on the terms of the applicable plan and deferral elections made by participants.

Parent Capital Units and Profits Units

Certain of certain of our and our affiliates' executives, employees, consultants and directors have been granted profits units and/or purchased or otherwise acquired capital units in the Parent.

The profits units provide the recipients with the opportunity to share in our future appreciation, subject to vesting. In general, 40% of the profits units vest in substantially equal installments on the last day of each of the first twenty (20) calendar quarters commencing on or after the applicable grant date and the remaining 60% of the profits units vest based on the achievement of certain investment returns to our Sponsor. The profits units we typically grant to directors on an annual basis generally vest on a time basis, on the date that is six months and one day from the date of grant. In addition, the time-vested profits units and the director profits units will vest in full on a sale of the Company.

The capital units and profits units are generally subject to the terms and condition set forth in the applicable award agreements or subscription agreements, as the case may be, and in the partnership agreement of the Parent, including, but not limited to, customary transfer restrictions, redemption rights and obligations, drag-along rights, tag-along rights, and preemptive rights

Equity Repurchases

From time to time, the Parent repurchases previously issued profits units and capital units held by certain of our former and current employees, including executive officers and directors. Additionally, transactions involving the Parent may impact the units held by such former and current employees. Refer to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by the Parent to our employees and directors and additional information regarding our accounting for stock-based compensation.

Director Retainers and Fees

Certain members of our Board of Directors are entitled to receive annual retainers and fees in accordance with our director compensation policy in connection with their service on our Board.

Management Agreement

In connection with the LifePoint/RCCH Merger, we entered into a Management Consulting Agreement (as amended, the "***Management Agreement***") with an affiliate of our Sponsor relating to the provision of certain management consulting and advisory services. In exchange for the provision of such services, we currently pay a non-refundable quarterly management fee of approximately $2 million. The Management Agreement will terminate on the earlier of (i) the eighth anniversary of July 25, 2021, (ii) the consummation of any transaction or series of transactions, whether or not related, as a result of which New Holders (as defined in the Management Agreement) become the beneficial owner, directly or indirectly, of more than 90% of our equity and voting securities and (iii) such earlier date as is mutually agreed upon. Our payment obligations under the Management Agreement may be subject to deferral to the extent such obligations would otherwise violate any prohibitions or limitations under our then existing indebtedness. Furthermore, we may be required to reimburse such affiliate of our Sponsor for all out-of-pocket expenses, including legal fees and expenses, incurred by such affiliate and its affiliates and each of their representatives in the connection with the performance of its obligations under the Management Agreement or the Transaction Fee Agreement (as defined below), including expenses incurred in connection with the transactions contemplated by the agreement governing the LifePoint/RCCH Merger (the "***Merger Agreement***") and any Underwritten Offering or Change of Control (as defined in the Merger Agreement).

Transaction Fee Agreement

In connection with the LifePoint/RCCH Merger, we entered into a transaction fee agreement (as amended, the "***Transaction Fee Agreement***") with an affiliate of our Sponsor relating to the provision of certain preparation services in support of the LifePoint/RCCH Merger. The Transaction Fee Agreement will terminate automatically upon the termination of the Management Agreement. As consideration for these transaction preparation services, we paid a nonrefundable fee of $55 million in full to an affiliate of our Sponsor upon the closing of the LifePoint/RCCH Merger. In addition, if we, or certain of our parent entities or controlled affiliates, consummate an acquisition (including of assets or equity interests) of any business or entity, we are also required to pay to an affiliate of our Sponsor a success fee equal to 1% of the aggregate enterprise value (i) paid or provided by or to the Company Group (as defined in the Transaction Fee Agreement) or us or (ii) otherwise indicated by such acquisition. Furthermore, we may be required to reimburse such affiliate of our Sponsor for all out-of-pocket expenses, including legal fees and expenses, incurred by such affiliate and its affiliates and each of their representatives in the connection with the performance of its obligations under the Transaction Fee Agreement, including expenses incurred in connection with the transactions contemplated by the Merger Agreement.

Participation of Apollo Global Securities, LLC

Apollo Global Securities, LLC is an affiliate of our Sponsor and received a portion of the gross spread as an initial purchaser in the sale of the Existing Unsecured Notes and the sale of the Existing Secured Notes. Apollo Global Securities, LLC or one of its affiliates also participated as an arranger in respect of the Term Loan Facility and the ABL Facility, for which it received customary fees.

Transition Services Agreements and Other Agreements with ScionHealth

In connection with the Kindred Transaction, we have entered into a number of transition services agreements and other ancillary agreements with ScionHealth and its subsidiaries with estimated proceeds of $61 million per year to LifePoint and an estimated cost of $3 million per year to LifePoint. In addition, we and ScionHealth are party to a number of commercial services agreements, pursuant to which the Knight Transferred Business provides ScionHealth with therapy services and rehabilitation unit management and development services, among other commercial services.

Item 14. *Principal Accounting Fees and Services*.

The Audit Committee has appointed Ernst & Young LLP as our independent registered public accounting firm. Services provided to us by Ernst & Young LLP in fiscal 2021 are described below.

Audit Fees. The aggregate audit fees billed by Ernst & Young LLP for professional services rendered for the audit of our annual consolidated financial statements and services that are normally provided by the independent registered public accounting firm in connection with statutory and regulatory filings totaled approximately $4 million for 2021 and 2020.

Audit-Related Fees. The aggregate fees billed by Ernst & Young LLP for assurance and related services other than those described under “Audit Fees” were approximately $2 million for 2021 and $1 million for 2020.

Tax Fees. The aggregate fees billed by Ernst & Young LLP for professional services rendered for tax compliance, tax advice and tax planning were approximately $1 million for 2021 and nominal for 2020.

All Other Fees. There were no fees billed by Ernst & Young LLP for products or services other than those described above in 2021 or 2020.

PART IV

Item 15. ***Exhibits, Financial Statement Schedules*.**

(a) The following documents are filed as part of this Report:

1. *Consolidated Financial Statements*:

2. *Financial Statement Schedule*: All schedules for which provision is made in the applicable accounting regulations of the SEC are omitted because they either are not required under the related instructions, are inapplicable, or the required information is shown in the consolidated financial statements or notes thereto.

3. *Exhibits*: The exhibits required by Item 601 of Regulation S-K that would be disclosed under Part IV, Item 15 of an annual report on Form 10-K filed with the SEC have been omitted as permitted pursuant to Section 4.02(a) of the Indentures.

Ernst & Young LLP
222 2nd Avenue South
Suite 2100
Nashville, TN 37201

Tel: (615) 252 2000
Fax: (615) 242 9128
ey.com

Report of Independent Auditors

Board of Directors and Shareholders of
LifePoint Health, Inc.

Opinion

We have audited the consolidated financial statements of LifePoint Health, Inc., which comprise the consolidated balance sheets as of December 31, 2021 and 2020, and the related consolidated statements of operations, comprehensive income (loss), equity and cash flows for each of the three years in the period ended December 31, 2021, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2021 and 2020, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2021 in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements. In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Other Information

Management is responsible for the other information. The other information comprises the financial and nonfinancial information included in the annual report but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.

April 5, 2022

LifePoint Health, Inc.

Consolidated Statements of Operations
For the Years Ended December 31, 2021, 2020 and 2019
(In millions)

	2021	2020	2019
Revenues	$ 8,937	$ 8,122	$ 8,753
Salaries and benefits	4,176	3,877	4,044
Supplies	1,505	1,418	1,472
Other operating expenses, net	2,245	2,190	2,150
Government stimulus income	(17)	(646)	-
Depreciation and amortization	345	378	376
Interest expense, net	466	528	569
Transaction-related costs	86	132	77
Other non-operating losses, net	19	4	9
	8,825	7,881	8,697
Income before income taxes	112	241	56
(Benefit from) provision for income taxes	(27)	(64)	78
Net income (loss)	139	305	(22)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(9)	(22)	(19)
Net income (loss) attributable to LifePoint Health, Inc.	$ 130	$ 283	$ (41)

LifePoint Health, Inc.

Consolidated Statements of Comprehensive Income (Loss)
For the Years Ended December 31, 2021, 2020 and 2019
(In millions)

	2021	2020	2019
Net income (loss)	$ 139	$ 305	$ (22)
Other comprehensive gain (loss):			
Unrealized gains (losses) on changes in funded status of pension benefit obligations	6	(1)	(5)
Other comprehensive gain (loss)	6	(1)	(5)
Comprehensive income (loss)	145	304	(27)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(9)	(22)	(19)
Comprehensive income (loss) attributable to LifePoint Health, Inc.	$ 136	$ 282	$ (46)

LifePoint Health, Inc.
Consolidated Balance Sheets
As of December 31, 2021 and 2020
(In millions)

	2021	2020
ASSETS		
Current assets:		
Cash and cash equivalents	$ 853	$ 2,653
Accounts receivable	1,035	1,042
Inventories	195	238
Prepaid expenses	121	103
Other current assets	250	332
	2,454	4,368
Property and equipment, at cost	4,315	4,476
Accumulated depreciation	(1,051)	(953)
Property and equipment, net	3,264	3,523
Intangible assets, net	85	58
Investments	655	256
Other long-term assets	742	475
Goodwill	3,914	2,919
Total assets	$ 11,114	$ 11,599
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 371	$ 358
Accrued salaries	284	295
Current portion of Medicare advance payments	-	370
Other current liabilities	521	591
Current maturities of long-term debt	106	30
	1,282	1,644
Long-term debt, net	7,017	7,206
Long-term portion of Medicare advance payments	-	621
Other long-term liabilities	954	760
Total liabilities	9,253	10,231
Redeemable noncontrolling interests	139	181
Equity:		
LifePoint Health, Inc. stockholders' equity	1,371	1,155
Noncontrolling interests	351	32
Total equity	1,722	1,187
Total liabilities and equity	$ 11,114	$ 11,599

LifePoint Health, Inc.

Consolidated Statements of Cash Flows
For the Years Ended December 31, 2021, 2020 and 2019
(In millions)

	2021	2020	2019
Cash flows from operating activities:			
Net income (loss)	$ 139	$ 305	$ (22)
Adjustments to reconcile net income (loss) to net cash (used in) provided by operating activities:			
Depreciation and amortization	345	378	376
Other non-cash amortization	33	35	40
Non-cash interest (income) expense, net	(24)	15	19
Debt transaction costs	-	115	-
Stock-based compensation	117	2	5
Other non-operating losses, net	19	4	9
Reserve for self-insurance claims, net of payments	6	30	(5)
Changes in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:			
Accounts receivable	(112)	110	(57)
Inventories, prepaid expenses and other current assets	(83)	(20)	(37)
Accounts payable, accrued salaries and other current liabilities	131	(36)	(54)
Medicare advance payments and deferred payroll taxes	(1,075)	1,075	-
Income taxes payable/receivable and deferred income taxes	(71)	(102)	136
Other	(15)	9	3
Net cash (used in) provided by operating activities	(590)	1,920	413
Cash flows from investing activities:			
Purchases of property and equipment	(274)	(170)	(337)
Net cash impact related to common control transactions	(875)	-	-
Proceeds from sales of hospitals and equity method investment	119	24	6
Other	(4)	26	21
Net cash used in investing activities	(1,034)	(120)	(310)
Cash flows from financing activities:			
Proceeds from borrowings	-	2,382	-
Payments of borrowings	-	(2,141)	(28)
Net change in ABL Facility and Prior ABL Facility	-	-	(20)
Proceeds from lease financing	-	-	700
Payments of debt financing costs	-	(103)	(18)
Cash distributed to parent	(93)	-	(11)
Distributions and other cash transactions associated with noncontrolling interests and redeemable noncontrolling interests	(26)	(13)	(18)
Termination of finance lease obligation in connection with sale of hospital	(28)	-	-
Finance lease payments and other	(29)	(20)	(19)
Net cash (used in) provided by financing activities	(176)	105	586
Change in cash and cash equivalents	(1,800)	1,905	689
Cash and cash equivalents at beginning of period	2,653	748	59
Cash and cash equivalents at end of period	$ 853	$ 2,653	$ 748
Supplemental disclosure of cash flow information:			
Interest payments	$ 379	$ 424	$ 516
Capitalized interest	$ 3	$ 2	$ 11
Property and equipment acquired under finance leases	$ 50	$ 43	$ 22
Income tax payments (refunds), net	$ 44	$ 38	$ (58)

LifePoint Health, Inc.

Consolidated Statements of Equity
For the Years Ended December 31, 2021, 2020 and 2019
(Dollars in millions)

	Common Stock		Capital in Excess of	Accumulated Other Comprehensive	Accumulated (Deficit)/	Noncontrolling	
	Shares	Amount	Par Value	Loss	Income	Interests	Total
Balance at December 31, 2018	100	$ -	$ 1,308	$ (3)	$ (382)	$ 30	$ 953
Adoption of ASU 2016-2	-	-	-	-	37	-	37
Comprehensive (loss) income	-	-	-	(5)	(41)	4	(42)
Stock-based compensation	-	-	5	-	-	-	5
Reclassification of vested stock-based compensation units to a liability	-	-	(3)	-	-	-	(3)
Distributions to parent	-	-	(3)	-	-	-	(3)
Fair value adjustments related to noncontrolling interests and redeemable noncontrolling interests	-	-	(11)	-	-	-	(11)
Distributions to noncontrolling interests	-	-	-	-	-	(8)	(8)
Balance at December 31, 2019	100	-	1,296	(8)	(386)	26	928
Comprehensive (loss) income	-	-	-	(1)	283	8	290
Stock-based compensation	-	-	2	-	-	-	2
Reclassification of equity to redeemable noncontrolling interests related to Emory joint venture	-	-	(26)	-	-	-	(26)
Fair value adjustments related to redeemable noncontrolling interests	-	-	(5)	-	-	-	(5)
Distributions to noncontrolling interests	-	-	-	-	-	(2)	(2)
Balance at December 31, 2020	100	-	1,267	(9)	(103)	32	1,187
Comprehensive income	-	-	-	6	130	5	141
Stock-based compensation	-	-	117	-	-	-	117
Net equity adjustments related to common control transactions	-	-	48	-	-	-	48
Distributions to parent	-	-	(85)	-	-	-	(85)
Noncontrolling interests recognized in common control transactions	-	-	-	-	-	317	317
Distributions to noncontrolling interests	-	-	-	-	-	(3)	(3)
Balance at December 31, 2021	100	$ -	$ 1,347	$ (3)	$ 27	$ 351	$ 1,722

Note 1. Organization and Summary of Significant Accounting Policies

Organization

LifePoint Health, Inc. ("LifePoint" or the "Company"), a Delaware corporation, acting through its subsidiaries, is a leading provider of healthcare serving patients, clinicians, communities and partner organizations across the healthcare continuum. The Company generates revenues by providing a broad range of general and specialized healthcare services to patients through a growing diversified healthcare delivery network comprised of 65 community hospital campuses, 28 inpatient rehabilitation facilities ("IRFs"), three behavioral health facilities and additional sites of care that include acute rehabilitation units, outpatient centers and post-acute care facilities. At December 31, 2021, on a consolidated basis, the Company operated 96 healthcare facilities in 29 states throughout the United States ("U.S.") with approximately 10,000 licensed beds and approximately 50,000 dedicated employees.

Unless otherwise indicated or the context otherwise requires, references throughout these notes to the consolidated financial statements to the "Company" or "LifePoint" refer to LifePoint Health, Inc., and each of its consolidated subsidiaries after giving effect to the LifePoint/RCCH Merger (defined below) and (ii) "RCCH" refer to RegionalCare Hospital Partners Holdings, Inc. and each of its consolidated subsidiaries before giving effect to the LifePoint/RCCH Merger. References in this Report to the "Sponsor" refer to certain funds that are affiliates of the Company (the "Apollo Funds") that are ultimately controlled and/or managed by certain affiliates of Apollo Management Holdings, L.P. ("Apollo Management" and, when acting on behalf of the Apollo Funds, "Apollo"), which is an affiliate of Apollo Global Management, Inc.

Additionally, references throughout these notes to the consolidated financial statements to the "LifePoint/RCCH Merger" refer to the merger, which was effective on November 16, 2018, of Legend Merger Sub, Inc., a Delaware corporation and wholly owned subsidiary of RCCH ("Legend Merger Sub"), with and into LifePoint Health, Inc., a Delaware corporation ("Legacy LifePoint"), with Legacy LifePoint surviving the LifePoint/RCCH Merger as a subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners, Inc." to "LifePoint Health, Inc."

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through majority voting control and variable interest entities which the Company controls. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation. Noncontrolling interests in non-wholly-owned consolidated subsidiaries of the Company are presented as noncontrolling interests and redeemable noncontrolling interests and distinguish between the interests of the Company and the interests of the noncontrolling owners. Net income attributable to noncontrolling interests and redeemable noncontrolling interests represents the amounts attributable to the noncontrolling interests for each of the applicable periods presented. Investments in entities the Company does not control but does have a substantial ownership interest and can exercise significant influence are accounted for using the equity method.

The Company's financial statements have been presented on the basis of push down accounting in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") No. 805-50-S99. Under the push down basis of accounting, certain transactions incurred by the parent company which would otherwise be accounted for in the accounts of the parent are "pushed down" and recorded on the financial statements of the subsidiary. Accordingly, certain items resulting from the acquisition by Apollo have been recorded on the financial statements of the Company.

Use of Estimates

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

Revenue Recognition and Accounts Receivable

Overview

The Company recognizes revenues in the period in which performance obligations are satisfied. Generally, the Company bills patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. Amounts the Company receives for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in the Company's financial statements are recorded at the net consideration to which the Company expects to be entitled to receive in exchange for providing patient care.

The majority of the Company's performance obligations are satisfied over time for the delivery of patient care in both outpatient and inpatient settings. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected charges for services anticipated to be provided. The Company believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the remaining services needed to satisfy the obligation. Generally, unsatisfied or partially unsatisfied performance obligations at the end of the reporting period are related to patients admitted to the Company's hospitals that have not yet been discharged. The performance obligations for these patients are typically satisfied when the patients are discharged, which generally occurs within a matter of days of admission. Patients are generally billed when discharged, though they may be billed on an interim basis for longer stays. Accordingly, because all of the Company's performance obligations are part of a contract that is expected to have a duration of one year or less, the Company has elected to apply the exemption provided by ASC 606, "Revenue from Contracts with Customers" ("ASC 606") to not disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied as of period end.

Subsequent adjustments that are determined to be the result of an adverse change in the patient's or the payer's ability to pay are recognized as bad debt expense. With the adoption of ASC 606, bad debt expense is included under the caption "Other operating expenses, net" in the accompanying consolidated statements of operations, instead of separately as a deduction to arrive at revenue. Bad debt expense for the years ended December 31, 2021, 2020 and 2019 was not material for the Company.

Contractual Discounts

The Company derives a significant portion of its revenues from Medicare, Medicaid and other payers that receive discounts from the Company's established billing rates. The Company must estimate the total amount of these discounts to prepare its financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Company estimates contractual discounts on a payer-specific basis given its interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Subsequent changes in estimates for contractual discounts are reflected as an adjustment to revenues in the period of the change. Medicare, Medicaid and other discounted payer accounts receivables are written off after they have been final settled with the payer.

Kentucky Hospital Rate Improvement Program

The Commonwealth of Kentucky has implemented a Medicaid Hospital Rate Improvement Program ("KY HRIP"), which provides supplemental Medicaid payments to all Kentucky hospitals, other than university hospitals and state mental hospitals, and is intended to reduce the gap between the Kentucky Medicaid program's regular inpatient Medicaid payments and each hospital's Medicare allowable costs. During the first quarter of 2021, CMS and the Commonwealth of Kentucky approved a modification to the KY HRIP, which increased the inpatient hospital reimbursement rate from a contracted managed care rate up to a percentage of the average commercial rate. This modification was applied retrospectively to the beginning of the KY HRIP fiscal year, which commenced on July 1, 2020. As a result of this modification, the Company recognized additional revenues of $113 million in its consolidated statement of operations for the year ended December 31, 2021, of which $33 million is related to the period from July 1, 2020 to December 31, 2020. Additionally, the Company recognized additional provider taxes of $15 million for the year ended December 31, 2021, included under the caption "Other operating expenses, net" in the accompanying consolidated statement of operations, of which $5 million is related to the period from July 1, 2020 to December 31, 2020.

Cost Report Settlements

Cost report settlements under reimbursement agreements with Medicare, Medicaid and certain other payers for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the payment terms of the reimbursement agreement with the payer, correspondence from the payer, and the Company's historical experience. Estimated settlements are adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. For the years ended December 31, 2021, 2020 and 2019, the net adjustments to estimated cost report settlements and other reimbursement adjustments resulted in an increase to revenues of $62 million, $34 million and $17 million, respectively.

The net cost report settlements due from the Company were nominal at December 31, 2021 and $2 million at December 31, 2020 and are included under the caption "Other current liabilities" on the accompanying consolidated balance sheets. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs consistent with the constraints that are required by ASC 606.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third-party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. The Company evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. The Company estimates the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that the Company utilizes include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that the Company expects to collect. Because the Company provides care to patients regardless of their ability to pay, the Company has determined that the differences between the amounts it bills based on gross or discounted charges and the amounts the Company expects to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and the Company accounts for this variable consideration in accordance with the provisions of ASC 606. Self-pay accounts receivable are written off after collection efforts have been followed in accordance with the Company's policies.

Charity Care

The Company provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the years ended December 31, 2021, 2020 and 2019, the Company estimates that its costs of care provided under its charity care programs approximated $23 million, $27 million and $34 million, respectively. The Company does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Company's policy not to pursue collection of amounts related to these patients, and therefore contracts with these patients do not exist.

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

Financing Component

The Company has elected to apply the practical expedient permitted under ASC 606 and does not adjust the estimated amount of consideration from patients and third-party payers for the effects of a significant financing component due to the Company's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payer pays for that service will be one year or less.

Rental Income

The Company leases certain real estate assets it owns to unrelated third parties, primarily medical office buildings to non-employed physicians. The Company recognizes rental income for these operating lease arrangements in which the Company is the lessor on a straight-line basis over the lease term in accordance with ASC 842, "Leases" ("ASC 842").

Concentration of Revenues

The Company's revenues by payer and approximate percentages of revenues were as follows for the years ended December 31, 2021, 2020 and 2019 (dollars in millions):

	2021		2020		2019	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,368	37.7 %	$ 3,134	38.6 %	$ 3,338	38.1 %
Medicaid	1,645	18.4	1,392	17.1	1,495	17.1
HMOs, PPOs and other private insurers	3,691	41.3	3,382	41.6	3,699	42.3
Self-pay	55	0.6	55	0.7	59	0.7
Other	156	1.8	137	1.7	144	1.6
Revenue from contracts with customers	8,915	99.8	8,100	99.7	8,735	99.8
Rental income	22	0.2	22	0.3	18	0.2
Revenues	$ 8,937	100.0 %	$ 8,122	100.0 %	$ 8,753	100.0 %

During the years ended December 31, 2021, 2020 and 2019, approximately 56.1%, 55.7% and 55.2%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs, collectively. The Company's management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies.

Any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs could have an adverse effect on the Company's revenues or results of operations. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payer or geographic area that would subject the Company to any significant credit risks in the collection of its accounts receivable.

The Company's revenues by primary service type and approximate percentages of revenues were as follows for the years ended December 31, 2021, 2020 and 2019 (dollars in millions):

	2021		2020		2019	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Inpatient services	$ 3,525	39.4 %	$ 3,379	41.6 %	$ 3,524	40.3 %
Outpatient services	5,234	58.6	4,584	56.4	5,067	57.9
Non-patient (a)	178	2.0	159	2.0	162	1.8
Revenues	$ 8,937	100.0 %	$ 8,122	100.0 %	$ 8,753	100.0 %

(a) Primarily represents revenues from ancillary goods, services and rental income.

General and Administrative Costs

The majority of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as "general and administrative" by the Company would include its corporate overhead costs, which were $156 million, $158 million and $159 million for the years ended December 31, 2021, 2020 and 2019, respectively, excluding depreciation and amortization, debt transaction costs, merger and integration costs, certain transaction and advisory costs recognized in connection with the Company's business development activities, and accelerated stock-based compensation expense recognized in connection with a transaction involving the Company's indirect parent, DSB Parent, L.P., a Delaware limited partnership (the "Parent").

Cash and Cash Equivalents

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

Inventories

Inventories of supplies are stated at the lower of cost (first-in, first-out) or market and consist of purchased items. Inventories acquired in connection with business combinations are recorded at fair value which approximates replacement cost. Inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

Investments

The Company accounts for its investments in entities in which the Company does not control under the equity method of accounting in accordance with ASC 321 "Investments – Equity Securities" ("ASC 321") and/or ASC 323, "Investments – Equity Method and Joint Ventures" ("ASC 323"). The Company does not consolidate its equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses or evaluates them for impairment and observable price changes. Refer to Note 9 for further discussion of the Company's investments.

Property and Equipment

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

The following table provides information regarding the Company's property and equipment included in the accompanying consolidated balance sheets as of December 31, 2021 and 2020 (in millions):

	2021	2020
Land	$ 179	$ 227
Buildings and improvements	2,357	2,612
Equipment	1,617	1,552
Construction in progress	162	85
Property and equipment, at cost	4,315	4,476
Accumulated depreciation	(1,051)	(953)
Property and equipment, net of accumulated depreciation	$ 3,264	$ 3,523

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

	Years		
Buildings and improvements (including those under finance leases)	3	-	40
Equipment	2	-	15
Equipment under finance leases	3	-	6

Depreciation expense (including amortization of finance lease obligations) totaled $344 million, $376 million and $375 million for the years ended December 31, 2021, 2020 and 2019, respectively.

Whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances. There were no long-lived asset impairments recorded for the years ended December 31, 2021, 2020 and 2019.

Goodwill and Intangible Assets

The Company accounts for its acquisitions in accordance with ASC 805 using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350, Intangibles – Goodwill and Other ("ASC 350"), goodwill and intangible assets with indefinite lives are reviewed by the Company annually for impairment on October 1. Prior to the LifePoint/RCCH Merger, the Company historically determined that each of its hospitals represented a reporting unit in accordance with ASC 280, "Segment Reporting" ("ASC 280") and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that the consolidated business comprises a single reporting unit for goodwill impairment testing purposes. There were no changes in the Company's determination of reporting units for the years ended December 31, 2021 and 2020. For the annual impairment evaluation, the Company determines fair value using a discounted cash flow ("DCF") analysis and consideration of certain market inputs including those of guideline public companies. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates, profitability and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing the Company's assumptions. The cash flows employed in the DCF analysis are based on the Company's most recent financial budgets and business plans and, when applicable, various growth rates and profitability for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the reporting unit.

The Company's intangible assets primarily relate to contract-based physician minimum revenue guarantees; certificates of need and certificates of need exemptions; and licenses, provider numbers, accreditations and other. Contract-based physician minimum revenue guarantees are amortized over the terms of the agreements. The certificates of need, certificates of need exemptions, licenses, provider numbers, accreditations and other have been determined to have indefinite lives and, accordingly, are not amortized. Refer to Note 5 for further discussion of the Company's goodwill and intangible assets.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the income tax provision in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is not likely, a valuation allowance is established. The establishment or increase in a valuation allowance is included as an expense within the provision for income taxes in the consolidated statements of operations. The Company classifies interest and penalties related to its tax positions as a component of income tax expense. Refer to Note 6 for further discussion of the Company's accounting for income taxes.

Reserves for Self-Insurance Claims

Given the nature of the Company's operating environment, the Company is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("SIR") and deductible levels. At December 31, 2021, the Company's SIR for professional liability claims is $15 million per claim at the majority of its acute care hospitals. Additionally, the Company participates in state-specific professional liability programs in Colorado, Indiana, Kansas, New Mexico and Pennsylvania. The Company has a $25,000 deductible for professional liability at each of its IRFs. At December 31, 2021, the Company's deductible for workers' compensation claims at each of its acute care hospitals was $1 million per claim in all states in which it operates except for Montana and Washington. The Company participates in state-specific programs for its workers' compensation claims arising in these states. There is no deductible for workers' compensation claims at IRFs. The Company's SIR and deductible levels are evaluated annually as a part of the Company's insurance program's renewal process.

The Company's reserves for self-insurance and deductible claims reflect the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The Company's expense for self-insurance and deductible claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's self-insured retention and deductible levels; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance and deductible claims was approximately $86 million, $85 million and $76 million for the years ended December 31, 2021, 2020 and 2019, respectively.

The Company's reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. These reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. The Company's reserves for self-insured claims have been discounted to their present value using a discount rate of 1.6% at December 31, 2021, 1.7% at December 31, 2020, and 1.9% at December 31, 2019. The Company's management selects a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

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

The following table provides information regarding the classification of the Company's reserves for self-insured claims at December 31, 2021 and 2020 (in millions):

	2021	2020
Current portion	$ 79	$ 82
Long-term portion	216	205
	$ 295	$ 287

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2021 and 2020 (in millions):

	2021	2020
Reserve at the beginning of the period	$ 287	$ 261
Increase for the provision of current year claims	72	88
Increase (decrease) for the provision of prior year claims	13	(4)
Payments related to current year claims	(5)	(6)
Payments related to prior year claims	(72)	(49)
Provision for the change in discount rate	1	1
Non-cash change in reserve for claims in excess of SIR levels	(5)	(4)
Liabilities received in connection with the Kindred Transaction	4	-
Reserve at the end of the period	$ 295	$ 287

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of the Company's quarterly and semi-annual actuarial calculations resulted in changes to its reserves for self-insured claims for prior years. As a result, the Company's related self-insured claims expense increased by $13 million and $7 million for the years ended December 31, 2021 and 2019, respectively, and decreased by $4 million for the year ended December 31, 2020.

Point of Life Indemnity, Ltd.

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

Self-Insured Medical Benefits

The Company is self-insured for substantially all of the medical expenses and benefits of its employees. The reserve for medical benefits primarily reflects the current estimate of incurred but not reported losses based upon an annual actuarial calculation as of the balance sheet date. The undiscounted reserve for self-insured medical benefits was $46 million and $38 million at December 31, 2021 and 2020, respectively, and is included in the Company's accompanying consolidated balance sheets under the caption "Other current liabilities".

Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to the Company. The Company's accompanying consolidated financial statements include all assets, liabilities, revenues, and expenses at their consolidated amounts, which include the amounts attributable to the Company and the noncontrolling interest. The Company recognizes as a separate component of earnings that portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company. Refer to Note 10 for further discussion of the Company's noncontrolling interests and redeemable noncontrolling interests.

Variable Interest Entities

The Company follows the provisions of ASC 810, "Consolidation" for determining whether an entity is a variable interest entity ("VIE"). In order to determine if the Company is a primary beneficiary of a VIE for financial reporting purposes, it must consider whether it has the power to direct activities of the VIE that most significantly impact the performance of the VIE and whether the Company has the obligation to absorb losses or the right to receive returns that are significant to the VIE. The Company consolidates a VIE when it is the primary beneficiary.

As of December 31, 2021, the Company consolidated 23 acute care hospitals and 28 IRFs which were partnerships subject to joint venture agreements. Under GAAP, the Company determined that six of its acute care hospital partnerships and 26 of its IRF partnerships qualify as VIEs, and furthermore, the Company concluded that it is the primary beneficiary in all of the VIE partnerships. The Company holds an ownership interest and acts as manager in each of the partnerships. Through the management services agreement, the Company is delegated necessary responsibilities to provide management services, administrative services and direction of the day-to-day operations. Based upon the Company's assessment of the most significant activities of the hospitals and IRFs, the Company, as manager, has the ability to direct the majority of those activities in all 32 partnerships which qualify as VIEs.

The analysis upon which the consolidation determination rests can be complex, can involve uncertainties, and requires judgment on various matters, some of which could be subject to different interpretations.

The Company's consolidated VIEs comprised approximately $1,268 million, or 11.4%, of the Company's total assets and $525 million, or 5.7%, of the Company's total liabilities as of December 31, 2021.

Stock-Based Compensation

The Company's Parent has issued profits units (the "Units") to certain employees, directors and consultants under the terms and conditions of the Second Amended and Restated Limited Partnership Agreement of the Parent dated June 25, 2021 (as amended, the "Parent Partnership Agreement") and forms of award agreements. The Company accounted for these stock-based awards in accordance with the provisions of ASC 718, "Compensation – Stock Compensation" ("ASC 718"). In accordance with ASC 718, the Company recognized compensation expense based on the estimated grant date fair value of each stock-based award. The Company recognizes forfeitures of Units as they occur. Refer to Note 13 for further discussion of the Company's accounting for the Units.

Defined Benefit Pension Plans

In connection with the LifePoint/RCCH Merger, the Company acquired certain assets and assumed certain liabilities associated with two separate defined benefit pension plans covering certain employees at two of Legacy LifePoint's facilities. The Company accounts for its defined benefit pension plans in accordance with ASC 715, "Compensation – Defined Benefit Plans", ("ASC 715"). In accordance with ASC 715, the Company recognizes the unfunded liability of its defined benefit pension plans in the Company's consolidated balance sheets and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the defined benefit pension plans' assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligations are measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality. Refer to Note 12 for further discussion of the Company's defined benefit pension plans.

Defined Contribution Plans

During 2021, the Company maintained a defined contribution retirement plan covering a majority of its employees and a separate defined contribution retirement plan covering the employees at Community Medical Center. These defined contribution retirement plans contain discretionary matching contribution formulas, as well as definite contribution formulas for employees at certain facilities. Refer to Note 12 for further discussion of the Company's defined contribution plans. Effective as of the end of the day on December 31, 2021, the plan covering Community Medical Center employees was merged into the plan covering LifePoint employees.

Reclassifications

Certain reclassifications have been made to the prior years to conform to current year presentation. These reclassifications had no effect on results of operations, financial position or cash flows as previously reported.

Note 2. Business Development Update

Kindred Transaction

On June 18, 2021, the Company entered into a Securities Purchase Agreement (the "SPA") with TPG Kentucky Co-Invest, LP ("TPG Co-Invest Seller"), TPG VII Kentucky Holdings I, LP ("TPG VII Seller"), Kentucky Hospital Management, LLC ("Management Seller"), Kentucky Hospital GP, Inc. ("Partnership GP Seller" and each of TPG Co-Invest Seller, TPG VII Seller, Management Seller and Partnership GP Seller, a "Direct Seller"), TPG VII Kentucky AIV I, LP ("TPG Blocker Seller"), Welsh, Carson, Anderson & Stowe XII, L.P. ("WCAS XII"), Welsh, Carson, Anderson & Stowe XII Delaware, L.P. ("WCAS XII Delaware"), Welsh, Carson, Anderson & Stowe XII Delaware II, L.P. ("WCAS XII Delaware II"), Welsh, Carson, Anderson & Stowe XII Cayman, L.P. ("WCAS XII Cayman"), WCAS Management Corporation ("WCAS Management"), WCAS XII Co-Investors LLC ("WCAS XII Co-Investors," and collectively with WCAS XII, WCAS XII Delaware, WCAS XII Delaware II, WCAS XII Cayman and WCAS Management, the "WCAS Blocker Sellers"), Port-aux-Choix Private Investments Inc. ("PSP Blocker Seller" and each of TPG Blocker Seller, WCAS Blocker Sellers and PSP Blocker Seller, a "Blocker Seller" and, each of the Direct Sellers and each of the Blocker Sellers, a "Seller" and collectively, the "Sellers"), Kentucky Hospital Holdings JV, LP (the "Knight"), the indirect parent of Kindred Healthcare, LLC ("Kindred"), and solely in its capacity as the initial seller representative hereunder, Partnership GP Seller ("Seller Representative"), pursuant to which, upon the terms and subject to the conditions set forth therein and in accordance with applicable law, the Sellers, which directly and indirectly owned all of the issued and outstanding equity interests in the Knight and the Blockers (as defined in the SPA), agreed to sell such equity interests to LifePoint and/or affiliates of LifePoint. Upon the closing of the Kindred Transaction, as described below, the Company and Kindred established a new healthcare company operating under the name ScionHealth.

On November 30, 2021, Knight Health LLC, a Delaware limited liability company formed at the direction of certain affiliates of the Company ("Knight Health"), assumed from the Company and the Company assigned to Knight Health the rights and obligations of the Company under the SPA in respect of the purchase of all of the issued and outstanding equity interests of the Knight and the Blockers and the payment of the purchase price for such equity interests.

On December 23, 2021, the Company, Knight, Knight Health Holdings LLC (d/b/a ScionHealth), a Delaware limited liability company and direct parent of Knight ("ScionHealth"), and certain of their respective affiliates entered into reorganization agreements (the "Reorganization Agreements") that, among other things, provided for (i) the separation of the inpatient rehabilitation facility, behavioral health, contract rehabilitation service and certain support center businesses (collectively, the "Knight Transferred Business") from the businesses of Knight and its subsidiaries, (ii) the separation of the equity and assets comprising 18 select acute care hospitals of the Company (the "Artemis Business") from the business of the Company and its subsidiaries, (iii) the transfer of the Knight Transferred Business to the Company, (iv) the transfer of the Artemis Business to Knight (v) the acquisition by the Company of Class B Units of ScionHealth, with an aggregate value of $350 million, and (vi) reciprocal indemnification obligations with respect to the businesses transferred, in each case of clauses (i) through (vi), pursuant to the reorganization, separation and distribution steps described therein, including the assignment by Knight Health of certain rights and obligations under the SPA, including any post-closing purchase price adjustments (the "Reorganization"). The Class B Units of ScionHealth acquired by the Company are perpetual non-convertible non-voting units that accrue cumulative dividends at the rate of 10.00% per annum and, upon liquidation, are entitled to a return of their nominal value issue price plus accrued, unpaid dividends.

On December 23, 2021, concurrently with the consummation of the Reorganization, the Sellers, the Seller Representative, Knight and the assignees of the rights and obligations of the Company as initial buyer under the SPA, including Knight Health, consummated the Kindred Transaction. Pursuant to the consummation of the Kindred Transaction and the Reorganization, (i) ScionHealth indirectly holds all of the transferred interests in the Artemis Business, (ii) ScionHealth directly holds all of the issued and outstanding limited partnership interests in Knight, (iii) Kentucky Hospital Holdings JV GP LLC, a Delaware limited liability company and direct subsidiary of ScionHealth ("Knight GP"), holds all of the issued and outstanding general partnership interests in Knight, and (iv) the Company holds all of the transferred interests in the Knight Transferred Business and the Class B Units of ScionHealth described above. The Company refers to the foregoing transactions as the "Kindred Transaction".

In connection with the Kindred Transaction, the Company entered into a number of transition services agreements and other ancillary agreements with ScionHealth and its subsidiaries with estimated proceeds of $61 million per year to the Company and an estimated cost of $3 million per year to the Company. In addition, the Company and ScionHealth are party to a number of commercial services agreements, pursuant to which the Knight Transferred Business provides ScionHealth with therapy services and rehabilitation unit management and development services, among other commercial services.

The Company accounted for the Kindred Transaction in accordance with ASC Subtopic 805-50 "Related Issues" ("ASC 805-50") as a transaction between entities under common control. In accordance with ASC 805-50, the Company recognized the assets and liabilities transferred in connection with the Kindred Transaction at the common parent's historical cost basis as of December 23, 2021. In accordance with ASC 805-50, combinations of entities under common control requires retrospective adjustment of comparative period financial information for the periods in which the entities were under common control. The Company and the Knight Transferred Business were under common control beginning December 23, 2021, and therefore, the Company has not retrospectively adjusted its previously issued financial statements. The Kindred Transaction did not have a material impact to the Company's consolidated revenues or income before income taxes for the year ended December 31, 2021.

The following tables summarize the impact of the net asset transfers in connection with the Kindred Transaction (in millions):

Net assets transferred from ScionHealth to LifePoint	$ 1,048
Net assets transferred from LifePoint to ScionHealth	(404)
Cash transferred to ScionHealth from LifePoint	(946)
Class B Units of ScionHealth transferred to LifePoint	350
Net equity adjustments related to common control transactions	$ 48

	From ScionHealth To LifePoint	From LifePoint To ScionHealth
Current assets	$ 200	$ (271)
Property and equipment, net	172	(501)
Other long-term assets	473	(30)
Goodwill and intangible assets	1,169	(121)
Current liabilities	(119)	118
Long-term liabilities	(530)	378
Noncontrolling interests and redeemable noncontrolling interests	(317)	23
Net assets transferred to (from) LifePoint	$ 1,048	$ (404)

Additionally, for the year ended December 31, 2021, the Company recognized transaction-related costs of $86 million, primarily in connection with the Kindred Transaction and other business development activities.

Divestitures

Providence Health and KershawHealth

Effective August 1, 2021, the Company sold Providence Health, comprised of two hospital campuses located in Columbia, South Carolina, and KershawHealth, located in Camden, South Carolina, to an unrelated third-party. The Company received cash proceeds from the transaction of $86 million, including net working capital, a portion of which was utilized to settle a $28 million finance lease obligation related to KershawHealth. Refer to Note 8 for additional information regarding the Company's accounting for leases.

In connection with the divestiture of Providence Health and KershawHealth, the Company recognized a net impairment loss of $42 million during the year ended December 31, 2021, which is included under the caption "Other non-operating losses, net" in the accompanying consolidated statement of operations for the year ended December 31, 2021. The net impairment loss is primarily attributable to the write-down of property and equipment and allocated goodwill to their estimated fair values, as well as the termination of a finance lease obligation related to KershawHealth.

Capital Medical Center

On December 23, 2020, the Company entered into a definitive agreement with an unrelated third-party to sell its majority ownership interest in Capital Medical Center, located in Olympia, Washington. Upon entry into the definitive agreement, the Company received a deposit of $5 million from the purchaser, which is included under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheet at December 31, 2020. Effective April 1, 2021, the Company sold its ownership interest in Capital Medical Center for additional cash proceeds of $33 million, including net working capital, in addition to the purchaser's assumption of certain finance lease obligations.

In connection with the Company's divestiture of Capital Medical Center, the Company recognized a net gain on sale of $24 million during the year ended December 31, 2021, which is included under the caption "Other non-operating losses, net" in the accompanying consolidated statement of operations for the year ended December 31, 2021. The net gain on sale is primarily attributable to the purchaser's assumption of certain finance lease obligations and liabilities, partially offset by the write-off of property and equipment, allocated goodwill, and certain other assets.

Teche Regional Medical Center

Effective October 1, 2019, the Company terminated its lease of Teche Regional Medical Center, located in Morgan City, Louisiana, and transferred the owned assets and operations of Teche Regional Medical Center to a new operator.

Joint Ventures

Emory Healthcare

Effective January 1, 2020, the Company formed a new joint venture with Emory Healthcare, Inc. ("Emory") to operate St. Francis Hospital ("St. Francis") located in Columbus, Georgia. Upon formation of the joint venture, the Company reclassified $26 million of its equity in St. Francis to redeemable noncontrolling interests representing the estimated fair value of Emory's ownership interest in St. Francis. The Company maintained a controlling interest in St. Francis such that it continued to be included in the Company's consolidated financial statements through December 23, 2021, at which time St. Francis was transferred to ScionHealth.

In-Home Healthcare Partnership

The Company maintains a joint venture with a wholly-owned subsidiary of LHC Group, Inc. ("LHC"), In-Home Healthcare Partnership ("IHHP"), the purpose of which is to own and operate the Company's home health agencies and hospices and certain of LHC's home health agencies and hospices. The Company accounts for its ownership interest in IHHP as an equity method investment in accordance with ASC 323, "Investments." Effective January 1, 2020, the Company sold a portion of its ownership interest in IHHP to LHC for cash proceeds of $24 million.

LifePoint/RCCH Merger

On July 22, 2018, RCCH, Legend Merger Sub and Legacy LifePoint entered into an agreement and plan of merger, pursuant to which, effective November 16, 2018, Legend Merger Sub merged with and into Legacy LifePoint, with Legacy LifePoint surviving the merger as a wholly-owned subsidiary of RCCH. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint changed its name from "LifePoint Health, Inc." to "Legacy LifePoint Health, Inc." and, immediately following the effective time of the LifePoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "LifePoint Health, Inc."

For the year ended December 31, 2019, the Company recognized merger and integration-related costs of $47 million, primarily related to legal and transaction advisory services as well as employee severance and retention and other integration-related expenses in connection with the LifePoint/RCCH Merger, which are included under the caption "Transaction-related costs" in the accompanying consolidated statement of operations for the year ended December 31, 2019.

Note 3. Impact of COVID-19 and the CARES Act

Impact of COVID-19

During March 2020, the global COVID-19 pandemic began to significantly affect the Company's facilities, employees, patients, communities, business operations and financial performance, as well as the U.S. economy and financial markets, as a whole. More than two years into the pandemic, the Company continues to be deeply committed to protecting the health of its communities and continues to respond to the evolving COVID-19 situation across the country. Importantly, the Company is taking every precaution to ensure it can continue providing quality care and safeguard the health and well-being of patients, employees, providers, volunteers and visitors in each community it serves. The national footprint of the Company's health system, along with its Health Support Center, has enabled the Company to support its communities during this challenging time.

CARES Act Overview

The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was signed into law on March 27, 2020. Among other things, the CARES Act contains a number of provisions that are intended to assist healthcare providers as they combat the effects of the COVID-19 pandemic. Those provisions include, among others:

- the temporary suspension of Medicare sequestration from March 1, 2020, to December 31, 2020;
- the delay of the planned reductions to the Medicaid disproportionate share hospital ("DSH") payments program until October 1, 2023;
- an appropriation of $180 million to Health Resources and Services Administration's Federal Office of Rural Health Policy that will be awarded to small rural hospitals by the states through the Small Rural Hospital Improvement Program;
- an appropriation of $250 million to the Hospital Preparedness Program; and
- an appropriation of $100 billion to the Public Health and Social Services Emergency Fund (the "Emergency Fund") for a new program to reimburse, through grants or other mechanisms, hospitals, healthcare providers and other approved entities for COVID-19-related expenses or lost revenues.

The Paycheck Protection Program and Health Care Enhancement Act was enacted on April 24, 2020, which, among other things, provides an additional allocation of $75 billion to the Emergency Fund and an allocation of $25 billion for COVID-19 testing.

On December 21, 2020, Congress adopted the Consolidated Appropriations Act, 2021 (the "CAA"), which provides an additional $900 billion in COVID-19 relief, including an additional allocation of $3 billion to the Emergency Fund. In addition, the CAA, among other things, delays the planned reductions to the Medicaid DSH payments program through federal fiscal year ("FFY") 2023, adds additional reductions to the Medicaid DSH payments program in FFYs 2026 and 2027, provided for a 3.75% increase in the Medicare Physician Fee Schedule ("PFS") rates in calendar year ("CY") 2021 and allocates $30 billion for the purchase and administration of COVID-19 vaccines and related therapeutics. In addition, the CAA extended the temporary suspension of Medicare sequestration through March 31, 2021. The temporary suspension was subsequently extended through December 31, 2021, by HR 1868, which, to offset the cost of the suspension, extended Medicare sequestration through 2030. The Protecting Medicare and American Farmers from Sequester Cuts Act (the "Sequester Cuts Act") further extends the temporary suspension of Medicare sequestration through March 31, 2022, and reduces the sequestration cuts for the period of April 1, 2022, through June 30, 2022, to 1%. The Sequester Cuts Act also delays application of 4% cuts to Medicare and other federal programs resulting from the requirements of the Statutory Pay-As-You-Go-Act of 2010 that were scheduled to go into effect in CY 2022 until CY 2023.

Stimulus Payments

The Emergency Fund distributed $50 billion to hospitals based on their 2018 net patient revenue. Additionally, since that time, the Emergency Fund has distributed more than $80 billion to a number of different types of healthcare providers, including participants in state Medicaid/CHIP programs, providers in areas particularly impacted by the COVID-19 outbreak, rural providers (including hospitals and rural health clinics), skilled nursing facilities, dentists, providers of services with lower shares of Medicare reimbursement or who predominantly serve Medicaid beneficiaries, and providers requesting reimbursement for the treatment of uninsured patients.

Payments made by the Emergency Fund to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, filing attestations acknowledging receipt of payments, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients, not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse, and submitting such reports as may be required by HHS regarding the provider's compliance with the terms and conditions of the Emergency Fund. Healthcare providers that received more than $10,000 from the Emergency Fund between April 10, 2020 through June 30, 2020 (the "First Payment Received Period") were required to submit a report on their use of those funds no later than September 30, 2021. The Company successfully submitted the required reports for all of its providers that received and retained payments from the Emergency Fund during First Payment Received Period prior to the deadline. However, the Company will be required to submit additional reports in the future for payments that were received and retained by the Company's providers from the Emergency Fund after the end of the First Payment Received Period. The reporting requirements and guidance from HHS related to the Emergency Fund have been subject to frequent clarifications and revision, and there can be no assurance that the Company will not be required to submit additional reports or provide additional information related to the payments it has received from the Emergency Fund in the future. In addition, HHS has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the Office of Inspector General of HHS (the "OIG"), will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

The Company has accounted for the stimulus payments received as a government grant related to income in a manner consistent with International Accounting Standards 20, "Accounting for Government Grants and Disclosure of Government Assistance" ("IAS 20"). In accordance with IAS 20, government grants are recognized either as other income or a reduction to a related expense when there is reasonable assurance that the grant will be received, and the entity will comply with any conditions attached to the grant.

For the years ended December 31, 2021 and 2020, the Company recognized $17 million and $646 million, respectively, of stimulus payments as other income under the caption "Government stimulus income" in the accompanying consolidated statements of operations.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, HHS temporarily expanded the Centers for Medicare and Medicaid Services ("CMS") Accelerated and Advance Payment Program to a broad group of Medicare Part A and Part B providers. Under the expanded CMS Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period. The repayment of these accelerated/advance payments did not begin until one year after the date of the provider's or supplier's receipt of the payment, which means repayment of these amounts did not commence until the second quarter of 2021. Under the applicable repayment terms, the amounts previously advanced to the provider or supplier are automatically recouped from the provider's or supplier's new Medicare claims at a rate of 25% for a period of 11 months. After the end of that 11-month period, the amounts previously advanced to the provider or supplier will be automatically recouped from the provider's or supplier's new Medicare claims at a rate of 50% for a period of six months. At the end of the 17-month recoupment period, a letter requesting repayment of any remaining balance will be issued, and the provider or supplier will have 30 days from the date of the letter to repay the balance in full. If the remaining balance is not repaid after 30 days, the unpaid balance will accrue interest at a rate of 4% from the date of the demand letter until the balance has been repaid in full.

The Company received a total of $991 million of Medicare advance payments under the CMS Accelerated and Advance Payment Program during the year ended December 31, 2020, of which $370 million and $621 million are included under the captions "Current portion of Medicare advance payments" and "Long-term portion of Medicare advance payments", respectively, in the accompanying consolidated balance sheet at December 31, 2020. During the year ended December 31, 2021, the Company fully repaid all Medicare advance payments and the Company does not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program.

CARES Act Tax Provisions

The CARES Act also provided for certain federal income tax changes, including an increase in the interest expense tax deduction limitation, the deferral of the employer portion of Social Security payroll taxes, refundable payroll tax credits, employee retention tax credits, net operating loss carryback periods, alternative minimum tax credit refunds and bonus depreciation of qualified improvement property. During the year ended December 31, 2020, the Company deferred cash payments of approximately $84 million related to Social Security payroll tax payments. During the year ended December 31, 2021, the Company fully repaid all previously deferred Social Security payroll taxes.

The federal income tax changes brought about by the CARES Act are complex and further guidance is expected. The Company may change its provision for income taxes and its deferred income taxes as its understanding of the CARES Act tax provisions evolves due to additional U.S. Department of Treasury guidance. Any such adjustments could materially impact the Company's provision for income taxes and, as a result, its financial results in the relevant periods.

Note 4. Long-Term Debt

The Company's long-term debt, including current portions and finance lease obligations, consisted of the following at December 31, 2021 and 2020 (in millions):

	2021	2020
ABL Facility	$ -	$ -
Term Loan Facility	3,215	3,215
6.75% Secured Notes	600	600
4.375% Secured Notes	600	600
9.75% Unsecured Notes	1,425	1,425
5.375% Unsecured Notes	500	500
Unamortized debt issuance costs and premium	(128)	(152)
Finance lease obligations	911	1,048
Total debt	$ 7,123	$ 7,236

Maturities of the Company's long-term debt outstanding at December 31, 2021, excluding finance lease obligations and unamortized debt issuance costs and premium, are as follows for the years indicated (in millions):

2022	$ -
2023	-
2024	-
2025	3,815
2026	1,425
Thereafter	1,100
	$ 6,340

ABL Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Company and Legend Merger Sub (together, prior to the effective time of the LifePoint/RCCH Merger, the "Co-Borrowers") entered into a new senior secured asset-based revolving credit facility (the "ABL Facility") in an aggregate principal amount of $800 million with a maturity of five years. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint assumed all of the rights and obligations of Legend Merger Sub under the ABL Facility. The ABL Facility also includes both a letter of credit sub-facility and a swingline loan sub-facility (including in its capacity as co-borrower under a senior secured term loan credit facility; the "Term Loan Facility") entered into between the Co-Borrowers on November 16, 2018. In addition, the Company may request one or more incremental revolving commitments in an aggregate principal amount up to the greater of (x) the greater of (i) $255 million and (ii) 0.23 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, and (y) the amount by which the borrowing base exceeds the aggregate commitments under the ABL Facility, subject to certain conditions and receipt of commitments by existing or additional lenders.

As of December 31, 2021, the Company had no borrowings outstanding under the ABL Facility and approximately $50 million in letters of credit outstanding primarily related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements. Amounts available for borrowing under the ABL Facility were approximately $598 million as of December 31, 2021.

Collateral and Guarantors

All obligations under the ABL Facility are unconditionally guaranteed by DSB Acquisition, LLC, a Delaware limited liability company ("Holdings"), on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Co-Borrowers, subject to certain exceptions.

The obligations under the ABL Facility are secured by a pledge of the capital stock of the Co-Borrowers and substantially all of their assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy LifePoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the "ABL Priority Collateral" (which generally includes most accounts receivable and certain related assets of the Co-Borrowers and the subsidiary guarantors) and a second-priority lien with respect to the "Non-ABL Priority Collateral" (which generally includes most inventory and fixed assets, equity interests and intellectual property of the Co-Borrowers and the subsidiary guarantors). Additionally, certain of the Company's restricted subsidiaries that are not guarantors will pledge certain of their assets (the "Credit Support Party Collateral") on a first-priority basis, as further security of the obligations under the ABL Facility. The Credit Support Party Collateral will secure only the obligations under the ABL Facility.

All borrowings under the ABL Facility are subject to the satisfaction of customary conditions, including the absence of a default and the accuracy of representations and warranties.

Interest Rates and Fees

Borrowings under the ABL Facility bear interest at a rate equal to, at the Company's option, either (a) a London Interbank Offered Rate ("LIBOR") rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an initial applicable margin of 1.75% for LIBOR loans and 0.75% for base rate loans. The applicable margin for borrowings is subject to step-downs based on average availability thresholds.

In addition to paying interest on outstanding principal under the ABL Facility, the Co-Borrowers are required to pay a commitment fee under the ABL Facility in respect of the unutilized commitments under the ABL Facility at an initial rate equal to 0.375% per annum. The commitment fee may be subject to one step-down based on the average daily utilization under the ABL Facility. The Co-Borrowers will also be required to pay customary agency fees as well as letter of credit participation fees.

Restrictive Covenants and Other Matters

The ABL Facility contains certain customary affirmative covenants and events of default. The negative covenants in the ABL Facility include, among other things, limitations (none of which are absolute) on the Co-Borrowers and their subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates, enter into sale-leaseback transactions, change their lines of business, restrict dividends from their subsidiaries or restrict liens, change their fiscal year, and modify the terms of certain debt.

The ABL Facility requires that the Co-Borrowers and its restricted subsidiaries maintain a minimum fixed charge coverage ratio of not less than 1.00 to 1.00 at any time when availability is less than an agreed amount.

The ABL Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the ABL Facility are entitled to take various actions, including the acceleration of amounts due under the ABL Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the ABL Facility.

ABL FILO Term Loan

On April 13, 2020, the Company executed the ABL Facility Amendment that provided for an $80 million last-out term loan (the "ABL FILO Term Loan") with a maturity of 364 days, which was incremental to the existing $800 million of revolving commitments under the ABL Facility. The ABL FILO Term Loan was fully drawn at closing of the ABL Facility Amendment and then subsequently repaid in full on December 14, 2020, which effectively terminated the ABL FILO Term Loan.

Term Loan Facility

General

Effective November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Co-Borrowers entered into the Term Loan Facility, which is a senior secured term loan credit facility in an aggregate principal amount of $3,550 million with a maturity of seven years. At the effective time of the LifePoint/RCCH Merger, Legacy LifePoint assumed all of the rights and obligations of Legend Merger Sub under the Term Loan Facility (including in its capacity as a Co-Borrower under the Term Loan Facility). In addition, the Company may request one or more incremental commitments in an aggregate principal amount up to the sum of (x) the greater of (i) $800 million and (ii) 0.75 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, plus additional amounts subject to certain agreed leverage requirements, certain other conditions and receipt of commitments by existing or additional lenders.

On January 21, 2020, the Company amended its Term Loan Facility to, among other things, reduce the applicable interest rate margin for the term loans by 0.75% to 3.75% with respect to LIBOR-based loans and 2.75% with respect to base rate loans.

On January 23, 2020, the Company made a prepayment of $400 million of term loans outstanding under the Term Loan Facility with a portion of the net proceeds from the sale-leaseback transaction with Medical Properties Trust completed effective December 17, 2019 (the "2019 Sale Leaseback Transaction"), which is discussed further in Note 8. After giving effect to the prepayment, the Company had prepaid all remaining quarterly amortization payments in respect of the Term Loan Facility.

On February 24, 2020, the Company closed the issuance of $600 million of incremental term loans (the "Incremental Term Loan") under the Term Loan Facility. The Incremental Term Loan bears interest at a rate equal to, at its option, (a) a LIBOR rate plus an applicable margin of 3.75% or (b) a base rate plus an applicable margin of 2.75%. There are no scheduled amortization payments required on the Incremental Term Loan prior to maturity. The net proceeds from the Incremental Term Loan, together with the net proceeds from the 4.375% Secured Notes and cash on hand, was used to fund the settlement of the tender offer, the redemption of the Company's 8.25% Senior Secured Notes due 2023 (the "8.25% Secured Notes") and the redemption of the Company's 11.5% Senior Notes due 2024 (the "11.5% Unsecured Notes") and to pay certain fees in connection with the refinancing transactions described herein.

On December 4, 2020, the Company made an optional prepayment of $500 million of term loans outstanding under the Term Loan Facility with the net proceeds from the offering of $500 million in aggregate principal amount of 5.375% Senior Notes due 2029 (the "5.375% Unsecured Notes"), together with cash on hand.

Collateral and Guarantors

All obligations under the Term Loan Facility are unconditionally guaranteed by Holdings on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Co-Borrowers, subject to certain exceptions. The obligations under the Term Loan Facility are secured by a pledge of the capital stock of the Company and substantially all of its assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy LifePoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the Non-ABL Priority Collateral and a second-priority lien with respect to the ABL Priority Collateral.

Interest Rates

Borrowings under the Term Loan Facility bear interest at a rate equal to, at the Company's option, either (a) a LIBOR rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an applicable margin of 3.75% for LIBOR loans and 2.75% for base rate loans.

Restrictive Covenants and Other Matters

The Term Loan Facility contains certain customary affirmative covenants and events of default. The negative covenants in the Term Loan Facility include, among other things, limitations (none of which are absolute) on the Co-Borrowers and their subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates enter into sale-leaseback transactions, change their lines of business, restrict dividends from subsidiaries or restrict liens, change their fiscal year and modify the terms of certain debt or organizational agreements.

The Term Loan Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the Term Loan Facility are entitled to take various actions, including the acceleration of amounts due under the Term Loan Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the Term Loan Facility.

6.75% Secured Notes

On April 13, 2020, the Company completed the offering of $600 million in aggregate principal amount 6.750% Senior Secured Notes due 2025 (the "6.75% Secured Notes"). The 6.75% Secured Notes will mature on April 15, 2025. Interest on the 6.75% Secured Notes will accrue at 6.75% per annum and will be paid semi-annually, in arrears, on April 15 and October 15 of each year, beginning October 15, 2020. The net proceeds from the offering were used for general corporate purposes.

The Company's obligations under the 6.75% Secured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Term Loan Facility and the 4.375% Senior Secured Notes due 2027 (the "4.375% Secured Notes"). The 6.75% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 6.75% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority Collateral.

Prior to April 15, 2022, the Company may redeem the 6.75% Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 6.75% Secured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to April 15, 2022, the Company may also redeem up to 40% of the original aggregate principal amount of the 6.75% Secured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 106.750%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 6.75% Secured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after April 15, 2022, the Company may redeem the 6.75% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of April 13, 2020 (as amended or supplemented from time to time, the "6.75% Secured Notes Indenture").

The 6.75% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions as described in the 6.75% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 6.75% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 6.75% Secured Notes Indenture also provides for customary events of default.

4.375% Secured Notes

On February 13, 2020, the Company completed the offering of $600 million in aggregate principal amount of its 4.375% Secured Notes. The 4.375% Secured Notes will mature on February 15, 2027. Interest on the 4.375% Secured Notes will accrue at 4.375% per annum and will be paid semi-annually, in arrears, on February 15 and August 15 of each year, beginning August 15, 2020. The net proceeds from the offering, together with the net proceeds from the Incremental Term Loan and cash on hand, were used to fund the settlement of the tender offer, the 8.25% Notes Redemption (as defined herein) and the 11.5% Notes Redemption (as defined herein) and to pay certain fees in connection with the refinancing transactions described herein.

The Company's obligations under the 4.375% Secured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Term Loan Facility. The 4.375% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 4.375% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority Collateral.

Prior to February 15, 2022, the Company may redeem the 4.375% Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 4.375% Secured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to February 15, 2022, the Company may also redeem up to 40% of the original aggregate principal amount of the 4.375% Secured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 104.375%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 4.375% Secured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after February 15, 2022, the Company may redeem the 4.375% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of February 13, 2020 (as amended or supplemented from time to time, the "4.375% Secured Notes Indenture").

The 4.375% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions as described in the 4.375% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 4.375% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 4.375% Secured Notes Indenture also provides for customary events of default.

9.75% Unsecured Notes

On November 16, 2018, concurrently with the closing of the LifePoint/RCCH Merger, the Company issued $1,425 million aggregate principal amount of 9.75% Unsecured Notes. The 9.75% Unsecured Notes will mature on December 1, 2026. Interest on the 9.75% Unsecured Notes accrues at 9.750% per annum and will be paid semi-annually, in arrears, on June 1 and December 1 of each year, beginning June 1, 2019.

The Company's obligations under the 9.75% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 9.75% Unsecured Notes and the related guarantees are unsecured obligations of the Company and the subsidiary guarantors.

After December 1, 2021, the Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of November 16, 2018 (as amended or supplemented from time to time, the "9.75% Unsecured Notes Indenture").

The 9.75% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 9.75% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 9.75% Unsecured Notes Indenture also provides for customary events of default.

5.375% Unsecured Notes

On December 4, 2020, the Company completed the offering of $500 million in aggregate principal amount of its 5.375% Unsecured Notes. The 5.375% Unsecured Notes will mature on January 15, 2029. Interest on the 5.375% Unsecured Notes will accrue at 5.375% per annum and will be paid semi-annually, in arrears, on January 15 and July 15 of each year, beginning July 15, 2021. The net proceeds of the offering, together with cash on hand, were used to prepay $500 million of the total aggregate principal amount outstanding under the Term Loan Facility and to pay related fees and expenses in connection with the offering.

The Company's obligations under the 5.375% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 5.375% Unsecured Notes and the related guarantees are unsecured obligations of the Company and the subsidiary guarantors.

Prior to January 15, 2024, the Company may redeem the 5.375% Unsecured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 5.375% Unsecured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to December 4, 2023, the Company may also redeem up to 40% of the original aggregate principal amount of the 5.375% Unsecured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 105.375%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 5.375% Unsecured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after January 15, 2024, the Company may redeem the 5.375% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of December 4, 2020 (the "5.375% Unsecured Notes Indenture").

The 5.375% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 5.375% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 5.375% Unsecured Notes Indenture also provides for customary events of default.

Tender Offer, Redemption and Discharge of 8.25% Secured Notes and 11.5% Unsecured Notes

On February 7, 2020, the Company commenced a tender offer and consent solicitation (the "tender offer") to purchase any and all of its outstanding (i) 8.25% Secured Notes issued pursuant to the indenture, dated as of April 29, 2016, among the Company, the guarantors party thereto and Wilmington Trust, National Association, as trustee (as amended, supplemented or otherwise modified, the "8.25% Secured Notes Indenture") and (ii) 11.5% Unsecured Notes issued pursuant to the indenture, dated as of April 29, 2016, among the Company, the guarantors party thereto and Wilmington Trust, National Association, as trustee (as amended, supplemented or otherwise modified, the "11.5% Unsecured Notes Indenture"). The early tender deadline for the tender offer was February 21, 2020, and the expiration date for the tender offer was March 6, 2020.

Upon expiration of the early tender deadline, on February 24, 2020, the Company accepted and purchased (i) $623 million of the aggregate principal amount of the 8.25% Secured Notes that were validly tendered for total consideration of $1,052.50 per $1,000 principal amount, plus accrued and unpaid interest thereon, and (ii) $84 million of the aggregate principal amount of the 11.5% Unsecured Notes that were validly tendered for a total consideration of $1,072.50 per $1,000 principal amount, plus accrued and unpaid interest thereon. Following the expiration of the tender offer, on March 9, 2020, the Company accepted and purchased an additional $0.2 million of the aggregate principal amount of the 8.25% Secured Notes that were validly tendered after the early tender deadline for a tender consideration of $1,022.50 per $1,000 principal amount, plus accrued and unpaid interest thereon. No additional 11.5% Unsecured Notes were tendered after the early tender deadline.

On March 9, 2020, (i) pursuant to the 8.25% Secured Notes Indenture, the Company provided notice to the holders that it had elected to redeem any and all of the 8.25% Secured Notes that remain outstanding after giving effect to the tender offer at a redemption price of 104.125%, plus accrued and unpaid interest thereon, on May 1, 2020 (the "8.25% Notes Redemption") and (ii) pursuant to the 11.5% Unsecured Notes Indenture, the Company provided notice to the holders that it had elected to redeem any and all of the 11.5% Unsecured Notes that remain outstanding after giving effect to the tender offer at a redemption price of 105.750%, plus accrued and unpaid interest thereon, on May 1, 2020 (the "11.5% Notes Redemption"). Concurrently with the delivery of the notices of redemption, on March 9, 2020, the Company (i) irrevocably deposited with the trustee for the 8.25% Secured Notes approximately $192 million, which was the amount sufficient to fund the 8.25% Notes Redemption and to satisfy and discharge the Company's obligations under the 8.25% Secured Notes and the 8.25% Secured Notes Indenture, and (ii) irrevocably deposited with the trustee for the 11.5% Unsecured Notes approximately $297 million, which was the amount sufficient to fund the 11.5% Notes Redemption and to satisfy and discharge the Company's obligations under the 11.5% Unsecured Notes and the 11.5% Unsecured Notes Indenture.

Debt Transaction Costs

The Company recognized $115 million of debt transaction costs associated with the various debt financing activities completed during 2020, which are included under the caption "Transaction-related costs" in the Company's accompanying consolidated statement of operations for the year ended December 31, 2020. These debt transaction costs were comprised of $61 million of early termination premiums associated with the tender offer, 8.25% Notes Redemption and 11.5% Notes Redemption, the write-off of $47 million of previously capitalized debt issuance costs associated with the Term Loan Facility, the 8.25% Secured Notes and the 11.5% Unsecured Notes and $7 million of other miscellaneous legal and financing costs.

Additionally, in connection with the offering of the 5.375% Unsecured Notes, the 6.75% Secured Notes, the 4.375% Secured Notes, the issuance of the Incremental Term Loan and the ABL FILO Term Loan, the Company capitalized $35 million of new debt issuance costs during the year ended December 31, 2020, which are included as a reduction to "Long-term debt, net" on the Company's accompanying consolidated balance sheet.

Finance Lease Obligations

Refer to Note 8 for discussion of the Company's finance lease obligations.

Interest Rate Swap Agreement

On December 21, 2018, the Company entered into an interest rate swap agreement with Citibank, N.A. as counterparty (the "Interest Rate Swap") whereby the Company paid a fixed rate of 2.63% on a notional amount of $1,100 million and received one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and terminated on February 19, 2022. Refer to Note 11 for additional information regarding the Company's accounting for its Interest Rate Swap.

Note 5. Goodwill and Intangible Assets

Goodwill

The following table presents the changes in the carrying amount of goodwill for the years ended December 31, 2021 and 2020 (in millions):

Balance at January 1, 2020	$	2,961
Write-off allocation related to 2020 divestiture		(41)
Other		(1)
Balance at December 31, 2020		2,919
Net goodwill impact related to the Kindred Transaction		1,013
Write-off allocation related to 2021 divestitures		(18)
Balance at December 31, 2021	$	3,914

Prior to the LifePoint/RCCH Merger, the Company historically determined that each of its hospitals represented a reporting unit in accordance with ASC 280 and ASC 350. Due to the significance of the LifePoint/RCCH Merger and its impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280 and ASC 350 during 2019 and determined that the consolidated business comprises a single reporting unit for goodwill impairment testing purposes. There were no changes in the Company's determination of reporting units for the years ended December 31, 2021 and 2020.

Under the current methodology, for which the consolidated Company comprises a single reporting unit, the Company performed goodwill impairment tests as of October 1, 2021 and 2020 and did not incur any impairment charges. Under the prior reporting unit methodology, for which each of the Company's hospitals represented a reporting unit, the Company performed a goodwill impairment test as of October 1, 2019 and recorded a non-cash impairment charge of $3 million related to one of its facilities, which is included under the caption "Other non-operating losses, net" in the Company's accompanying consolidated statement of operations for the year ended December 31, 2019.

Intangible Assets

The following table provides information regarding the Company's intangible assets included in the accompanying consolidated balance sheets as of December 31, 2021 and 2020 (in millions):

	2021	2020
Amortizable intangible assets:		
Physician minimum revenue guarantees and other		
Gross carrying amount	$ 24	$ 32
Accumulated amortization	(13)	(15)
Net total	11	17
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	28	29
Licenses, provider numbers, accreditations and other	46	12
Net total	74	41
Total intangible assets:		
Gross carrying amount	98	73
Accumulated amortization	(13)	(15)
Net total	$ 85	$ 58

Physician Minimum Revenue Guarantees

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or "physician minimum revenue guarantees," with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460, "Guarantees" ("ASC 460"). In accordance with ASC 460, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized as a component of other operating expenses, in the accompanying consolidated statements of operations, over the period of the physician contract, which typically ranges from four to five years.

Certificates of Need and Certificates of Need Exemptions

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and certain equipment at the Company's facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. The Company has acquired facilities in certain states that have adopted certificate of need laws. The Company has determined that these intangible assets have an indefinite useful life.

Licenses, Provider Numbers, Accreditations and Other

To operate hospitals, the Company must obtain certain licenses, provider numbers and accreditations from federal, state and other accrediting agencies. The Company has acquired facilities in certain jurisdictions that require licenses, provider numbers and accreditations.

Kindred Transaction

In connection with the Kindred Transaction, indefinite-lived intangible assets comprised of certificates of need and licenses totaling $41 million were transferred from ScionHealth to the Company, and indefinite-lived intangible assets comprised of certificates of need and provider numbers totaling $6 million were transferred from the Company to ScionHealth.

Amortization Expense

Amortization expense for the Company's intangible assets during the years ended December 31, 2021, 2020 and 2019 was $8 million, $9 million and $14 million, respectively.

Total estimated amortization expense for the Company's intangible assets during the next five years are as follows (in millions):

2022	$ 5
2023	3
2024	2
2025	1
	$ 11

Note 6. Income Taxes

For the years ended December 31, 2021 and 2020, the Company recognized a benefit from income taxes of $27 million and $64 million, respectively, compared to a provision for income taxes of $78 million for the year ended December 31, 2019. The benefit from income taxes recognized for the year ended December 31, 2021 is primarily a result of a reduction in the valuation allowance for certain deferred tax assets, partially offset by limitations on the tax deductibility of interest expense (back to its previous limitation of 30% of adjusted taxable income), stock-based compensation expense, write-offs of goodwill associated with divestitures and certain transaction and advisory costs recognized during the year ended December 31, 2021.

The (benefit from) provision for income taxes for the years ended December 31, 2021, 2020 and 2019 consisted of the following (in millions):

	2021	2020	2019
Current:			
Federal	$ 46	$ (73)	$ 68
State	5	8	8
	51	(65)	76
Deferred:			
Federal	23	99	(81)
State	(7)	38	(20)
	16	137	(101)
Change in valuation allowance	(94)	(136)	103
Total	$ (27)	$ (64)	$ 78

The following table reconciles the differences between the statutory federal income tax rate to the Company's effective tax rate on net income before income taxes and including net income attributable to noncontrolling interests and redeemable noncontrolling interests for the years ended December 31, 2021, 2020 and 2019:

	2021	2020	2019
Federal statutory rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal income tax benefits	(2.6)	3.8	(26.3)
Change in valuation allowance	(83.3)	(56.5)	171.0
Tax effect of goodwill write-offs and impairments	9.9	0.2	1.8
Noncontrolling interests and redeemable noncontrolling interests	-	(1.9)	(7.4)
State net operating loss carryforward expirations, refunds and rate change	-	10.4	-
Rate benefit from federal net operating loss carryback to 35% year	-	(3.8)	-
Nondeductible acquisition and merger-related costs	30.2	-	(24.2)
Other nondeductible expenses and other items	1.1	0.4	7.1
Effective income tax rate	(23.7) %	(26.4) %	143.0 %

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects were as follows as of December 31, 2021 and 2020 (in millions):

	2021	2020
Deferred income tax liabilities:		
Depreciation and amortization	$ (130)	$ (61)
Right-of-use operating lease assets	(61)	(99)
Tax deductible goodwill	(26)	(29)
Investments in partnerships	(123)	-
Other	(6)	(6)
Total deferred income tax liabilities	(346)	(195)
Deferred income tax assets:		
Provision for doubtful accounts	34	64
Employee compensation	51	64
Net operating loss carryforwards	109	99
Insurance reserves	76	72
Section 163(j) interest expense carryforward	47	14
Investments in partnerships	36	60
Right-of-use operating lease obligations	62	100
Deferred loss on sale of facilities	37	-
Other	52	64
Total deferred income tax assets	504	537
Valuation allowance	(197)	(360)
Net deferred income tax assets	307	177
Deferred income taxes	$ (39)	$ (18)

Noncurrent deferred income tax liabilities totaled $39 million and $18 million at December 31, 2021 and 2020, respectively, and are included under the caption “Other long-term liabilities” on the accompanying consolidated balance sheets. As of December 31, 2021, the Company had federal net operating loss carryforwards (“NOLs”) of approximately $31 million and state and local NOLs of approximately $3.2 billion that expire at various dates between 2022 and 2039 or have an indefinite carryforward period. The Company has established a valuation allowance for deferred tax assets at December 31, 2021 and 2020, due to the uncertainty of realizing these assets in the future. During the year ended December 31, 2021, we reduced our valuation allowance by $163 million as a result of the transfers and utilization of certain net deferred tax assets and liabilities between us and ScionHealth.

The Company made federal income tax payments of $50 million and $33 million for the years ended December 31, 2021 and 2020, respectively. No federal income tax payments were made during the year ended December 31, 2019. A net refund of federal income taxes previously paid by Legacy LifePoint for the tax year ended December 31, 2013, in the amount of $23 million was received during the year ended December 31, 2021 related to the carryback of the final Legacy LifePoint federal NOL generated for the year ended November 16, 2018, to the tax year ended December 31, 2013. In addition, the Company received a net refund of federal income taxes previously paid by Legacy LifePoint for the tax year ended December 31, 2017, in the amount of $59 million during the year ended December 31, 2019. The 2017 tax year refund resulted from an automatic accounting method change, for tax purposes, related to income recognition made by Legacy LifePoint. The Company made net state and local income tax payments in the amount of $17 million, $5 million, and $1 million for the years ended December 31, 2021, 2020 and 2019, respectively.

The Company’s policy is to accrue interest and penalties related to potential underpayment of income taxes within the provision for income taxes. Interest is computed on the difference between the Company’s uncertain tax benefit positions and the amount deducted or expected to be deducted in our income tax returns.

The Company files a consolidated U.S. federal income tax return, as well as income tax returns in various state jurisdictions. All of the Company’s tax years are subject to examination by the Internal Revenue Service and various state taxing authorities.

Note 7. Other Current Liabilities

The following table provides information regarding the Company's other current liabilities, which are included in the accompanying consolidated balance sheets at December 31, 2021 and 2020 (in millions):

	2021	2020
Accrued interest	$ 44	$ 33
Current portion of self-insurance reserves	79	82
Self-insured medical benefits liabilities	46	38
Current portion of right-of-use operating lease obligations	61	44
Accrued property taxes	23	20
Medicaid supplemental payment program provider taxes	23	24
Liabilities held for sale	-	129
Accrued expenses and other	245	221
	$ 521	$ 591

Note 8. Leases

Summary

The Company leases real property and equipment under finance and operating leases. The leases expire at various times and have various renewal options. For leases with terms greater than 12 months, the Company records the related assets and obligations at the present value of lease payments over the term. Interest rates used in computing the present value of the lease payments are based on the Company's incremental borrowing rate at the inception of the lease. The Company's lease agreements generally require the Company to pay maintenance, repairs, taxes and insurance costs.

The following table presents certain information related to the Company's lease assets and liabilities at December 31, 2021 and 2020 (dollars in millions):

	Balance Sheet Classification	2021	2020
Assets:			
Finance leases	Property and equipment, net	$ 635	$ 678
Operating leases	Other long-term assets	609	368
Total lease assets		$ 1,244	$ 1,046
Liabilities:			
Current:			
Finance leases	Current maturities of long-term debt	$ 106	$ 30
Operating leases	Other current liabilities	61	44
Long-term:			
Finance leases	Long-term debt, net	805	1,018
Operating leases	Other long-term liabilities	546	335
Total lease liabilities		$ 1,518	$ 1,427
Weighted-average remaining term (in years):			
Finance leases		13.2	22.6
Operating leases		10.1	12.9
Weighted-average discount rate:			
Finance leases		6.4 %	7.9 %
Operating leases		7.3 %	8.9 %

The following table presents certain information related to finance and operating lease expense for the years ended December 31, 2021, 2020 and 2019 (in millions):

	Statement of Operations Classification	2021	2020	2019
Finance lease expense:				
Amortization related to lease assets	Depreciation and amortization	$ 44	$ 47	$ 28
Interest related to lease liabilities	Interest expense, net	82	91	36
Operating lease expense	Other operating expenses, net	76	86	80
Short-term, variable and other lease expense	Other operating expenses, net	45	47	48
Total lease expense		$ 247	$ 271	$ 192

The following table presents supplemental cash flow information related to finance and operating leases for the years ended December 31, 2021, 2020 and 2019 (in millions):

	2021	2020	2019
Operating cash flows related to operating leases	$ 118	$ 128	$ 123
Operating cash flows related to finance leases	$ 79	$ 82	$ 33
Financing cash flows related to finance leases	$ 29	$ 20	$ 19

The following table reconciles the undiscounted cash flows to the finance and operating lease obligations included in the consolidated balance sheet at December 31, 2021 (in millions):

	Finance Leases	Operating Leases
2022	$ 147	$ 105
2023	75	101
2024	75	88
2025	83	83
2026	76	76
Thereafter	707	406
Total minimum lease payments	1,163	859
Less: Amounts attributable to interest	(575)	(252)
Present value of minimum lease payments	588	607
Non-cash portions of finance lease obligations	323	-
Less: Current portions of lease obligations	(106)	(61)
Long-term portion of lease obligations	$ 805	$ 546

Kindred Transaction

In connection with the Kindred Transaction, right-of-use operating lease assets and liabilities of $439 million and $435 million, respectively, were transferred from ScionHealth to the Company, and right-of-use operating lease assets and liabilities of $21 million and $22 million, respectively, were transferred from the Company to ScionHealth. Additionally, the Company transferred finance lease obligations with a carrying value of $332 million to ScionHealth.

2021 Lease Modifications

On August 1, 2021, the Company sold KershawHealth, which was subject to the Amended and Restated Master Lease Agreement with certain affiliates of Medical Properties Trust, Inc. (“MPT”), dated March 21, 2016 (the “A&R Capella Master Lease”) and paid $28 million to MPT to terminate its lease obligation associated with KershawHealth. The removal of KershawHealth from the A&R Capella Master Lease triggered a lease modification for accounting purposes in accordance with ASC 842, which resulted in the reclassification of right-of-use operating lease assets and obligations of $98 million and $106 million, respectively, related to certain other properties subject to the A&R Capella Master Lease, to property and equipment and finance lease obligations of $129 million and $137 million, respectively.

Effective December 23, 2021, the Company terminated the A&R Capella Master Lease, the Amended and Restated Hot Springs Master Lease Agreement with certain affiliates of MPT, dated March 21, 2016 (the "Hot Springs Lease") and the 2019 Master Lease (defined below), and certain subsidiaries of the Company entered into a new master lease agreement with certain affiliates of MPT, dated December 23, 2021, with respect to ten of the Company's facilities (the "2021 Master Lease"). The 2021 Master Lease has a term of 15 years. The entry into the 2021 Master Lease triggered a lease modification for accounting purposes in accordance with ASC 842, which resulted in the reclassification of right-of-use operating lease assets and obligations of $61 million and $66 million, respectively, related to the Hot Springs Lease, to property and equipment and finance lease obligations of $41 million and $46 million, respectively. All of the facilities subject to the 2021 Master Lease are accounted for as finance leases as of December 31, 2021. Additionally, as a result of decreases in the lease term and discount rates associated with the 2021 Master Lease, the Company's finance lease obligations include a non-cash end-of-term deferred gain of $316 million.

2019 Sale Leaseback Transaction

Effective December 17, 2019, certain subsidiaries of the Company (collectively, the "2019 LifePoint Entities") entered into a Real Property Asset Purchase Agreement (the "Real Property APA") with certain affiliates of MPT (the "2019 Sale Leaseback Transaction"). Pursuant to the Real Property APA, the 2019 LifePoint Entities sold the real estate of eleven facilities to certain affiliates of MPT, and immediately thereafter the 2019 LifePoint Entities and certain affiliates of MPT entered into an agreed upon master lease agreement dated December 17, 2019 (the "2019 Master Lease").

In connection with the 2019 Sale Leaseback Transaction, the Company received an aggregate amount of sale proceeds of $700 million and incurred $18 million of transaction-related expenses, which is included under the caption "Transaction-related costs" in the accompanying consolidated statement of operations for the year ended December 31, 2019.

Lease Covenants

Certain of the Company's lease agreements contain financial covenants based on certain fixed charges. The failure to meet or obtain a waiver of such covenants or otherwise cure such non-compliance could result in an event of default under the applicable lease.

Note 9. Investments

Investments

The Company accounts for its investments in entities in which the Company does not control under either the cost method or the equity method of accounting in accordance with ASC 321 or ASC 323, respectively. The Company does not consolidate its cost and equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period or evaluates them for impairment and observable price changes. Investment income is included under the caption "Other operating expenses, net" in the accompanying consolidated statements of operations.

The following table presents the changes in the Company's investments during the years ended December 31, 2021 and 2020 (in millions):

Balance at January 1, 2020	$	274
Income		44
Contributions		4
Distributions and other		(42)
Sale of equity method investment		(24)
Balance at December 31, 2020		256
Income		83
Contributions		7
Distributions and other		(61)
ScionHealth Class B Units		350
Other investments recognized in connection with the Kindred Transaction		20
Balance at December 31, 2021	$	655

ScionHealth Class B Units

In connection with the Kindred Transaction, LifePoint acquired Class B Units in ScionHealth (the "Class B Units") with an aggregate value of $350 million. The Class B Units in ScionHealth, a privately held company, do not have a readily determinable fair value, and therefore, the Company has accounted for the Class B Units using the measurement alternative in accordance with ASC 321. The Company's investment in the Class B Units was recorded at $350 million and there were no observable price changes or transactions between the date of acquisition and December 31, 2021. The Class B Units are perpetual non-convertible non-voting units that accrue cumulative dividends at the rate of 10.00% per annum and, upon liquidation, are entitled to a return of their nominal value issue price plus accrued, unpaid dividends.

Note 10. Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling Interests

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

The following table presents the changes in the Company's noncontrolling interests during the years ended December 31, 2021 and 2020 (in millions):

Balance at January 1, 2020	$	26
Net income attributable to noncontrolling interests		8
Distributions		(2)
Balance at December 31, 2020		32
Net income attributable to noncontrolling interests		5
Distributions		(3)
Noncontrolling interests recognized in connection with the Kindred Transaction		317
Balance at December 31, 2021	$	351

Redeemable Noncontrolling Interests

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

The following table presents the changes in the Company's redeemable noncontrolling interests during the years ended December 31, 2021 and 2020 (in millions):

Balance at January 1, 2020	$	148
Reclassification of equity to redeemable noncontrolling interests related to Emory joint venture		26
Net income attributable to redeemable noncontrolling interests		14
Fair value adjustments		5
Distributions and repurchases		(12)
Balance at December 31, 2020		181
Net income attributable to redeemable noncontrolling interests		4
Distributions and repurchases		(23)
Redeemable noncontrolling interests transferred in connection with the Kindred Transaction		(23)
Balance at December 31, 2021	$	139

Note 11. Fair Value of Financial Instruments

Fair Value Hierarchy

Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the fair value hierarchy pursuant to ASC 820, "Fair Value Measurements and Disclosures" ("ASC 820") that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

Level 1: Quoted market prices in active markets for identical assets or liabilities.
Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.
Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability.

Cash and Cash Equivalents, Accounts Receivable, Accounts Payable and Other Current Liabilities

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

Long-Term Debt

The carrying amounts and fair values of the Company's ABL Facility, Term Loan Facility, 6.75% Secured Notes, 4.375% Secured Notes, 9.75% Unsecured Notes and 5.375% Unsecured Notes, excluding unamortized debt issuance costs and premium, as of December 31, 2021 and December 31, 2020 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2021	December 31, 2020	December 31, 2021	December 31, 2020
ABL Facility	$ -	$ -	$ -	$ -
Term Loan Facility	$ 3,215	$ 3,215	$ 3,211	$ 3,211
6.75% Secured Notes	$ 600	$ 600	$ 626	$ 641
4.375% Secured Notes	$ 600	$ 600	$ 603	$ 600
9.75% Unsecured Notes	$ 1,425	$ 1,425	$ 1,500	$ 1,557
5.375% Unsecured Notes	$ 500	$ 500	$ 493	$ 496

The fair values of the Company's long-term debt instruments were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820.

Interest Rate Swap

The Company measures its Interest Rate Swap at fair value on a recurring basis. The fair value of the Company's Interest Rate Swap is based on quotes from its counterparty. The Company considers those inputs to be Level 2 in the fair value hierarchy. At December 31, 2021 and 2020, the fair value of the Company's Interest Rate Swap was a total liability of $4 million and $31 million, respectively. At December 31, 2021, the total liability is included under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheet. Of the total liability at December 31, 2020, $26 million is included under the caption "Other current liabilities" and $5 million is included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheet.

The Company has not designated its Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging." Accordingly, all changes in the fair value of the Company's Interest Rate Swap are recognized through interest expense in its statements of operations. The Company recognized non-cash interest income of $27 million during the year ended December 31, 2021, compared to non-cash interest expense of $7 million and $19 million during the years ended December 31, 2020 and 2019, respectively, related to changes in the fair value of its Interest Rate Swap. The Interest Rate Swap terminated on February 19, 2022.

Financial Liabilities

The Company has a contingent consideration liability payable to the former owners of Canyon Vista Medical Center ("Canyon Vista") that represents the Level 3 estimated fair value of the contingent consideration using unobservable inputs and assumptions available to the Company. The key assumptions used in estimating the fair value of the Canyon Vista contingent consideration liability are the range of probabilities that the payments will be earned by the seller and a discount rate adjusted for the Company's credit risk.

At December 31, 2021 and 2020, the Canyon Vista contingent consideration liability was recorded at an estimated fair value of $19 million, of which $2 million is included under the caption "Other current liabilities" at December 31, 2021 and 2020, and $17 million is included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheets. For the year ended December 31, 2020, the Company recognized a non-cash charge of $5 million related to the change in the estimated fair value of the Canyon Vista contingent consideration liability, which is included under the caption "Other non-operating losses, net" on the accompanying consolidated statement of operations.

Note 12. Employee Benefit Plans

Defined Benefit Pension Plans

In connection with the LifePoint/RCCH Merger, the Company acquired certain assets and assumed certain liabilities associated with two separate defined benefit pension plans (i) associated with certain employees of Marquette General Hospital covered by a collective bargaining agreement (the "Marquette Pension Plan") and (ii) associated with certain non-union employees of Bell Hospital (the "Bell Pension Plan" and, collectively with the Marquette Pension Plan, the "Pension Plans"). Both Pension Plans are closed to new participants. Participants in the Marquette Pension Plan are required to make annual contributions totaling 6% of annual compensation to the Marquette Pension Plan to continue accruing benefits. Participants in the Bell Pension Plan no longer accrue benefits. The Company makes contributions to the Pension Plans sufficient to meet its minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended.

Status and Expense

The following table presents the changes in the benefit obligations and plan assets of the Pension Plans during the years ended December 31, 2021 and 2020 and the unfunded liability of the Pension Plans at December 31, 2021 and 2020 (in millions):

	2021	2020
Change in benefit obligations:		
Benefit obligations at beginning of year	$ 77	$ 70
Service costs	1	1
Interest costs	2	2
Actuarial (gain) loss	(4)	6
Benefits paid	(3)	(2)
Benefit obligations at end of year	73	77
Change in plan assets:		
Fair value of plan assets at beginning of year	54	47
Actual return on plan assets	5	7
Employer contributions	2	2
Benefits and expenses paid	(2)	(2)
Fair value of plan assets at end of year	59	54
Unfunded pension benefit obligations	$ 14	$ 23

The Company recognizes changes in the funded status of the Pension Plans as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). For the year ended December 31, 2021, the Company recognized a comprehensive gain of $6 million as an increase in equity. For the years ended December 31, 2020 and 2019, the Company recognized a comprehensive loss of $1 million and $5 million, respectively, as a decrease in equity. These adjustments were primarily related to changes in the Company's unfunded pension liability due to changes in the discount rates and mortality assumptions used to measure the projected benefit obligation.

The following table summarizes the projected benefit obligation, accumulated benefit obligation and fair value of plan assets related to the Pension Plans as of December 31, 2021 and 2020 (in millions):

	2021	2020
Projected benefit obligation	$ 74	$ 77
Accumulated benefit obligation	$ 70	$ 72
Fair value of plan assets	$ 59	$ 54

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligation as of December 31, 2021 and 2020 (in millions):

	2021	2020
Discount rate	2.8 %	2.5 %
Rate of compensation increases, when applicable	3.0 %	3.0 %

Plan Assets

The investment policy for the Pension Plans has been formulated to achieve a risk adjusted return that balances the need for asset growth against the risk of significant fluctuations in asset prices and the need for significant contributions from the Company. On a quarterly basis, or more frequently as necessary, the current risk levels, asset performance and expected return on assets are reviewed and evaluated against goals and targets by a committee appointed to oversee investment of the Pension Plans' assets (the "Investment Committee"). The Investment Committee strives to maintain a balance between risk and return through the use of modern portfolio theory methods, in conjunction with Monte Carlo modeling to evaluate the behavior of the portfolio under different scenarios. At December 31, 2021, the Pension Plans' investments include a balance of mutual funds and money market funds in order to achieve an overall rate of return that minimizes the need for additional employer contributions. The Company measures the fair value of its Pension Plans' assets in accordance with ASC 820.

The Pension Plans' investments in mutual funds are valued at the net asset value ("NAV") of shares reported in the active market in which the funds are traded. Because quoted prices are available for mutual funds and the markets in which they are traded are generally considered active, the Company has classified each of them as a Level 1 investment. The Pension Plans' investments in money market funds are valued at quoted prices in markets that are not active by a combination of inputs, including but not limited to dealer quotes who are market makers in the underlying funds and other directly and indirectly observable inputs. Because the inputs used to value money market funds are either directly or indirectly observable, but are not quoted prices in active markets, the Company has classified these assets as Level 2 investments. The Pension Plans' investments in pooled, common and collective funds are valued at the NAV of shares owned based on the readily determinable quoted market price that each fund publishes at the end of each day. While the underlying assets are actively traded on an exchange, the pooled, common and collective funds are not and, therefore, the Company has classified these assets as Level 2 investments.

The following table summarizes the assets of the Pension Plans, measured at fair value as of December 31, 2021 and 2020, by major asset category and aggregated by level within the fair value hierarchy (in millions):

	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
December 31, 2021:				
Mutual funds	$ 2	$ -	2	-
Money market funds	39	39	-	-
Pooled, Common and Collective Funds	18	-	18	-
Total	$ 59	$ 39	$ 20	$ -
December 31, 2020:				
Mutual funds	$ 52	$ 52	$ -	$ -
Money market funds	2	-	2	-
Total	$ 54	$ 52	$ 2	$ -

The Company expects to contribute approximately $2 million to the Pension Plans during the year ended December 31, 2022. Additionally, the Company expects to make future benefit payments from the Pension Plans as follows for the years indicated (in millions):

2022	$ 3
2023	3
2024	3
2025	3
2026	4
Five years thereafter	18
	$ 34

Multiemployer Pension Plan

In connection with the LifePoint/RCCH Merger, the Company assumed the obligation to contribute to a multiemployer pension plan on behalf of certain employees covered by collective bargaining agreements, in accordance with the terms of such collective bargaining agreements. The Company's contributions to the multiemployer pension plan are determined based on the terms of the applicable collective bargaining agreements. Multiemployer plans are different from single-employer plans because assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers. Also, if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers. If the Company stops participating in the multiemployer plan, the Company may be required to pay a withdrawal liability based on its portion of the unfunded status of the plan. Currently, the Company does not anticipate ending its participation in this plan.

Defined Contribution Plans

During 2021, the Company maintained a defined contribution retirement plan covering a majority of its employees and a separate defined contribution retirement plan covering the employees at Community Medical Center. These defined contribution plans contain discretionary matching contribution formulas and definite non-elective contribution formulas for employees at certain facilities. The Company's expense related to its defined contribution plans was $30 million for the year ended December 31, 2021 and $31 million for each of the years ended December 31, 2020 and 2019, respectively. Effective as of the end of the day on December 31, 2021, the plan covering Community Medical Center employees was merged into the plan covering LifePoint Employees.

Deferred Compensation Plans

The Company maintains supplemental deferred compensation plans with respect to certain of its employees and affiliated physicians. As of December 31, 2021 and 2020, the assets associated with these deferred compensation plans were $64 million and $56 million, respectively, and the liabilities were $68 million and $60 million, respectively. These amounts are included under the captions "Other long-term assets" and "Other long-term liabilities", respectively, on the accompanying consolidated balance sheets at December 31, 2021 and 2020.

Note 13. Stock-Based Compensation

The Parent is authorized to issue profits units (the "Units") to employees, executives, and directors of the Company, under the terms and conditions of the Parent Partnership Agreement. The Company has determined that the Units are a substantive class of members' equity for accounting purposes because the Units are legal equity of the Parent, they have participation features, including distribution and liquidation rights, which allow them to participate in the residual returns of the Parent and vested interests are retained upon termination. As a result, these awards are accounted for under ASC 718, "Compensation – Stock Compensation" ("ASC 718").

In June 2021, certain affiliates of the Parent completed the sale of the Parent, including the Company and its subsidiaries, to other affiliates of the Parent (the "Parent Transaction"). Following the Parent Transaction, the Company continues to be owned by affiliates of the Parent and the transaction had no business or operational impact on the Company. However, in connection with the Parent Transaction, all unvested and outstanding Units held by certain current employees, executives, and directors of the Company became vested. The Company has accounted for this event as a modification in accordance with ASC 718 and recognized additional stock-based compensation expense of $112 million during the nine months ended September 30, 2021 related to the modification and accelerated vesting of such Units. Additionally, for the nine months ended September 30, 2021, the Company made cash distributions to the Parent of $93 million to partially fund the Parent's repurchase of certain previously issued Units and capital units, primarily held by certain former employees, as well as certain current employees, executives, and directors of the Company.

Following the Parent Transaction, on June 25, 2021, an aggregate of 20,775,000 Units were granted to certain executives and employees of the Company under the Parent Partnership Agreement and a newly adopted equity incentive plan and an additional 1,000,000 Units were granted on September 28, 2021.

Service Units

Service Units have been granted to certain members of the board of directors, but there are none currently outstanding, and Tranche A Units to certain of our and our affiliates' employees, executives and consultants. Units that have been granted to members of the board of directors vest on a time-basis only, on the date that is the earliest of (i) six months and one day following grant date or (ii) the date of the applicable director's termination of service due to death, disability or as a result of the director's removal from the board of directors other than for cause. Tranche A Units granted to certain employees, executives and consultants vest in equal installments on the last day of each of the first twenty calendar quarters that commence on or after the grant date. Service Units will automatically vest upon the sale of the Company. In the event of an initial public offering, all unvested Service Units will remain outstanding and continue to vest based on the stated vesting pattern. Unvested Service Units are forfeited upon a holder's termination of service.

Service Units are accounted for as equity awards and related compensation expense is recognized ratably over the vesting period. As of December 31, 2021, Service Units had unrecognized compensation expense of $23 million. The expense is expected to be recognized over a weighted-average period of 2.4 years from December 31, 2021.

Performance Units

Performance Units, which have been granted as Tranche B Units and Tranche C Units, will vest based upon equity holders of the Parent realizing certain targeted multiples of invested capital ("MOIC thresholds"). Performance Units are accounted for as equity awards with expense recognition occurring upon the realization of the stated MOIC thresholds due to a liquidity event. Unvested Units that do not vest on termination are forfeited upon such termination, subject to certain conditions.

The following table summarizes the Company's total stock-based compensation expense for the years ended December 31, 2021, 2020 and 2019 (in millions):

	2021	2020	2019
Service Units	$ 30	$ 2	$ 4
Performance Units	87	-	1
	117	2	5
Modification expense for awards classified as a liability	-	3	3
Total stock-based compensation expense	$ 117	$ 5	$ 8

Valuation Assumptions

The fair value of all Units was determined using a Monte Carlo simulation framework. The following table shows the weighted average assumptions used by the Company to develop the fair value estimates and the resulting estimates of weighted-average fair value per Unit granted during the years ended December 31, 2021, 2020 and 2019:

	2021	2020	2019
Common equity value of the Company (in millions)	$ 3,600	$ 1,999	$ 1,672
Expected volatility	63.1 %	48.0 %	38.0 %
Risk-free interest rate	0.92 %	0.60 %	2.90 %
Expected dividends	-	-	-
Average expected term (years)	5.0	3.7	5.0

Units Activity

The following represents the activity of the Units for the years ended December 31, 2021, 2020 and 2019:

	Service Units		Performance Units			
	Tranche A and Units to the Board	Weighted Average Grant Date Fair Value per Unit	Tranche B	Weighted Average Grant Date Fair Value per Unit	Tranche C	Weighted Average Grant Date Fair Value per Unit
Unvested at January 1, 2019	2,709,758	$ 0.97	4,475,010	$ 0.47	2,237,505	$ 0.31
Granted	6,996,576	1.23	6,868,920	0.80	3,884,460	0.63
Vested	(2,893,910)	1.07	(891,400)	0.54	-	-
Forfeited	(85,044)	1.18	(136,640)	0.60	(514,020)	0.38
Unvested at December 31, 2019	6,727,380	1.19	10,315,890	0.68	5,607,945	0.53
Granted	2,197,487	1.08	2,103,320	1.08	1,051,660	1.08
Vested	(2,217,947)	1.10	-	-	-	-
Forfeited	(75,100)	1.19	(110,000)	0.74	(55,000)	0.60
Unvested at December 31, 2020	6,631,820	1.19	12,309,210	0.75	6,604,605	0.61
Granted	7,329,723	3.51	7,258,331	2.39	7,258,316	2.04
Vested	(7,381,809)	1.41	(12,221,590)	0.75	(6,560,795)	0.61
Forfeited	(30,529)	1.18	(87,620)	0.58	(43,810)	0.38
Unvested at December 31, 2021	6,549,205	$ 3.53	7,258,331	$ 2.39	7,258,316	$ 2.04

Note 14. Commitments and Contingencies

Capital Expenditure Commitments

The Company is reconfiguring some of its facilities to more effectively accommodate patient services and to provide for a greater variety of services. The Company has incurred approximately $162 million in costs related to uncompleted projects as of December 31, 2021, which is included under the caption "Property and equipment, at cost" in the Company's accompanying consolidated balance sheet. At December 31, 2021, these uncompleted projects had an estimated cost to complete of approximately $179 million. The estimated timeframe for completion of these projects generally ranges from less than one year up to two years. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities. At December 31, 2021, the Company estimated its total remaining capital expenditure commitments to be approximately $738 million. The majority of this amount represents long-term commitments that are computed as a percentage of revenues.

Legal Proceedings and General Liability Claims

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

In addition, the Company is subject to the regulation and oversight of various state and federal governmental agencies. Further, under the False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against healthcare facilities that submit false claims for payments to, or improperly retain identified overpayments from, governmental payers. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without the Company's knowledge. If a provider is found to be liable under the False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus substantial civil monetary penalties that are subject to annual adjustment for inflation for each separate false claim.

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

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

The Company accrues an estimate for a contingent liability when losses are both probable and reasonably estimable. The Company reviews its accruals each quarter and adjusts them to reflect the impact of developments, advice of legal counsel and other information pertaining to a particular matter.

Note 15. Subsequent Events

In accordance with the provisions of ASC 855, "Subsequent Events," the Company evaluated all material events subsequent to the balance sheet date through April 5, 2022, the date of issuance, for events requiring disclosure or recognition in the Company's consolidated financial statements. There were no subsequent events requiring disclosure or recognition in the Company's consolidated financial statements other than those noted below or included elsewhere in this Report.

Entry into Agreement to Sell Colorado Plains Medical Center and Western Plains Medical Complex

On January 31, 2022, the Company entered into a definitive agreement with an unrelated third-party to sell Colorado Plains Medical Center, located in Fort Morgan, Colorado, and Western Plains Medical Complex, located in Dodge City, Kansas. The Company expects the transaction to close in the second quarter of 2022.

Investment in ScionHealth Term Loan Facility

On March 10, 2022, certain of the Company's subsidiaries invested approximately $47 million for an aggregate $50 million face amount of ScionHealth's senior secured term loan principal.

SIGNATURES

LifePoint Health, Inc. has caused this Report to be signed on its behalf by the undersigned thereunto duly authorized.

LIFEPOINT HEALTH, INC.

Date: April 5, 2022

By: /s/ Michael S. Coggin
Michael S. Coggin
Executive Vice President and Chief Financial Officer

ANNUAL REPORT

OF

LIFEPOINT HEALTH, INC.

FOR THE

FISCAL YEAR ENDED DECEMBER 31, 2022

PREPARED IN ACCORDANCE WITH

ANNUAL REPORT ON FORM 10-K
(AS MODIFIED UNDER DEBT AGREEMENTS)

Lifepoint Health, Inc.
(Exact Name of Company as Specified in Its Charter)

Delaware	**27-0500485**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**

330 Seven Springs Way **Brentwood, Tennessee**	**37027**
(Address of Principal Executive Offices)	**(Zip Code)**

(615) 920-7000
(Company's Telephone Number, Including Area Code)

Lifepoint Health, Inc.

Annual Report

For the Fiscal Year Ended December 31, 2022

TABLE OF CONTENTS

DISCLOSURE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report for the fiscal year ended December 31, 2022 (this "***Report***") contains forward-looking statements that involve risks and uncertainties. Forward-looking statements include any statements that address future results or occurrences. In some cases, you can identify forward-looking statements by terminology such as: "may," "might," "will," "would," "should," "could" or the negatives thereof. Generally, the words "anticipate," "believe," "continue," "expect," "intend," "estimate," "project," "plan" and similar expressions identify forward-looking statements. In particular, statements about our expectations, beliefs, plans, objectives, assumptions or future events or performance contained elsewhere in this Report are forward-looking statements. These forward-looking statements include statements that are not historical facts, including statements concerning our possible or assumed future actions and business strategies. We have based these forward-looking statements on our current expectations, assumptions, estimates and projections. While we believe these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks, uncertainties and other factors, many of which are outside of our control, which could cause our actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. Such factors include, among others, the following:

- uncertainty about the effect that pending acquisitions may have on our business, financial condition, results of operations, employees, patients local communities, business relationships and other parties, and the possibility that the anticipated benefits from pending acquisitions will not be realized within the timeframe expected or at all;
- uncertainty about the effect that integrating acquired facilities, including our expansion and diversification into new services and segments may continue to have on our employees, patients, local communities, business relationships and other parties, and the possibility that the anticipated benefits from the acquired facilities will not be realized within the timeframe expected or at all;
- the length and severity of the evolving and ongoing novel coronavirus ("***COVID-19***") pandemic, the measures we are taking to respond to the pandemic, the vaccination rates in the communities we serve, the number and severity of variants of the virus, and the effectiveness of vaccines against the virus (and any variants) on a widespread basis, and the potential impact of sudden increases and fluctuations in the volume of COVID-19 patients cared for across our facilities;
- the uncertainty of future patient volumes and related revenues, including shifts from in-person patient services to telehealth services;
- supply shortages, workforce disruptions or shortages and increased costs of providing care to our patients, including increased equipment, staffing and supply expenses;
- the emergence of and effects related to other pandemics, epidemics and highly contagious infectious diseases;
- payment changes, including policy considerations and changes resulting from federal and state budgetary restrictions;
- impact from or likelihood of the repeal of, or material modification to, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "***Affordable Care Act***"), as a result of court or legislative action;
- potential impact from the repeal of the penalties associated with the "***individual mandate***" to purchase health insurance under the Affordable Care Act, included in the Tax Cuts and Jobs Act of 2017;
- impact from changes to or limitations on Medicaid supplemental payment programs;
- our compliance with new and existing laws and regulations, as well as costs and benefits associated with compliance;
- any potential action brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the "qui tam" or "whistleblower" provisions of the federal False Claims Act (the "***False Claims Act***");
- impact from the changes in payer mix marked by a shift of patients from private insurance to Medicare and Medicaid programs;
- our acquisition strategy, including healthcare delivery network diversification and integration risks relating to future acquisitions such as our most recently acquired IRFs (as defined in this Report);
- the potential for material obligations if we acquire facilities with unknown or contingent liabilities;
- claims and legal actions relating to professional liabilities and other litigation risks;
- delayed payments and repayments resulting from reviews of claims to Medicare and Medicaid for our services;
- impact of controls imposed by payers designed to reduce inpatient services;
- risks associated with outsourcing functions to third parties;
- our relationships with our joint venture partners;
- changes in physician employment regulations;
- increases in the amount and risk of collectability of patient accounts receivable, particularly in connection with the increase in the unemployment rate and number of underinsured and uninsured patients as a result of the continuing COVID-19 pandemic or other factors;
- our need to make investments continually in our processes and information systems to protect the privacy of patients, employees and other persons and reduce the risk of successful cybersecurity attacks;
- damage to our reputation, regulatory penalties, legal claims and liability under state and federal laws that we could suffer upon any cybersecurity or privacy breaches;
- anticipated capital expenditures, including routine projects, investments in information systems and capital projects related to acquisitions, construction of new facilities and construction projects and the expectation that capital commitments could be a component of future acquisitions;

- effects of competition in a facility's market;
- changes in industry and general economic trends, including macroeconomic conditions negatively impacted by the COVID-19 pandemic, general inflationary pressures, significant disruptions to global supply networks, and an extremely competitive labor market;
- recruitment and retention of senior executives, qualified management, experienced physicians and nurses, and other healthcare professionals;
- our ability to acquire facilities on favorable terms and successfully complete asset sales and divestitures;
- effects of union organizing activities;
- potential recoupment of previously recognized income from electronic health record ("***EHR***") incentive programs;
- timeframes for completion of capital projects;
- changes in depreciation and amortization expenses;
- accounting estimates and the impact of accounting methodologies and new accounting pronouncements;
- consolidation of commercial insurance companies and patient shifts to lower cost healthcare plans, including association health plans and short-term limited duration health insurance plans, which generally provide lower payment for services rendered;
- participation in the healthcare insurance exchanges (the "***Exchanges***") and the impact of increasing enrollment by patients in insurance plans with narrow networks, tiered networks, high deductibles or high co-payments;
- governmental or third-party investigations, legal actions and voluntary self-disclosures relating to overpayments or other regulatory compliance matters;
- the ability of our local management teams to identify and meet the needs of our patients, medical staffs and their communities;
- the efforts of insurers, healthcare providers and others to contain healthcare costs;
- our ability to obtain adequate levels of general and professional liability insurance;
- our ability to implement initiatives promoting cost reductions and operational efficiencies;
- possible future indebtedness that may be incurred; and
- other factors referenced under the caption "Risk Factors" in this Report.

Given these uncertainties, readers are cautioned not to place undue reliance on such forward-looking statements. We disclaim any obligation to update any such factors or to announce the result of any revisions to any of the forward-looking statements contained herein to reflect future results, events or developments.

Statements in this Report are made as of the date hereof unless stated otherwise. New factors emerge from time to time, and it is not possible to predict all such factors.

EXPLANATORY INFORMATION REGARDING THIS REPORT

This Report has been prepared in accordance with the obligations of the Company under (i) Section 4.02 of the Indenture, dated as of December 4, 2020 (the "***5.375% Unsecured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee ("***Wilmington Trust***"), relating to the Company's 5.375% Senior Notes due 2029 (the "***5.375% Unsecured Notes***"), (ii) Section 4.02 of the Indenture, dated as of April 13, 2020 (as amended or supplemented from time to time, the "***6.75% Secured Notes Indenture***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, as trustee and notes collateral agent, relating to the Company's 6.750% Senior Secured Notes due 2025 (the "***6.75% Secured Notes***"), (iii) Section 4.02 of the Indenture, dated as of February 13, 2020 (as amended or supplemented from time to time, the "***4.375% Secured Notes Indenture***") among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, as trustee and notes collateral agent, relating to the Company's 4.375% Senior Secured Notes due 2027 (the "***4.375% Secured Notes***"), (iv) Section 4.02 of the Indenture, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***9.75% Unsecured Notes Indenture***" and, together with the 5.375% Unsecured Notes Indenture, the 6.75% Secured Notes Indenture and the 4.375% Secured Notes Indenture , the "***Indentures***"), among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, as trustee, relating to the Company's 9.750% Senior Notes due 2026 (the "***9.75% Unsecured Notes***" and, together with the 5.375% Unsecured Notes, 6.75% Secured Notes and the 4.375% Secured Notes, the "***Notes***"), (v) Section 5.04 of the Asset-Based Revolving Credit Agreement, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***ABL Agreement***" and the revolving facility provided thereunder, the "***ABL Facility***"), among the Company, as Lead Borrower, DSB Acquisition LLC, a Delaware limited liability company ("***Holdings***"), the lenders party thereto from time to time and Citibank, N.A., as administrative agent and collateral agent, and (vi) Section 5.04 of the First Lien Credit Agreement, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***Term Loan Agreement***", the term loan facility provided thereunder, the "***Term Loan Facility***," and the Term Loan Agreement together with the ABL Agreement, the "***Credit Agreements***"), among the Company, as Lead Borrower, Holdings, the lenders party thereto and Citibank, N.A., as administrative agent and collateral agent. This Report has been prepared in all material respects in accordance with the rules and regulations of the Securities and Exchange Commission (the "***SEC***") applicable to an Annual Report on Form 10-K for the fiscal year ended December 31, 2022, except to the extent exceptions, exclusions and other differences in presentation are permitted to be excluded by the Indentures and the Credit Agreements.

USE OF NON-GAAP FINANCIAL INFORMATION

In this Report, we have provided same-facility information for the three months and years ended December 31, 2022 and 2021, as if the Kindred Transaction (as defined in this Report) had occurred on January 1 for each of the years then ended, EBITDA and Adjusted EBITDA (collectively, the "***Non-GAAP Measures***") because we believe they provide the holders of our Notes (the "***Holders***") and the lenders under our Credit Agreements ("***Lenders***") with additional information to measure our performance and evaluate our ability to service our indebtedness. We believe that the presentation of Non-GAAP Measures is appropriate to provide additional information to the Holders and Lenders about certain material non-cash items and about unusual items that we do not expect to continue or to continue at the same level in the future as well as other items. Further, we believe the Non-GAAP Measures provide a meaningful measure of operating profitability because we use them for evaluating our business performance and understanding certain significant items.

The Non-GAAP Measures are not presentations made in accordance with United States ("***U.S.***") generally accepted accounting principles ("***GAAP***"), and our Non-GAAP Measures may not be comparable to similarly titled measures of other companies because such measures may include or exclude other specified items. The Non-GAAP Measures should not be considered as alternatives to operating income or any other performance measures derived in accordance with GAAP as measures of operating performance or cash flows as measures of liquidity. The Non-GAAP Measures have important limitations as analytical tools, and you should not consider them in isolation or as substitutes for analysis of our results as reported under GAAP. Because of these limitations, we rely primarily on our GAAP results and use the Non-GAAP Measures only as a supplement. Refer to "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" for a description of the calculation and limitations of these measures.

DOCUMENT SUMMARIES AND REQUESTS

This Report contains summaries believed to be accurate with respect to certain documents, but reference is made to the actual documents for complete information. All such summaries, which do not purport to be complete, are qualified in their entirety by such reference. Copies of the documents referred to herein will be made available without cost to Holders and Lenders by making a written or oral request to us. Any such request may be made to us at the following address and telephone number:

Lifepoint Health
330 Seven Springs Way
Brentwood, Tennessee 37027
Attn: General Counsel
Tel. (615) 920-7000

FISCAL YEAR

All references to "fiscal year" are to the twelve months ended December 31 of the year referenced.

OTHER ITEMS

Lifepoint Health, Inc. (formerly known as RegionalCare Hospital Partners Holdings, Inc.), a Delaware corporation, along with each of its consolidated subsidiaries, is referred to herein as the "***Company***," "***Lifepoint***," "***we***," "***our***," "***us***," and, before giving effect to the Lifepoint/RCCH Merger (as defined below), "***RCCH***," in each case, unless the context otherwise requires.

References in this Report to the "***Lifepoint/RCCH Merger***" refer to the merger, which was effective on November 16, 2018, of Legend Merger Sub, Inc., a Delaware corporation and wholly-owned subsidiary of RCCH ("***Legend Merger Sub***"), with and into Lifepoint Health, Inc., a Delaware corporation ("***Legacy Lifepoint***"), with Legacy Lifepoint surviving the Lifepoint/RCCH Merger as a subsidiary of RCCH. At the effective time of the Lifepoint/RCCH Merger, Legacy Lifepoint changed its name from "Lifepoint Health, Inc." to "Legacy Lifepoint Health, Inc." and, immediately following the effective time of the Lifepoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "Lifepoint Health, Inc." Subsequently, Legacy Lifepoint converted from a corporation to a limited liability company.

References in this Report to the "***Sponsor***" refer to certain funds that are affiliates of the Company (the "***Apollo Funds***") that are ultimately controlled and/or managed by certain affiliates of Apollo Management Holdings, L.P. ("***Apollo Management***" and, when acting on behalf of the Apollo Funds, "***Apollo***"), which is an affiliate of Apollo Global Management, Inc.

PART I

Item 1. *Business.*

Our Company

We are a leading provider of healthcare serving patients, clinicians, communities and partner organizations across the healthcare continuum. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a growing diversified healthcare delivery network, which at December 31, 2022 was comprised of 62 community hospital campuses, 31 inpatient rehabilitation facilities ("***IRFs***"), three behavioral health facilities, and additional sites of care that include acute rehabilitation units ("***ARUs***"), outpatient centers and post-acute care facilities. As of December 31, 2022, we operated 96 healthcare facilities in 28 states throughout the U.S. with approximately 10,000 licensed beds and approximately 50,000 dedicated employees.

We seek to fulfill our mission of *making communities healthier*® and strive to create places where people choose to come for healthcare, physicians and providers want to practice and employees want to work. Additionally, we are committed to upholding our core values, which are champion patient care; do the right thing; embrace individuality; act with kindness; and make a difference together. Together, our shared mission, vision and values guide our work and unite our employees across our organization.

Our Business Strategy

The key elements of our business strategy include:

- *Commitment to the Delivery of Exceptional Quality Patient Care*. Providing high quality patient care is essential to our mission and will always be our top priority across all business units. We believe our quality efforts are central to creating places where people choose to come for healthcare, physicians and providers want to practice and employees want to work. Our National Quality Program provides a structured, evidence-based approach to enhancing quality and patient safety and is nationally renowned. Several factors contribute to providing high quality patient care, including leadership and accountability at all levels of our organization, aligning ourselves with talented physicians and medical staff who share our commitment to quality, and providing a clinical environment that is satisfactory to our patients, physicians and employees. We continually strive to improve physician and employee satisfaction, which we believe is critical to delivering quality patient care. We also partner with academic medical centers, regional health systems and specialty providers to better serve the needs of our communities. In addition, demonstrating our results in delivering high quality patient care is increasingly vital to achieving our operating and financial success, including with governmental and commercial payers.

- *Continue to Grow in Existing Markets by Expanding Services and Access Points to Care*. We regularly conduct in-depth strategic reviews of the major service lines offered at each of our facilities and evaluate additional services through which we could better serve our communities and grow in our markets. We leverage our market-specific knowledge together with input and guidance from our local physician and community leaders to prioritize the healthcare services our communities are seeking. Focus areas include: expansion of specialty service lines to meet unserved or underserved patient needs; expansion of access points to care, including outpatient, ancillary, retail and virtual health services; and investment in technology and equipment. We invest strategically in our markets in order to increase the quality and scope of services we provide, meet the needs of our communities and maintain our strong reputation as the healthcare provider of choice. This, in turn, helps us to continue recruiting physicians and growing the revenue of our facilities.

- *Leverage Lifepoint Forward Innovation Strategy to Develop Solutions that Transform and Improve Community-based Healthcare Delivery*. Through our innovation strategy, Lifepoint Forward, we are developing meaningful solutions to enhance quality, increase access to care, and improve value across the Lifepoint footprint and communities across the country. This includes a significant focus on digital health capabilities that span the healthcare continuum. For example, we have already invested in, either directly or indirectly through unconsolidated affiliates, or implemented new technologies for on-demand telehealth services, artificial intelligence functionality, online scheduling for in-person and telehealth visits, virtual check-in and waiting room options, remote patient monitoring, data interoperability and advanced analytics of medical records, and computational linguistics designed to identify at-risk patients.

- *Continue to Recruit and Retain Leading Physicians*. Our physician engagement strategies drive our ability to enhance and expand our services to meet the healthcare needs of our communities. We have a comprehensive recruiting program that is directed by an experienced department at our Health Support Center ("***HSC***") and is supported at the local level by our hospital system chief executive officers ("***CEOs***") and Boards of Trustees. We supplement our local teams with experienced specialists at our HSC and several third-party recruiting firms to assist us in identifying candidates that match the profile of our physician needs. We maintain a flexible approach to aligning our goals with our physician partners, including our willingness to recruit physicians through multi-year employment and/or income guarantee arrangements. In addition, we believe our physicians are attracted to our facilities because of several factors, including our commitment to quality care, our focus on employing and developing high quality nurses and support staff and our integration into, and support of, the communities we serve.

- *Routinely Optimize Our Portfolio to Strengthen Our Position in Existing Markets and Expand into New Markets*. We evaluate and selectively pursue acquisitions of hospitals, outpatient and ancillary clinics and other healthcare facilities in new and existing markets, with the goal of improving our operating performance and better meeting the healthcare needs of our communities. We also continue to expand the footprint of our rehabilitation and behavioral health division. We employ a rigorous and disciplined approach to new market acquisitions and focus on a range of criteria, including expected financial returns and strategic benefits, to evaluate a target's suitability and fit within our portfolio. We seek to operate health systems that are, or have the potential to become, market leaders in communities with favorable demographic trends. Furthermore, we routinely evaluate our existing portfolio to assess whether we are meeting our strategic and financial objectives in our markets. We evaluate and may seek to opportunistically divest assets that do not meet our strategic and/or financial objectives and which may deliver more value to our stakeholders and the respective communities through a sale.

- *Continue to Engage in Strategic Relationships with Local Partners*. We partner with like-minded providers to strengthen the care continuum, bring more services to our communities, better support hospitals and providers, and improve the overall health of patients across the nation. For example, we have an established national partnership with Duke University Health System, in addition to several other provider organizations. We also pursue collaborations and flexible partnership models, including wholly-owned, joint venture and managed services relationships, to advance the delivery of rehabilitation and behavioral health services.

- *Continue to Focus on Operational Efficiency*. We strive to improve our operating performance by making our revenue cycle processes more efficient, making an even higher level of purchases through our group purchasing organization, operating more efficiently and effectively, and working to appropriately standardize our policies, procedures and practices across all of our affiliated facilities. As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have partnered with various third parties to provide certain nonclinical business functions, including payroll processing, supply chain management and revenue cycle functions. We believe this model is the most cost effective and efficient approach to managing these nonclinical business functions across multi-facility enterprises. Additionally, in connection with our efforts to responsibly manage purchasing costs, we participate along with other healthcare companies in a group purchasing organization, HealthTrust Purchasing Group, which makes certain national supply and equipment contracts available to our facilities. We also implement this operating discipline when we enter a new market through acquisitions, where we focus on optimizing staffing levels to reduce labor costs, leveraging our national scale and group purchasing organizations to reduce supply costs and standardizing revenue cycle and information technology ("***IT***") systems. We have made substantial progress implementing these initiatives consistently across our network, and we believe that opportunity exists for continued improvement in the near term, particularly among our recently acquired facilities.

- *Attracting and Retaining Experienced Executive Management and Leadership Teams.* Our executive management team has an average of more than 20 years of healthcare industry experience with a proven record of achieving strong operating and quality results. The executive management team is highly respected in the healthcare industry and has significant experience in managing and acquiring hospitals. Our executive management team is led by David Dill, who serves as our Chairman and Chief Executive Officer. Mr. Dill has more than 20 years of operational and financial leadership experience in the healthcare industry.

Our Background

Lifepoint/RCCH Merger

Summary

At the effective time of the Lifepoint/RCCH Merger, November 16, 2018, Legacy Lifepoint changed its name from "Lifepoint Health, Inc." to "Legacy Lifepoint Health, Inc." and, immediately following the effective time of the Lifepoint/RCCH Merger, RCCH changed its name from "RegionalCare Hospital Partners Holdings, Inc." to "Lifepoint Health, Inc." Subsequently, Legacy Lifepoint converted from a corporation to a limited liability company.

Kindred Transaction

On June 18, 2021, we entered into a securities purchase agreement (the "***Kindred Purchase Agreement***") for us and/or one or more affiliated assignees to acquire, directly or indirectly, Kindred Healthcare, LLC ("***Kindred***"), a leading specialty hospital company that operates facilities providing post-acute care, rehabilitation services and behavioral health services throughout the U.S. Upon the closing of the Kindred Transaction, as described below, the Company and Kindred established a new healthcare company operating under the name ScionHealth, which is separate from Lifepoint.

On December 23, 2021, the Company, Kentucky Hospital Holdings JV, LP ("***Knight***"), the indirect parent of Kindred, Knight Health Holdings LLC (d/b/a ScionHealth), a Delaware limited liability company and direct parent of Knight ("***ScionHealth***"), and certain of their respective affiliates entered into reorganization agreements (the "***Reorganization Agreements***") that, among other things, provided for (i) the separation of the IRF, behavioral health, contract rehabilitation service and certain support center businesses (collectively, the "***Knight Transferred Business***") from the businesses of Knight and its subsidiaries, (ii) the separation of the equity and assets comprising 18 select acute care hospitals of the Company (the "***Artemis Business***") from the business of the Company and its subsidiaries, (iii) the transfer of the Knight Transferred Business to the Company, (iv) the transfer of the Artemis Business to Knight, (v) the acquisition by the Company of Class B Units of ScionHealth, with an aggregate value of $350 million, and (vi) reciprocal indemnification obligations with respect to the businesses transferred, in each case of clauses (i) through (vi), pursuant to the reorganization, separation and distribution steps described therein, including the assignment by Knight Health, LLC, a Delaware limited liability company formed at the direction of certain affiliates of the Company, of certain rights and obligations under the Kindred Purchase Agreement, including any post-closing purchase price adjustments (the "***Reorganization***"). The Class B Units of ScionHealth acquired by the Company are perpetual non-convertible non-voting units that accrue cumulative dividends at the rate of 10.00% per annum and, upon liquidation, are entitled to a return of their nominal value issue price of $350 million plus accrued, unpaid dividends.

On December 23, 2021, concurrently with the consummation of the Reorganization, the Kindred Transaction was consummated. Pursuant to the consummation of the Kindred Transaction and the Reorganization, (i) ScionHealth indirectly holds all of the transferred interests in the Artemis Business, (ii) ScionHealth directly holds all of the issued and outstanding limited partnership interests in Knight, (iii) Kentucky Hospital Holdings JV GP LLC, a Delaware limited liability company and direct subsidiary of ScionHealth, holds all of the issued and outstanding general partnership interests in Knight, and (iv) the Company holds all of the transferred interests in the Knight Transferred Business and the Class B Units of ScionHealth described above. We refer to the foregoing transactions as the "***Kindred Transaction***".

In connection with the Kindred Transaction, we have entered into a number of transition services agreements ("***TSAs***") and other ancillary agreements with ScionHealth and its subsidiaries. For the year ended December 31, 2022, in connection with the TSAs, we were reimbursed by ScionHealth for certain costs incurred on their behalf of $61 million, and paid ScionHealth $3 million for certain costs incurred on our behalf. In addition, we and ScionHealth are party to a number of commercial services agreements, pursuant to which we provide ScionHealth with therapy services, rehabilitation unit and behavioral health unit management, consulting and development services, among other commercial services. For the year ended December 31, 2022, the Company recorded revenues related to these commercial services agreements of $55 million.

Lastly, given the recency of the Kindred Transaction and our ongoing integration efforts with ScionHealth, we may, from time to time, have a net receivable/payable recorded from/to ScionHealth with respect to net working capital and TSAs. We had a net receivable of $84 million recorded under the caption "Other current assets" in our accompanying consolidated balance sheet at December 31, 2022.

Our Operations

Services

We operate health systems that provide a broad range of general and specialized healthcare services across inpatient and outpatient settings, including general surgery, internal medicine, cardiology, radiology, oncology, orthopedics, women's services, neurology, rehabilitation services, behavioral services, pediatric services, emergency services and, primarily through our joint venture with LHC Group Inc. ("***LHC***"), home health and hospice services. In some of our health systems, we offer specialized services such as open heart surgery, skilled nursing, psychiatric care and neurosurgery. In many markets, we also provide outpatient services such as same day surgery, clinical laboratory services, diagnostic imaging services, respiratory therapy services, sports medicine services, urgent care services and lithotripsy. The services provided in any specific health system depend on many factors, including the community need for the service, whether physicians necessary to safely operate the service line are members of the medical staff of that hospital and the existence of any contractual or certificate of need restrictions.

Ongoing Impact of COVID-19

While we continue to diagnose and treat COVID-19 patients in our facilities, the prevalence and widespread impact of the virus has decreased both across our organization and the country at large. Our focus continues to be on protecting our patients, our people and our communities by managing this infectious disease according to standard infection prevention and control protocols and guidance from the Centers for Disease Control and Prevention (the "***CDC***"). Our internal COVID-19 taskforce, which was established during the early stages of the pandemic, continues to carefully monitor any trends that may impact the organization and meets on an ad hoc basis to address the specific needs of our facilities.

We initially implemented during the early stages of the COVID-19 pandemic and have continued to retain a number of health and safety measures to protect our patients, providers, employees, volunteers and visitors. These include monitoring local COVID-19 infection and hospitalization trends, adhering to stringent infection control protocols, maintaining rigorous cleaning and disinfection practices, and regularly assessing crucial supplies, among others.

Our evaluation of the measures taken across our health system in response to COVID-19 is ongoing and additional updates to our policies, procedures and operations could occur as best practices continue to evolve. Furthermore, our facilities are located across a wide geographic range of communities, which may require us to modify measures we take at specific facilities based on local conditions, including the severity of COVID-19 and any variants of the virus in the community served by a facility and changes in state and local executive orders that may restrict certain services or activities.

Taking into account the COVID-19 pandemic and other factors, the U.S. economy has recently experienced general inflationary pressures, significant disruptions to global supply networks, and an extremely competitive labor market, including staffing shortages and increases to expenses related to staffing. We have incurred, and may continue to incur, certain increased expenses arising from the pandemic and these economic conditions, including additional labor, supply chain, capital and other expenditures. While we have implemented cost containment and other measures to try to counteract these developments, we may be unable to fully offset these increases in our costs and otherwise effectively respond to supply disruptions.

For additional information about the risks presented by the COVID-19 pandemic, our responses to the pandemic, and the resources available to healthcare providers, refer to "—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" below and "Part I, Item 1A. Risk Factors" and "Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Developments, Trends and Operating Environment—Ongoing Impact of COVID-19" included in this Report.

Management and Oversight

Our executive management team has extensive experience in operating a broad range of general as well as specialized healthcare services across a diversified healthcare delivery network and plays a vital role in the strategic planning for our facilities. Our local acute care hospital management teams are typically comprised of a CEO, chief operating officer, chief financial officer and a chief nursing officer, and our local IRF management teams are typically comprised of a CEO, controller, and chief nursing officer. Local management teams work with an acute care hospital's Board of Trustees or the governing board of our IRF joint ventures, and our HSC management teams, to develop annual operating plans setting forth growth strategies through the expansion of current services, implementation of new services and the recruitment and retention of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each of these local management teams to identify and meet the needs of patients, medical staffs and the community as a whole is critical to the success of these facilities. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including quality of care, patient satisfaction and financial measures.

The Board of Trustees at each acute care hospital, consisting of local community leaders, members of the medical staff and the facility CEO, advises the local management teams and helps develop the strategic operating plan for their facility. In addition, it plays a key role in providing the patient care excellence that we demand. Members of each Board of Trustees are identified and recommended by our local management teams. The Boards of Trustees oversee policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

The majority of our acute care hospitals have a physician engagement group (PEG) or a physician leadership group (PLG) comprised of key physicians and members of the facility's administrative team, and the majority of our IRFs have a similar medical executive committee. The mission of such groups is to provide ongoing dialogue between facility administration and members of the medical staff and community physicians primarily in the areas of operations, quality patient care, employee satisfaction and/or community relations.

We also provide support to the local management teams through our HSC resources in areas such as revenue cycle, business office, legal, managed care, clinical efficiency, physician services and other administrative functions. These resources allow for sharing best practices and standardization of policies and processes among all of our facilities.

Cost Management

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

As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have partnered with various third parties to provide certain nonclinical business functions, including payroll processing, supply chain management and

revenue cycle functions. We believe this model is the most cost effective and efficient approach to managing these nonclinical business functions across multi-facility enterprises.

Attracting Patients

We believe that the most important factors influencing a patient's choice in where to receive healthcare services are the quality of care delivered by the facility, the overall reputation of the facility, the availability and expertise of physicians and nurses, and the location and convenience of the facility. Other factors that affect utilization include local demographics and population growth, local economic conditions and the facility's success in contracting with a wide range of local payers.

Outpatient Services

The healthcare industry continues to experience a shift from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology also have supported the shift to outpatient utilization. However, we expect the decline in inpatient admission use rates to moderate over the long term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through expanding service offerings and increasing the throughput and convenience of our emergency departments, outpatient surgery facilities and other ancillary units in our facilities.

Sources of Revenues

General

Our facilities generate revenues by providing healthcare services to our patients. Depending upon the patient's medical insurance coverage, we are paid for these services by governmental Medicare and Medicaid programs, commercial insurance, including health maintenance organizations ("***HMOs***"), preferred provider organizations ("***PPOs***") and plans offered through the Exchanges, private insurers, and directly by the patient. The amounts we are paid for providing healthcare services to our patients vary depending upon the payer. Governmental payers generally pay significantly less than the hospital's customary charges for the services provided. Insured patients are generally not responsible for any difference between customary hospital charges and the amounts received from commercial insurance payers. However, insured patients are responsible for payments not covered by insurance, such as exclusions, deductibles and co-payments.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2022, 2021 and 2020 (dollars in millions):

	2022		2021		2020	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,227	40.2 %	$ 3,368	37.7 %	$ 3,134	38.6 %
Medicaid	1,353	16.9	1,645	18.4	1,392	17.1
HMOs, PPOs and other private insurers	3,030	37.8	3,691	41.3	3,382	41.6
Self-pay	57	0.7	55	0.6	55	0.7
Other (a)	338	4.2	156	1.8	137	1.7
Revenue from contracts with customers	8,005	99.8	8,915	99.8	8,100	99.7
Rental income	15	0.2	22	0.2	22	0.3
Revenues	$ 8,020	100.0 %	$ 8,937	100.0 %	$ 8,122	100.0 %

(a) Includes revenues from managed ARUs and ancillary goods and services.

Medicare

For the year ended December 31, 2022, approximately 40.2% of our revenues related to patients participating in the Medicare program. Medicare provides hospital and medical insurance benefits, regardless of income, to persons aged 65 and over, some disabled persons and persons with end-stage renal or Lou Gehrig's disease. All of our hospitals are currently certified as providers of Medicare services.

Over the years, Congress and the Centers for Medicare and Medicaid Services ("***CMS***") have made several sweeping changes to the Medicare program and its reimbursement methodologies, including the numerous changes contained in the Affordable Care Act. Many of these changes have resulted in decreased reimbursement to healthcare providers. In addition, the Budget Control Act of 2011, which is intended to reduce the federal deficit, imposed a 2% reduction in Medicare spending which began on April 1, 2013. Congress has extended the 2% reduction in Medicare spending on numerous occasions. The Families First Coronavirus Response Act, the Coronavirus Aid, Relief, and Economic Security Act (the "***CARES Act***") and the Consolidated Appropriations Act, 2021 (the "***CAA***") temporarily suspended Medicare sequestration from May 1, 2020 until March 31, 2021. The temporary suspension was subsequently extended through December 31, 2021, by HR 1868, which, to offset the cost of the suspension, extended Medicare sequestration through 2030. The Protecting Medicare and American Farmers from Sequester Cuts Act (the "***Sequester Cuts Act***"), which was adopted December 10, 2021, further extended the temporary suspension of Medicare sequestration through March 31, 2022, and reduced the sequestration cuts for the period of April 1, 2022 through June 30, 2022, to 1%. The Consolidated Appropriations Act, 2023 (the "***CAA23***"), which was adopted December 23, 2022, reduces the Medicare sequestration cuts through CY 2024, and extends Medicare sequestration through 2032. In addition, the American Rescue Plan Act of 2021 ("***ARP***") increased the federal budget deficit in a manner that triggers an additional sequestration mandated under the Pay As You Go Act of 2010 (the "***PAYGO Act***"); however, Congress has delayed implementation of this payment reduction until 2025. Additional reductions in Medicare reimbursement could result from changes to the Affordable Care Act, or as a result of the enactment of Medicare reform, deficit reduction or other legislation.

Medicare Inpatient Prospective Payment System

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

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor each federal fiscal year ("***FFY***"), which begins on October 1 (for example, FFY 2023 began on October 1, 2022). The index used to adjust the base MS-DRG payment rate, which is known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. For FFYs 2023, 2022, and 2021, the hospital market basket index increased 4.1%, 2.7%, and 2.4%, respectively. Generally, however, the percentage increase in the MS-DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the Bureau of Labor Statistics' 10-year moving average of changes in annual economy-wide productivity. For FFYs 2023, 2022, and 2021, the productivity adjustment equated to a 0.3%, 0.7%, and 0.0% reduction in the market basket increase, respectively. As a result of these reductions and other changes implemented by CMS, the MS-DRG-rate increased by 4.3% for FFY 2023.

CMS has implemented a number of programs and requirements that are intended to promote value-based purchasing and to link payments to quality and efficiency. For example, all acute care hospitals are required to participate in CMS' Hospital Inpatient Quality Reporting Program (the "***IQR Program***") in order to receive the full hospital market basket update. Hospitals that do not participate in the IQR Program receive a 25% reduction in their IPPS annual payment update for the applicable FFY. Our acute care hospitals reported all quality measures required by CMS related to the IQR Program and nearly all will receive the full market basket update through FFY 2023. In addition, hospitals that are not meaningful EHR users are also subject to an additional 75% reduction of the hospital market basket increase.

In addition, the Affordable Care Act requires U.S. Department of Health and Human Services ("***HHS***") to implement a value-based purchasing program for inpatient hospital services. This program rewards hospitals based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period. As part of the program, the Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by 2.0% each FFY. HHS pools the amount collected from these reductions to fund payments to reward hospitals that meet and exceed certain quality performance standards established by HHS. Under the program, each hospital's performance is evaluated during a specified performance period, and hospitals receive points on each of a number of pre-determined measures based on the higher of (i) their level of achievement relative to an established standard or (ii) their improvement in performance from their performance during a prior baseline period. Each hospital's combined scores on all the measures are translated into value-based incentive payments. Hospitals that receive higher total performance scores receive higher incentive payments than those that receive lower total performance scores. Because the Affordable Care Act provides that the funds pooled and otherwise set aside for the value-based purchasing program will be fully distributed, hospitals with high scores may receive greater reimbursement under the value-based purchasing program than they would have otherwise, and hospitals with low scores may receive reduced Medicare inpatient hospital payments.

Medicare also does not allow an inpatient hospital discharge to be assigned to a higher paying MS-DRG if certain designated hospital acquired conditions ("***HACs***") were not present on admission and the identified HAC is the only condition resulting in the assignment of the higher paying MS-DRG. In those situations, the case is paid as though the secondary diagnosis was not present. In addition, hospitals that fall into the top 25.0% of national risk-adjusted HAC rates for all hospitals in the previous year receive a 1.0% reduction in their total Medicare payments.

Furthermore, inpatient payments are reduced pursuant to the Affordable Care Act if a hospital experiences "excessive readmissions" within a 30-day period of discharge for certain conditions designated by CMS including heart attack, chronic obstructive pulmonary disease, heart failure, pneumonia, coronary artery bypass, and total hip arthroplasty. Hospitals with what HHS defines as "excessive readmissions" for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Each hospital's performance is publicly reported by HHS. HHS has the discretion to determine what "excessive readmissions" means, the amount of the payment reduction and other terms and conditions of this program. The basic maximum payment reduction amount is 3.0%. The 21st Century Cures Act (the "***Cures Act***") does, however, allow for an adjustment factor that would reduce the penalties imposed on hospitals, based on the portion of beneficiaries the hospitals serve that are eligible for both Medicare and Medicaid.

In response to the COVID-19 public health emergency, CMS has announced that it will temporarily suppress, or not use, certain hospital performance data that has been affected by COVID-19 in any of its hospital quality measurement and payment programs. In addition, CMS has also announced that for FFY 2023, all hospitals will receive a neutral adjustment under the Medicare value-based purchasing program that is equal to the 2.0% that is withheld under the program.

Medicare Hospital Outpatient Prospective Payment System and Other Outpatient Services

CMS reimburses hospital outpatient services under the Medicare hospital outpatient prospective payment system ("***OPPS***"), and generally uses fee schedules to pay for durable medical equipment and physical, occupational and speech therapy, clinical diagnostic laboratory and independent diagnostic testing facility services. Under the OPPS, hospital outpatient services are classified into groups called ambulatory payment classifications ("***APCs***"). Services in each APC are clinically similar and are similar in terms of the resources they require. Depending on the services provided, a hospital may be paid for more than one APC for an encounter. CMS establishes a payment rate for each APC by multiplying the scaled relative weight for the APC by a conversion factor. The payment rate is further adjusted to reflect geographic wage differences. The APC conversion factor for calendar year ("***CY***") 2023 is $85.585 and the APC conversion factors for CYs 2022 and 2021 were $84.177 and $82.797, respectively, after the inclusion of the productivity adjustments and other reductions that were required by the Affordable Care Act. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, acute care hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Reporting Program (the "***OQR Program***"). Hospitals that do not satisfy the reporting requirements of the OQR Program are subject to a reduction of 2.0% in their annual payment update under the OPPS. Our acute care hospitals reported all quality measures required by CMS related to the OQR Program and will receive the full market basket update through CY 2023.

Section 603 of the Bipartisan Budget Act of 2015 limits reimbursement for items and services that are furnished by certain off-campus outpatient provider-based departments ("***off-campus PBDs***") of hospitals. CMS included several provisions implementing Section 603 in the OPPS final rule for CY 2017. Under the final rule, CMS continues to make OPPS payments to off-campus PBDs that were billing Medicare as hospital departments under the OPPS prior to November 2, 2015 ("***grandfathered PBDs***"). However, grandfathered PBDs generally are not able to relocate, and CMS has indicated that it may adopt limitations on the expansion of the service lines provided at grandfathered PBDs in the future. In addition to grandfathered PBDs, CMS continues to reimburse all items and services that are furnished in a "dedicated emergency department" of a hospital, as such term is defined for the purposes of the Emergency Medical Treatment and Active Labor Act ("***EMTALA***"), regardless of whether the items and services are emergency items and services, and all items and services that are furnished in off-campus PBDs that are located within 250 yards of a remote location of a hospital, which is a facility that is either created or acquired by a hospital for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the hospital, under the OPPS. All items and services not provided at a grandfathered or otherwise excepted off-campus PBD are generally paid by CMS under Medicare physician fee schedule ("***PFS***") rates that are approximately 40% of the applicable OPPS rate (the "***PFS Adjusted Rate***"). In addition, in 2018, CMS issued a final rule that generally reimburses clinic visit services provided at all off-campus PBDs, including grandfathered PBDs, at a reduced Medicare PFS-equivalent payment rate. The payment reduction for clinic visit services provided at off-campus PBDs was to be phased in over a two year period beginning in FFY 2019.

In December 2018, a lawsuit was filed challenging the portion of CMS' final rule that reduced reimbursement for clinic visit services provided at grandfathered PBDs to the lower Medicare PFS-equivalent payment rate. On September 17, 2019, the U.S. District Court for the District of Columbia ruled that the reduction in reimbursement for clinic services provided at grandfathered PBDs exceeded CMS' statutory authority. As a result of the ruling, CMS paid claims for clinic visit services provided at grandfathered PBDs in CY 2019 at the full OPPS payment rate. However, in the OPPS final rule for CY 2020, CMS noted that the court's ruling only applied to clinic visit services provided in CY 2019, and, as a result, CMS moved forward with the planned phase-in of the second year of the clinic visit service payment reduction in CY 2020 while it appealed the court's decision. A new lawsuit was filed on January 13, 2020, challenging the continued phase-in of the reduction for CY 2020. On July 17, 2020, the U.S. Court of Appeals for the District of Columbia reversed the lower court's ruling regarding the CY 2019 reductions and upheld CMS' reimbursement reductions for clinic visit services provided at grandfathered PBDs. The ruling of the U.S. Court of Appeals for the District of Columbia was appealed to the U.S. Supreme Court, but the Supreme Court declined to hear the appeal. CMS has since reprocessed claims for clinic services provided at grandfathered PBDs in CY 2019 at the reduced payment rate. However, in an effort to maintain access to care in rural areas, CMS finalized a policy in its CY 2023 PFS final rule that exempts rural Sole Community Hospitals from its site-neutral payment policy for clinic visit services provided in excepted off-campus PBDs of these hospitals and pays for such clinic visits at the full OPPS payment rate.

In addition to those reimbursement reductions and in furtherance of its efforts to increase site neutrality in Medicare payments, CMS announced in the OPPS final rule for CY 2021 that it would eliminate the Medicare program's inpatient only procedure list over a three-year period, beginning with the removal of approximately 300 primarily musculoskeletal-related procedures, with the list being completely phased out by CY 2024. The elimination of the inpatient only procedure list would have made those procedures eligible to be paid by Medicare in the hospital outpatient setting when outpatient care was appropriate. However, in the OPPS final rule for CY 2022, CMS reversed course and reinstated the Medicare program's inpatient only procedure list. As a result, almost all of the procedures that had been removed from the Medicare inpatient only procedure list for CY 2021 have been added back to the list for CY 2022.

As part of the OPPS final rule for CY 2018, CMS also finalized a change to the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B Drug Pricing Program (the "***340B Program***"). The 340B Program allows certain non-profit and governmental hospitals and other healthcare providers to obtain substantial discounts on covered outpatient drugs (prescription drugs and biologics other than vaccines) from drug manufacturers. Under the final rule, CMS pays for separately reimbursable, non-pass through drugs and biologicals (other than vaccines) purchased through the 340B Program at the average sales price ("***ASP***") minus 22.5% rather than ASP plus 6%. CMS estimated that this change reduced Medicare payments for drugs and biologicals by $1.6 billion in CY 2018. To maintain budget neutrality, CMS implemented an offsetting increase in the conversion factor. As a result, OPPS reimbursement rates for non-drug items and services provided by all hospitals, including those not eligible to participate in the 340B Program, were increased in connection with the reduction to 340B Program payments. In the OPPS final rule for CY 2019, CMS expanded the 340B Program payment reductions to drugs that are obtained through the 340B Program and furnished by non-excepted, off-campus PBDs.

In September 2018, a lawsuit was filed challenging the authority of CMS to make the 340B Program payment reductions set forth in the OPPS final rule for CY 2018. On December 27, 2018, the U.S. District Court for the District of Columbia held that the payment reductions exceeded CMS' statutory authority and entered a permanent injunction against the reductions. However, because the 340B Program payment reductions were made in a budget-neutral manner and the savings derived from the reductions were used to increase reimbursement for all of the other items and services provided under the OPPS, the court ordered the parties to submit briefs as to how the issue should be remedied. The lawsuit was subsequently expanded to include the 340B Program payment reductions that were made in CY 2019, and an additional lawsuit has been filed against the 340B Program payment reductions being made by CMS in CY 2020. CMS appealed the District Court's rulings, and, on July 31, 2020, the U.S. Court of Appeals for the District of Columbia reversed the lower court's ruling and upheld CMS' 340B Program payment reductions. The ruling of the U.S. Court of Appeals for the District of Columbia was appealed to the U.S. Supreme Court, and on June 15, 2022, the U.S. Supreme Court unanimously rejected the decision of the U.S. Court of Appeals and held that CMS' 340B Program payment reductions exceeded HHS's statutory authority.

In light of the U.S. Supreme Court's decision, in its CY 2023 OPPS final rule, CMS agreed to increase the payment rate for 340B Program-acquired drugs and biologicals from the ASP minus 22.5% to ASP plus 6%, beginning after September 28, 2022, consistent with its policy for drugs not acquired through the 340B Program. CMS stated that it would implement a -3.09% reduction to the payment rates for non-drug services to achieve budget neutrality for the 340B drug payment rate change for CY 2023. CMS further noted in the CY 2023 OPPS final rule that it would address the remedy for 340B drug payments from 2018 through 2022 in future rulemaking prior to the CY 2024 OPPS proposed rule. It is currently unknown what remedies HHS will propose to repay 340B Program hospitals for past underpayments and whether, due to budget neutrality requirements, OPPS payments to hospitals may be reduced (either retroactively or prospectively) in connection with such remedies. If OPPS payments to hospitals are reduced (either retroactively or prospectively) in connection with the 340B Program, we would be materially adversely affected.

Medicare Disproportionate Share Hospital Payments

Hospitals may also qualify for Medicare disproportionate share hospital ("***DSH***") payments, if they treat a high percentage of low-income patients (as determined by a ratio involving Medicare and Medicaid patients eligible to receive Supplemental Security Income). DSH payments are determined annually based on certain statistical information specified by HHS and are paid as an addition to MS-DRG payments. The Affordable Care Act requires Medicare DSH payments to providers to be reduced by 75% beginning in FFY 2014, subject to adjustment if the Affordable Care Act does not decrease uncompensated care to the extent anticipated. The amount that is withheld is reduced by the percentage change in uninsured individuals under the age of 65, and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. The IPPS final rule for FFY 2023 established the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2023 at approximately $6.8 billion, a decrease of approximately $300 million from FFY 2022.

Medicare Dependent and Low Volume Hospital Programs

On April 16, 2015, the Medicare Access and CHIP Reauthorization Act of 2015 ("***MACRA***") was enacted. Among other things, MACRA extended the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by Medicare, and the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located a certain distance from another general acute care hospital and have less than a certain number of Medicare discharges each fiscal year, through September 30, 2017. The Bipartisan Budget Act of 2018 extended both of these programs through FFY 2022. The CAA23 further extended both of these programs through FFY 2024.

Rural Emergency Hospitals

Pursuant to the CAA, Congress established Rural Emergency Hospitals ("***REHs***") as a new provider type to address the growing concern over closures of rural hospitals. REHs provide emergency department services and observation care and, at the election of the REH, other services furnished on an outpatient basis, but do not provide acute care inpatient services (other than post-hospital extended care services furnished in a distinct part unit licensed as a skilled nursing facility). To qualify as an REH, a facility must, as of December 27, 2020 (the enactment date of the CAA), have been a critical access hospital or a rural hospital with not more than 50 beds. Effective January 1, 2023, REHs that participate in Medicare will be paid for all "covered outpatient services" at a rate that is equal to the OPPS payment rate for the equivalent covered outpatient department service, increased by 5% to reflect the higher costs incurred by such hospitals. REHs will also receive a monthly facility payment, equal to $272,866 for CY 2023, which amount will increase in subsequent years by the hospital market basket percentage increase. In the CY 2023 OPPS final rule, CMS finalized its policies relating to payment, provider enrollment and quality reporting for REHs, in addition to the conditions of participation that REHs must meet in order to participate in the Medicare and Medicaid programs.

Medicare Inpatient Rehabilitation Facility Prospective Payment System

Under the Medicare program, IRFs and ARUs in acute care hospitals meeting certain criteria established by CMS are reimbursed under the Medicare inpatient rehabilitation facility prospective payment system ("***IRF-PPS***"). Payments under the IRF-PPS are made on a per-discharge basis and cover the inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) and, for teaching institutions, are adjusted to include reimbursement for graduate medical education costs. Under the IRF-PPS, patients are classified into case mix groups that reflect the relative resource intensity typically associated with the patient's clinical condition. IRFs and ARUs reimbursed under the IRF-PPS are paid a predetermined amount per discharge that reflects the patient's case mix group that is adjusted for facility-specific factors, such as area wage levels, proportion of low-income patients, and location in a rural area. Each FFY, payment rates under the IRF-PPS are updated using a market basket index, which is reduced by a productivity adjustment. For FFY 2023, CMS increased IRF-PPS payment rates by 3.9% based on a IRF market basket update of 4.2% minus a productivity adjustment of 0.3%. To receive the full increase, IRFs and ARUs must satisfy the reporting requirements of the Inpatient Rehabilitation Facility Quality Reporting Program (the "***IRF QRP***"). IRFs and ARUs that do not satisfy the reporting requirements of the IRF QRP are subject to a reduction of 2.0% in their annual payment update under the IRF-PPS. Our IRFs and ARUs reported all quality measures required by CMS related to the IRF QRP and will receive the full market basket update for FFY 2023.

In order to qualify for reimbursement under the IRF-PPS, at least 60% of an IRF's or ARU's inpatients during the most recent 12-month CMS-defined review period must have required intensive rehabilitation services for one or more of 13 specified conditions. IRFs and ARUs must also meet additional coverage criteria, including patient selection and care requirements relating to pre-admission screenings, ongoing coordination of care and involvement of rehabilitation physicians. An IRF or ARU that fails to meet the 60% threshold, or other criteria to be reimbursed under the IRF-PPS, will be paid under either the Medicare IPPS or OPPS, which generally provide for lower payment amounts.

Medicare Inpatient Psychiatric Facility Prospective Payment System

Under the Medicare program, inpatient psychiatric facilities ("***IPFs***"), which include freestanding psychiatric hospitals and inpatient psychiatric units in acute care hospitals that meet certain criteria established by CMS are reimbursed under the Medicare inpatient psychiatric facility prospective payment system ("***IPF-PPS***"). Under the IPF-PPS, IPFs receive predetermined per diem rates based primarily on the patient's condition (age, diagnosis, comorbidities), length of stay, and the location of the IPF. Payment rates are intended to cover all routine, ancillary, and capital costs of furnishing covered inpatient psychiatric services, including adjustments for teaching hospitals and IPFs with qualifying emergency departments. The IPF PPS has additional payment policies for outlier cases, interrupted stays, and a per treatment payment for patients who undergo electroconvulsive therapy. Each FFY, payment rates under the IPF-PPS are updated using a market basket index, which is reduced by a productivity adjustment. For FFY 2023, CMS increased the IPF-PPS base payment rate by 3.8% (to $865.63 per day) based on a IPF market basket update of 4.1% minus a productivity adjustment of 0.3%. To receive the full increase, IPFs must satisfy the reporting requirements of the Inpatient Psychiatric Facility Quality Reporting Program (the "***IPF QRP***"). IPFs that do not satisfy the reporting requirements of the IPF QRP are subject to a reduction of 2.0% in their annual payment update under the IPF-PPS. Our IPFs reported all quality measures required by CMS related to the IPF QRP and will receive the full market basket update for FFY 2023.

In order to qualify for reimbursement under the IPF-PPS, IPFs must meet certain classification and coverage criteria, including being primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons by, or under the supervision of, a physician, in addition to special staffing and medical record retention requirements. An IPF that fails to meet the criteria to be reimbursed under the IPF-PPS will be paid under either the Medicare IPPS or OPPS, which generally provide for lower payment amounts.

Cost Reports

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

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

Medicare Bad Debt Reimbursement

Under Medicare, the costs attributable to the deductible and coinsurance amounts that remain unpaid by Medicare beneficiaries after reasonable collection efforts can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the Medicare administrative contractor (*"**MAC**"*) from prior cost report filings.

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

Medicare Physician Fee Schedule and other Medicare Part B Services

Professional medical services provided to Medicare beneficiaries by physicians, physician assistants, nurse practitioners, and certain other healthcare practitioners, outpatient physical, occupational, and speech therapy services, and telehealth services are reimbursed under the PFS. Under the PFS, CMS has assigned a national relative value unit ("***RVU***") to most medical procedures and services that reflects the various resources required by a physician or practitioner to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service and the practice overhead and malpractice insurance expenses that are attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs and are then aggregated. The aggregated amount is multiplied by a conversion factor to determine the payment rate for the service. The conversion factor is updated by CMS on an annual basis.

MACRA, which was adopted in 2015, significantly changed how CMS determines the annual updates to the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased annually by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the Bipartisan Budget Act of 2018, were increased by 0.25% for CY 2019. PFS payment rates are scheduled to remain at their CY 2019 levels through CY 2025. The final PFS rule for CY 2023 initially set the PFS conversion factor for CY 2023 at $33.06, which was a decrease of $1.55 from the CY 2022 PFS conversion factor of $34.61 and reflected, among other things, the required statutory update of 0.0% and the expiration of the temporary 3% supplemental increase for CY 2022 that was provided by the Sequester Cuts Act. However, in response to the CAA23, on January 5, 2023, CMS announced an updated PFS conversion factor for CY 2023 of $33.89, which reflects a temporary increase to the PFS conversion factor by 2.5% for CY 2023 and a decrease of $0.72 from the CY 2022 PFS conversion factor of $34.61. The CAA23 also included a 1.25% positive adjustment to the PFS conversion factor for CY 2024.

In addition to revising the methodology that is used to update payments that are made under the PFS, MACRA also established a Quality Payment Program ("***QPP***") for incentivizing physician and practitioner care that meets certain value, quality, cost, and performance criteria. Beginning in CY 2019, amounts paid to physicians and practitioners under the PFS are subject to adjustment through the QPP and participation in either the Merit-Based Incentive Payment System ("***MIPS***") or an Advanced Alternative Payment Model ("***APM***") program. Beginning with the 2023 performance year, physicians and practitioners will have the opportunity to participate in a new reporting option known as MIPS Value Pathways ("***MVPs***"). Physicians participate in "traditional" MIPS unless they are participants of specific forms of APM, report MVPs (beginning with performance year 2023), are newly enrolled in Medicare, or see a low volume of Medicare patients. Groups or eligible clinicians who choose not to participate and fall within specified circumstances may request an exception through a hardship application and incur no MIPS impact on Medicare payments. CMS also permits hardship applications, including, in 2020, 2021, and 2022 hardships based on circumstances arising from COVID related operational issues, through which clinicians can request reweighing of any or all performance categories if they encounter an extreme and uncontrollable circumstance or a public health emergency.

Physicians and practitioners who participate in the MIPS program, which essentially consolidated the prior Physician Quality Reporting System, the Value-Based Modifier, and the Meaningful Use of EHR incentive programs, are subject to positive, zero, or negative performance adjustments depending on how the physician's or practitioner's performance compared to a performance threshold. The payment adjustments are based on the physician's or practitioner's performance in the year that is two years prior to the current payment period. As a result, PFS payments in CY 2023 will be based on CY 2021 performance scores, and so on for the following years. HHS and CMS revise the MIPS reporting measures on an annual basis and have indicated that they intend to routinely increase the performance thresholds in connection with those revisions. In addition, from CY 2019 through CY 2024, MACRA provides $500 million per year for an additional performance adjustment for physicians and practitioners who participate in MIPS and achieve exceptional performance. Physicians and practitioners who participate in a specified APM program, which, among other things, requires the physician or practitioner to receive a substantial amount of their revenue from an APM, will receive, from CYs 2019 through 2024, a lump-sum incentive payment equal to 5% of their Medicare payments in the prior year for services paid under the PFS. Pursuant to the CAA23, for CY 2025, physicians and practitioners who participate in a specified APM program will receive a lump-sum incentive payment equal to 3.5 % of their Medicare payments in the prior year for services paid under the PFS. Beginning in CY 2026, PFS payment rates for physicians and practitioners participating in an APM program would be increased by 0.75% a year. Payments for other physicians and practitioners would be increased by 0.25% per year.

Medicaid

For the year ended December 31, 2022, approximately 16.9% of our revenues related to patients participating in the various state Medicaid programs. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. Medicaid programs are funded by both the federal government and states to provide healthcare benefits to limited categories of low-income individuals under 65 years of age. These programs and the reimbursement methodologies are administered by the states under approved plans and vary from state to state and from year to year. Amounts received under the Medicaid programs are often significantly less than the hospital's customary charges for the services provided. Most state Medicaid payments are made under a prospective payment system, fee schedule, cost reimbursement program, or some combination of these three methods. All of our hospitals are currently certified to participate in their respective state Medicaid programs.

As enacted, the Affordable Care Act essentially required states to expand Medicaid coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level ("FPL"). However, that portion of the Affordable Care Act was held to be unconstitutional by the U.S. Supreme Court, and, as a result, states may opt out of the expansion without losing their existing Medicaid funding. Therefore, the income level required for individuals to qualify for Medicaid varies widely from state to state. To offset the cost of the Medicaid program's expansion, the Affordable Care Act authorized the federal government to provide states with "matching funds," in the form of increases to the Federal Medical Assistance Percentage (the "***FMAP***" and, as increased, referred to as "***Enhanced FMAP***"), to cover the costs of covering the newly eligible individuals. The Enhanced FMAP was 100% for CYs 2014 through 2016; 95% in CY 2017; 94% in CY 2018; 93% in CY 2019; and will be 90% in CYs 2020 and thereafter. The ARP, which was signed into law on March 11, 2021, provides a new incentive, in the form of a temporary 5% increase to the FMAP, to states that have not yet expanded their Medicaid programs in an effort to encourage them to do so. In addition, to assist state Medicaid programs with the additional expenses attributable to the COVID-19 pandemic, the CARES First Act provides a 6.2% increase in the FMAP from January 1, 2020, until the Secretary of the HHS ends the official COVID-19 public health emergency.

In recent years, we have benefited from the expansion of Medicaid under the Affordable Care Act, and since January 1, 2020, Missouri, Oklahoma, and Utah, three additional states in which we operate, expanded their Medicaid programs. However, a number of states in which we operate have not expanded their Medicaid programs or are seeking waivers that could reduce their Medicaid-eligible populations. Several states have adopted or are considering legislation designed to reduce or control their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs, and imposing additional taxes on hospitals to help finance such states' Medicaid systems. Given the reductions in the Enhanced FMAP, the temporary nature of the assistance provided by the ARP and the CARES Act, and the potential for further modifications to the Affordable Care Act, we are unable to predict how many, if any, additional states in which we operate will expand their Medicaid programs or how many, if any, of the states in which we operate that have expanded their Medicaid programs will keep their expansions in place in the future.

The Affordable Care Act also included a number of provisions that are intended to improve the quality of care that is provided to Medicaid beneficiaries. Among other things, the Affordable Care Act prohibits federal funds from being used to reimburse providers for services related to provider preventable conditions, such as HACs, wrong site surgeries and other provider preventable conditions that may be designated by each state Medicaid program.

Medicaid Supplemental Payments

Medicaid supplemental payments ("***MSPs***") are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and Upper Payment Limit ("***UPL***") payments.

Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating those patients. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. Although federal Medicaid law defines some level of hospitals that must receive Medicaid DSH funding, states have broad discretion to define additional hospitals that also may qualify for Medicaid DSH payments and the amount of such payments. However, the total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law.

Pursuant to the Affordable Care Act, as amended by subsequent legislation, funding for Medicaid DSH programs was to be reduced by $4 billion in FFY 2020 and $8 billion per year from FFY 2021 through FFY 2025. Congress has delayed the reduction in funding for Medicaid DSH programs on a number of occasions, most recently through the CCA, which eliminates the scheduled Medicaid DSH reductions for FFYs 2021 through 2023 but adds additional Medicaid DSH reductions for FFYs 2026 and 2027. We cannot predict whether Congress will further delay or otherwise modify the reductions in the future. Because many of the states in which we operate have not expanded Medicaid programs as intended under the Affordable Care Act, the reduction in Medicaid DSH payments may take place without a coupled increase in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars. UPL programs have expanded in recent years, and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs.

On November 18, 2019, CMS released a proposed rule, the Medicaid Fiscal Accountability Rule, that was intended to increase federal oversight of MSPs and state Medicaid financing policies. Among other things, the proposed rule would have added new reporting requirements on UPL payment arrangements, imposed limitations on UPL payments that are made to physicians and certain other practitioners, and imposed limits on the use of healthcare provider taxes, intergovernmental transfers and certified public expenditures. CMS withdrew the proposed rule in 2020. However, some of the reporting requirements contained in the Medicaid Fiscal Accountability Rule were included in the CCA, and, beginning in FFY 2022, each state will be required to provide CMS with, among other things, (i) a description of the stated purpose and intended effects of the state's MSPs, (ii) an explanation of how the state's MSPs will result in payments that are consistent with the requirements of the Medicaid program, including the program's standards with respect to efficiency, economy, quality of care, and access, (iii) the criteria used to determine provider eligibility for the state's MSPs, (iv) a comprehensive description of the methodology used to calculate the amount of, and distribute, MSPs to each eligible provider, and (v) an assurance that the total Medicaid payments made by the state to inpatient hospital providers, including any MSPs, will not exceed the UPL. The CCA also further clarifies how third-party payments are to be considered when determining Medicaid DSH hospital-specific limits. We cannot predict the impact, if any, that the reporting requirements and other Medicaid provisions in the CCA will have on MSPs and UPL payments that are made by state Medicaid programs or whether Congress or CMS will adopt any additional legislation or regulations that will eliminate or otherwise limit MSPs and/or UPL payments. In addition, we cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease.

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

Medicaid Block Grants and Capped Federal Funding

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

On November 11, 2019, Tennessee, one of the states in which we operate, submitted an amendment to CMS for its Medicaid demonstration waiver that would convert federal funding for the Tennessee Medicaid program to a modified block grant program. CMS approved the amendment on January 8, 2021, and as required by state law, the Tennessee General Assembly approved the implementation of the amendment on January 15, 2021. Under the amendment, the Tennessee Medicaid program would receive federal matching funds for expenditures up to an aggregate annual cap. The aggregate cap would be based on the Tennessee Medicaid program's historical expenditures and would be increased to reflect a reasonable growth rate over time and for unexpected increases in enrollment. In exchange, the Tennessee Medicaid program would be given increased flexibility in how it operates and would be entitled to 55% of any savings that are achieved if spending is below the aggregate cap and the state meets certain quality targets. Any savings would generally be required to be re-invested in the Tennessee Medicaid or other health related programs. Despite being granted increased administrative flexibility, the Tennessee Medicaid program would be required to maintain the coverage and benefit levels that were in place as of December 31, 2020. A lawsuit was filed in the U.S. District Court for the District of Columbia on April 22, 2021, seeking to stop the conversion of the Tennessee Medicaid program to a modified block grant program. On June 30, 2022, following a public comment period, CMS sent a letter to Tennessee requesting that the state make certain modifications to the Tennessee Medicaid demonstration waiver, which included, among other things, a request that the state submit a new financing and budget neutrality model based on a traditional per member per month cap, instead of an aggregate cap. In response, on August 30, 2022, following a public comment period, Tennessee sent CMS a proposed amendment to its demonstration waiver intended to address CMS's concerns, including changes to the financing of the demonstration, moving from an aggregate cap to a per member per month cap, and revising the framework for reinvestment of demonstration savings. We cannot predict whether CMS will accept Tennessee's proposed amendments to its demonstration waiver or whether CMS will request further modifications or rescind altogether its approval of the amendment to the Tennessee Medicaid program or the impact that the amendment and related changes to the Tennessee Medicaid program would have on our operations and revenues.

Recovery Audit and Other Review Contractors

Recovery audit contractors ("***RACs***") are used by CMS and state agencies to detect Medicare and Medicaid overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare and Medicaid claims filed by healthcare providers. RACs perform post-discharge audits of medical records to identify overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services and are paid on a contingency basis. Any claims identified as overpayments are subject to a RAC program appeals process. In 2016, in connection with the procurement of the new recovery audit contracts, CMS made a number of enhancements to the RAC program, including the establishment of a RAC program Provider Relations Coordinator, requiring RACs to maintain an overturn rate of less than 10% at the first level of appeal, requiring RACs to maintain an accuracy rate of at least 95%, and establishing additional documentation request limits based on a provider's compliance with Medicare rules, that are intended to address provider and other stakeholder concerns. CMS has also limited the number of claims that RACs may audit by limiting the number of records that RACs may request from hospitals based on each hospital's claim denial rate for the previous year.

In addition to RACs, CMS employs Unified Program Integrity Contractors ("***UPICs***"), which integrate the functions of the former Zone Program Integrity Contractors, Program Safeguard Contractors, and Medicaid Integrity Contractors, to perform post-payment audits of Medicare and Medicaid claims and identify overpayments. A number of state Medicaid agencies and other contractors have also increased their review activities.

Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our facilities have had Medicare claims audited by the RAC program. While our facilities have successfully appealed many of the adverse determinations raised by Medicare RAC audits, we cannot predict if this trend will continue or the results of any future audits. We cannot predict the volume or outcome of any future audits conducted by the various RACs and other review programs to which our facilities will be subject.

Utilization and Claim Review

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

In addition to utilization reviews, CMS has also adopted a nationwide claim review and provider education program known as the Targeted Probe and Educate ("***TPE***") program, which is intended to reduce errors in the claims submission process and focuses on items and services that pose the greatest risk to the Medicare program or that have a high national error rate, such as short inpatient stays. Under the TPE program, MACs use data analysis to identify providers who, for a particular item or service, have high claim denial rates or billing practices that vary significantly from their peers. Once a provider has been identified, the MAC reviews between 20 and 40 of the provider's claims for the item or service and, if issues are noted, offers the provider an individualized education session that is based on the results of the review. The provider is then generally given 45 days to improve its systems and processes, and, after that period has ended, the MAC conducts another review of the provider's claims. If additional issues are identified, the provider is given the opportunity for another education session. Providers are typically given three rounds of review and education before being referred to CMS for further action, potentially including pre-payment review, referral for RAC review, or in some cases revocation of billing privileges.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payers including HMOs, PPOs and other private insurers. Also included in this category are the patient responsibility portions for co-payment and deductible obligations under these programs. Our revenues from HMOs, PPOs and other private insurers were approximately 37.8% of our revenues for the year ended December 31, 2022. Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services or accept fixed, pre-determined fees for our services. These discounted contractual arrangements often limit our ability to increase charges or revenues in response to increasing costs. We actively negotiate with these payers in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payer with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. Additionally, plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when we are not a participating provider in the network, it can result in higher patient responsibility amounts that a patient may not have the ability to pay or may choose not to pay. We expect these trends to continue in the coming years.

Self-Pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Our revenues from self-pay patients were approximately 0.7% of our revenues for the year ended December 31, 2022. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities experienced in prior years, which included increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. We cannot predict how administrative or judicial interpretations, legislative actions or any other modifications to the Affordable Care Act that may be implemented or adopted, such as the cessation of cost sharing reduction payments or the repeal of the individual mandate, may impact our self-pay revenues. We also cannot predict whether the layoffs that may occur as a result of a decline in economic conditions, such as recession, economic downturn, and/or inflationary conditions in the U.S. will increase the number of underinsured and uninsured patients that seek treatment at our facilities.

In addition, effective January 1, 2022, the No Surprises Act requires healthcare providers, including hospitals and other healthcare facilities, to provide uninsured patients with a good faith estimate of the provider's total expected charges for scheduled items or services, including any expected ancillary services, before providing the items or services to the patient. Uninsured patients will be able to utilize a patient-provider dispute resolution process to challenge the provider's charges if they receive a bill that is substantially higher than the good faith estimate that was provided by the healthcare provider. We cannot predict how the uninsured patient good faith estimate and dispute resolution provisions of the No Surprises Act will impact the amounts collected by the Company's facilities for self-pay patients.

Surprise Medical Billing

On December 21, 2020, Congress adopted legislation that is intended to limit the "surprise" medical bills that are issued to individuals receiving emergency and certain other services (such as anesthesia services) from out-of-network providers. Effective as of January 1, 2022, the No Surprises Act prohibits, among other things, out-of-network providers from balance billing patients for emergency care services that are provided by out-of-network facilities or at in-network facilities by out-of-network providers. The No Surprises Act also generally prohibits out-of-network providers from billing patients for non-emergency medical treatment unless the provider first notifies the patient of the provider's network status and estimated charges and the patient agrees to be financially liable for the additional amounts. Violations of the No Surprises Act are punishable by civil monetary penalties of up to $10,000, and the No Surprises Act may be enforced by both the state and federal governments.

When the prohibitions of the No Surprises Act apply, a patient's financial liability will generally be limited to his or her in-network amount. In addition, the patient's third-party payer must either pay the out-of-network provider an initial payment amount or issue a notice of denial to the provider for the services that were rendered within 30 days of the payer's receipt of the provider's claim. If the provider is not satisfied with the payer's initial payment amount, the provider and the payer will begin a 30-day negotiation period. If the provider and the payer cannot agree on a payment amount during the negotiation period, the parties may elect to initiate an independent dispute resolution ("***IDR***") process. The IDR process will be conducted by a neutral arbitrator that has been approved by the federal government. Under regulations that have been issued by HHS, the Department of Labor, and the Department of Treasury (collectively, the "***Departments***"), in making a payment determination, the arbitrator must consider the "qualifying payment amount" (the "***QPA***"), which generally will be the plan or the insurer's median contracted rate, among additional information submitted by a party. A number of lawsuits have been filed against the Departments challenging various aspects of the final rules implementing the No Surprises Act, including the weight an arbitrator should give to the QPA in the IDR process. The regulations that have been issued by the Departments in connection with the No Surprises Act also require certain healthcare providers and facilities to make publicly available, post on a public website and provide a one-page notice to individuals about the requirements and prohibitions applicable to the facility or provider under the No Surprises Act, any applicable state balance billing limitations or prohibitions, and how the individual can contact the appropriate state and federal agencies if he or she believes the provider or facility has violated the requirements set forth in the notice.

We cannot predict the outcome of the lawsuits that have been filed in connection with the No Surprises Act or how the No Surprises Act will be implemented by the Departments, or how it will ultimately be enforced by the federal and various state governments. We also cannot predict the amounts that will be received by our facilities and our employed providers for out-of-network services, whether the No Surprises Act will impact the in-network payment rates that are offered by third-party payers and the willingness of those payers to enter into participation agreements with us and our facilities in the future, or the costs that we will incur in complying with the requirements of the No Surprises Act. In addition, a number of states are considering or have already adopted legislation to eliminate surprise medical billing. We cannot predict how state legislative actions to modify or pass these proposals may be implemented or adopted, or what impact, if any, those actions may have on our operations and revenues.

Price Transparency

Transparency in healthcare pricing has become a focal point for CMS, Congress, and many state legislatures. For example, effective as of January 1, 2021, hospitals generally are required to post their standard charges prominently on a publicly available website. Under CMS regulations, each hospital's standard charges must be posted in two ways: (1) a single machine-readable digital file containing the gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for all items and services provided by the hospital and (2) a public display in a consumer-friendly manner of cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for at least 300 "shoppable" services (70 CMS-specified and 230 hospital-selected). CMS is actively auditing and monitoring hospital compliance with its reporting requirements and has taken a number of steps to address hospital noncompliance, including issuing warning notices to and requesting corrective action plans from hospitals that are determined to be out of compliance with the price transparency requirements, implementing measures that are intended to increase the availability of the required machine-readable file, and increasing the civil monetary penalties that are applicable to violations of the price transparency requirements. CMS issued its first civil monetary penalties under the CMS hospital price transparency regulations in June of 2022. In addition to the CMS hospital price transparency regulations, the Departments have issued regulations that require most private health plans, including group health plans and individual health insurance market plans, to disclose pricing and cost-sharing information to their beneficiaries. A number of states have also adopted their own healthcare price transparency and/or disclosure statutes.

In addition to addressing surprise billing, the No Surprises Act contains a number of provisions that are intended to promote provider and health plan price transparency. Among other things, under the No Surprises Act, healthcare providers will be required to provide "good faith estimates" of their total expected charges for scheduled items and services to the patient's health plan if the patient is insured prior to the item and/or service being provided. Health plans will be required to provide patients with an "advanced explanation of benefits" that includes: (1) information regarding the network status of the provider, (2) a copy of the provider's "good faith estimate," (3) an estimate of the amount that the patient will be expected to pay for the item or service, and (4) information on any applicable pre-authorization requirements.

Although we continue to evaluate, and are taking proactive steps in response to, the legislative and regulatory developments regarding price transparency, we cannot predict how existing regulations will be implemented or interpreted or whether any other requirements will be imposed on providers and health plans. We also cannot predict what affect the public disclosure of hospitals' or insurance providers' negotiated rates will have on our future negotiations with payers or the effect that the disclosure of pricing information by healthcare providers and health plans will have on our patient volumes and revenues.

Executive Order - Competition in the American Economy

On July 9, 2021, President Biden issued an executive order that is intended to promote competition in the American economy. Among other things, the executive order encourages the Federal Trade Commission (the "***FTC***") to ban or limit non-compete agreements, directs the Food and Drug Administration to work with states and tribes to import prescription drugs from Canada, directs HHS to increase its support for generic and biosimilar drugs, issue a comprehensive plan to combat high drug prices, and support existing price transparency rules, and encourages the Department of Justice ("***DOJ***") and the FTC to review and revise their merger guidelines to ensure that patients are not harmed by hospital mergers. In response, on January 6, 2023, the FTC issued a proposed rule that would ban employers from imposing post-termination non-competes on its workers (whether employees or independent contractors), subject to certain exceptions, and require employers to rescind existing non-competes and actively inform workers that they are no longer in effect. The proposed rule may not apply to non-profit hospitals, which could create a competitive disadvantage for us in our hiring and retention efforts. Although we cannot predict whether the FTC's proposed rule will be adopted in its current form, any limitation or ban on our ability to enter into non-compete agreements with employed or contracted staff may impact our ability to hire and retain qualified physicians, nurses and other medical support personnel and may adversely affect our costs of doing business or our ability to deliver services in our communities. Also in response to the executive order, on February 3, 2023, the DOJ announced its withdrawal of three long-standing antitrust policy statements related to enforcement in the health care industry. These statements had provided guidance in the form of "safety zones," which described conduct that the antitrust agencies would not challenge under the antitrust laws, absent extraordinary circumstances. The safety zones covered a wide variety of collaborations between health care providers, including mergers, joint ventures, joint purchasing arrangements, information exchanges, and the formation and operation of financially and clinically integrated networks. The withdrawal of these antitrust policy statements signals increased antitrust scrutiny for collaborations within the health care industry. We cannot predict the impact that the withdrawal of DOJ's antitrust policy statements will have on our operations or future transactions or how, if at all, the various other initiatives set forth in the executive order will be implemented by the regulatory agencies involved.

U.S. Supreme Court Decision – Dobbs v. Jackson Women's Health Organization

On June 24, 2022, the U.S. Supreme Court issued a decision in *Dobbs v. Jackson Women's Health Organization* (the "***Dobbs Decision***") that overturned *Roe v. Wade* (the "***Roe Decision***") and held that the U.S. Constitution does not confer a right to an abortion. This decision sparked a litany of changes in state laws across the country, including a number of state "trigger" laws that have or are set to take effect and which ban or severely restrict the performance of abortion services and in some cases impose civil and criminal penalties on service providers and patients. In turn, many state legislatures have introduced bills or proposed state constitutional amendments to protect access to abortions, and lawsuits have been filed in numerous states challenging trigger bans and other abortion restrictions that went into effect after the Dobbs Decision. We cannot predict the full implications of the U.S. Supreme Court's Dobbs Decision or the impact that such decision, or any litigation arising therefrom, will have on us, our employees, or our patients.

Executive Order - Protecting Access to Reproductive Health Care Services

Following the U.S. Supreme Court's Dobbs Decision that overturned the Roe Decision, President Biden issued an executive order on July 8, 2022, that is intended, among other things, to coordinate the implementation of federal efforts to safeguard access to reproductive health care services (including abortion and contraception) and to protect patient privacy and access to accurate information. As directed by the executive order, on July 11, 2022, HHS announced new guidance that is intended to clarify provider responsibilities and protections under the federal Emergency Medical Treatment and Labor Act ("***EMTALA***") with respect to providing stabilizing medical treatment for pregnant women and those experiencing pregnancy loss. Notably, HHS affirms that EMTALA obligations preempt directly conflicting state abortion laws or bans when needed for emergency care. Consequently, according to HHS, under federal law, providers in emergency situations are required to provide stabilizing care to someone with an emergency medical condition, including the performance of abortion services if necessary, regardless of the state where they live. A violation of EMTALA could result in termination of a provider's Medicare provider agreement and/or the imposition of civil monetary penalties. On August 23, 2022, at the request of the Attorney General of the State of Texas, the U.S. District Court for the Northern District of Texas issued a preliminary injunction against enforcement of HHS's new EMTALA guidance as it pertains to Texas's abortion law. The next day, the U.S. District Court for the District of Idaho issued a preliminary injunction in favor of the DOJ blocking enforcement of Idaho's abortion ban to the extent the law conflicts with EMTALA-mandated care. As expected, the federal government appealed the decision in Texas, and we expect the Idaho decision to be appealed as well following its failed motion for reconsideration. We cannot predict the outcome of these and other lawsuits, or how federal and state government agencies will ultimately enforce EMTALA or related state laws in light of HHS's new guidance or the impact that the new guidance will have on our operations. We also cannot predict how, if at all, the various initiatives set forth in President Biden's executive order relating to reproductive health care services will be implemented by the regulatory agencies involved or the impact that the executive order will have on us, our employees, or our patients.

Healthcare Reform

In recent years, Congress has passed a number of laws, including the Affordable Care Act, that are intended to effect major changes in the U.S. healthcare system. The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The net effect of the Affordable Care Act, as currently adopted, on our business continues to be subject to a number of variables, including the law's complexity, its changing and often incomplete implementation of regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. While the U.S. Supreme Court rejected the most recent challenge to constitutionality of the Affordable Care Act, we cannot predict the outcome of other lawsuits that are still pending in lower courts regarding the implementation of various aspects of the Affordable Care Act or whether the U.S. Supreme Court will decide to hear future cases. Additionally, we cannot predict the impact that the current or future Presidential administrations and Congresses will have on the implementation and enforcement of the provisions of the Affordable Care Act or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

Expanded Coverage

Based on original Congressional Budget Office ("***CBO***") and CMS estimates, by 2020, the Affordable Care Act was originally expected to expand coverage for 32 to 34 million people, resulting in coverage of an estimated 95% of the legal U.S. population and an uninsured population of approximately 27 million individuals. This increased coverage was expected to occur through a combination of public program expansion and private sector health insurance and other reforms. In July 2021, the CBO estimated that, due to a number of factors, approximately 28 million people were uninsured in 2020 and that the number of uninsured individuals would remain relatively consistent through 2031.

Public program expansion has been driven primarily by expanding the categories of individuals who are eligible for Medicaid coverage and allowing individuals with relatively higher incomes to qualify for Medicaid coverage. When the Affordable Care Act was adopted, it essentially made the expansion of the Medicaid program mandatory. However, in 2012, the U.S. Supreme Court held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that chose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. Based on the U.S. Supreme Court's ruling, a number of states, including several in which the Company has facilities, have opted not to expand their Medicaid programs. Additional public program expansion has occurred through provisions of the Affordable Care Act that authorize the federal government to subsidize states that create non-Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL and allow Medicaid participating hospitals to make presumptive determinations of Medicaid eligibility for certain categories of individuals, such as pregnant women, infants, children, and parents and other caretaker relatives and their spouses. If an individual is found to be presumptively eligible for Medicaid benefits, the hospital will get paid for the services it provides during the temporary presumptive eligibility period, just as though the patient were already enrolled in the Medicaid program.

The expansion of health coverage through the private sector as a result of the Affordable Care Act has occurred through new requirements on health insurers, employers and individuals. For example, commencing January 1, 2014, health insurance companies were prohibited from imposing annual coverage limits, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. In addition, since January 1, 2011, each health plan has been required to keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. Also, since September 23, 2010, health insurers have not been permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old. Larger employers are subject to new requirements and incentives to provide health insurance benefits to their full-time employees, and, effective January 1, 2016, all employers subject to the requirement were required to offer health insurance coverage to 95% of their full-time employees and their dependents in order to avoid penalties.

To facilitate the purchase of health insurance by individuals and small employers, each state was required to establish an Exchange by January 1, 2014. For individuals and families below 400% of the FPL, the cost of obtaining health insurance through the Exchanges is subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. The ARP temporarily extends the availability of those subsidies to individuals and families with incomes over 400% of the FPL and increases the amount of the subsidies that are available for individuals and families who were already eligible for financial assistance under the Affordable Care Act. Health insurers participating in the Exchanges must offer a set of minimum benefits to be defined by HHS and may offer more benefits. Any benefits to us from the expansion of private sector coverage depend in large part on our success in contracting with payers whose policies are listed on the Exchanges. We currently have contracts with Exchange payers in every state in which we operate, and the reimbursement rates paid under those contracts generally are comparable to that paid to us by other private payers.

Public Program Spending

The Affordable Care Act provides for a number of Medicare, Medicaid and other federal healthcare program spending reductions. The CBO previously estimated that between 2013 and 2023, these program spending reductions would include $415 billion in Medicare fee-for-service market basket and productivity reimbursement reductions for all providers, the majority of which ($260 billion) would come from hospitals. The CBO's estimate also included an additional $56 billion in reductions of Medicare and Medicaid DSH funding. CMS had originally estimated that the Affordable Care Act would result in $64 billion in reductions of Medicare and Medicaid DSH funding, with $50 billion of the reductions coming from Medicare. Some of those reductions, most notably the Medicaid DSH funding reductions, have been delayed by subsequent legislation, and we cannot predict whether the public program spending reductions required by the Affordable Care Act will be further delayed or modified in the future.

Accountable Care Organizations

The Affordable Care Act required HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("***ACOs***"). ACOs are groups of hospitals and/or physicians and other designated professionals and suppliers who come together voluntarily to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS are eligible to share in a portion of the amounts saved by the Medicare program. There are several types of ACO programs, and as of January 17, 2023, 456 ACOs participate in the Medicare Shared Savings Program, and additional ACOs are being established by private payers. The number of ACOs participating in the Medicare Shared Savings Program decreased in 2023, but the policies finalized in the final PFS rule for CY 2023 are expected to grow participation next year. On November 1, 2022, CMS issued the CY 2023 PFS final rule which includes "significant reforms" to the Medicare Shared Savings Program intended to incentivize participation and promote equity and alignment across quality programs. Among other things, such measures include providing advance shared savings payments to certain new ACOs that serve underserved populations, allowing smaller ACOs more time to transition to downside risk, a health equity adjustment that would upwardly adjust ACOs' quality performance scores to reward excellent care delivered to underserved populations, and certain changes to benchmarking methodologies that are designed to encourage more ACOs to participate and succeed. A few of our facilities currently participate in ACOs.

Bundled Payment Pilot Programs

The Affordable Care Act created the Center for Medicare & Medicaid Innovation ("***CMMI***") and made it responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs while improving quality of care. Under these projects and initiatives, participating providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care and accept accountability for costs and the quality of care that is provided. By financially rewarding providers for quality, cost-effective care and penalizing providers when costs exceed a certain amount, these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. In connection with these programs, CMMI has developed a voluntary Bundled Payment for Care Improvement Advanced Model ("***BPCI Advanced***") to test innovative payment and service delivery models that have the potential to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care for beneficiaries. Participation in bundled payments programs is generally voluntary, but CMS does currently require hospitals in certain geographic areas to participate in the Comprehensive Care for Joint Replacement model, which covers certain extremity joint replacement procedures and is scheduled to end in 2024. CMS has developed a radiation oncology bundled payment program that was expected to begin on January 1, 2022, but has been delayed indefinitely until CMS determines a date through future rulemaking. CMS has indicated that it expects to develop additional voluntary and mandatory bundled payment models in the future. Several of our facilities currently participate in bundled payment programs.

Specialty Hospital Limitations

Over the last decade, we have faced competition from hospitals that have physician ownership. The Affordable Care Act prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand. As of December 31, 2022, we operated two hospitals through joint ventures with physicians in which we own a controlling interest.

Competition for Patients

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

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

In addition, tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, exemptions from sales, property and income taxes, and participation in the 340B Program. In certain states, some not-for-profit hospitals are permitted by law to directly employ physicians while for-profit hospitals are prohibited from doing so.

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

Human Capital Resources

Overview

Our facilities must compete with other healthcare providers for professional talent. A significant factor in our future success will be the ability of our facilities to attract and retain physicians, as it is physicians who decide whether a patient is admitted to the hospital and the procedures to be performed.

We also compete with other healthcare providers in recruiting and retaining qualified management and other healthcare providers such as nurses, pharmacists, and lab technicians and other non-physician personnel responsible for day-to-day operations of each of our facilities. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue, which has been heightened by the COVID-19 pandemic or other recent factors. This shortage has required, and may continue to require us, to enhance wages and benefits to recruit and retain nurses and other medical support personnel, recruit personnel from foreign countries, and utilize more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate.

At December 31, 2022, our subsidiaries collectively had approximately 50,000 employees, including approximately 12,000 part-time employees. The majority of these employees are hospital-based, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our facilities. We understand that, to fulfill our mission of Making Communities Healthier®, we must create places where people choose to come for healthcare, physicians want to practice, and employees want to work. To support this mission, talent development has been a longstanding strategic pillar for the organization.

Diversity, Equity and Inclusion

We are committed to creating an inclusive, community-based healthcare delivery system that provides equitable opportunities for all people, starting with our employees. We have appointed a Chief Diversity and Patient Experience officer who is leading an enterprise-wide strategy focused on training and education of our workforce, targeted efforts to address health equity in our communities, and the recruitment and development of diverse talent. This includes the creation of new formal partnerships to recruit more diverse talent and match new recruits with carefully selected mentors and sponsors within our organization.

Serving the Community

We have a culture of giving and service that impacts the community of care beyond the bedside. We do this by: (i) educating our employees on the importance of positively impacting the communities they call home, (ii) serving our communities by advancing our mission both inside and outside our facilities' walls, (iii) investing in organizations that align with our mission and are making a difference and (iv) leading by example through our collective impact nationwide.

Our Lifepoint Community Foundation guides our charitable giving and economic development efforts, reviews requests for local financial or in-kind support and continuously evaluates the effectiveness of our social responsibility efforts in supporting our mission. Our local community support includes, among other charitable causes, strategic community impact partnerships with Second Harvest Food Bank of Middle Tennessee and Special Olympics Tennessee.

We are committed to taking care of our Lifepoint family so we can better care for others. The Lifecare Fund was established in 2010 as a safety net for employees experiencing serious financial hardship from unforeseen or unpreventable circumstances. Managed by the Community Foundation of Middle Tennessee, Lifecare has provided financial assistance for thousands of our employees during their times of greatest need.

Recruitment and Retention

We believe that healthcare is best delivered close to home, and our facilities strive to recruit and retain qualified management and staff personnel. Our frontline caregivers, including nurses, are the heartbeat of our organization, and we have a robust strategy to enhance the recruitment and retention of clinical staff into the future. This strategy includes meaningful education and career advancement opportunities, and competitive compensation. The scarce availability of nurses and other medical support personnel in some markets, which has been heightened by the COVID-19 pandemic and other recent factors, has required us to enhance wages and benefits and/or utilize more expensive temporary personnel in certain situations.

Our facilities also employ and have affiliations with physicians. Many physicians today prefer to be employed, rather than operating their own practices or joining existing medical groups. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians and incur additional expenses as a result. We expect this trend to continue.

We seek to attract both employed and affiliated physicians by maintaining a sharp focus on quality, driven by our National Quality Program; employing high performing talent; equipping our facilities with technologically advanced equipment and an attractive, up-to-date physical plant; and otherwise creating an environment within which physicians choose to practice. While physicians may terminate their association with our facilities at any time, we believe that by striving to maintain and improve the quality of care at our facilities and by maintaining ethical and professional standards, our facilities will be better positioned to attract and retain qualified physicians with a variety of specialties.

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

Labor Costs and Union Activity

Approximately 2,000 of our employees across certain of our facilities are unionized. While some of our non-unionized facilities experience union organizing activity from time to time, currently we do not expect these efforts to affect our future operations materially. Our facilities, like most facilities, have experienced rising labor costs and increases in the rate and utilization of contract labor. Our labor costs also may increase at higher rates among unionized employees. Unionized employees also may have rights under their collective bargaining agreements that restrict the ability of a facility to take certain actions with respect to these employees.

Government Regulation

Overview

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

Legislative and Regulatory Developments in Response to COVID-19

Numerous legislative and regulatory actions were taken in an attempt to provide businesses, including healthcare providers, with relief from the negative impacts of the COVID-19 pandemic. The legislative and regulatory responses to COVID-19 generally impact many of the statutes, regulations and policies summarized or discussed throughout this Report. Unless otherwise noted, such summaries or discussions have not been updated to reflect the impact of the COVID-19 legislative and regulatory developments.

CARES Act and Related Stimulus Legislation

The CARES Act was signed into law on March 27, 2020. Among other things, the CARES Act contains a number of provisions that are intended to assist healthcare providers as they combat the effects of the COVID-19 pandemic. Those provisions include, among others:

- the temporary suspension of Medicare sequestration from March 1, 2020, to December 31, 2020;
- the delay of the planned reductions to the Medicaid DSH payments program until October 1, 2023;
- an appropriation of $180 million to Health Resources and Services Administration's Federal Office of Rural Health Policy that will be awarded to small rural hospitals by the states through the Small Rural Hospital Improvement Program;
- an appropriation of $250 million to the Hospital Preparedness Program; and
- an appropriation of $100 billion to the Public Health and Social Services Emergency Fund (the "***Emergency Fund***") for a new program to reimburse, through grants or other mechanisms, hospitals, healthcare providers and other approved entities for COVID-19-related expenses or lost revenues.

The Paycheck Protection Program and Health Care Enhancement Act was enacted on April 24, 2020, and, among other things, provides an additional allocation of $75 billion to the Emergency Fund and an allocation of $25 billion for COVID-19 testing.

On December 21, 2020, Congress adopted the CAA, which provides an additional $900 billion in COVID-19 relief, including an additional allocation of $3 billion to the Emergency Fund. In addition, the CAA, among other things, delays the planned reductions to the Medicaid DSH payments program through FFY 2023, adds additional reductions to the Medicaid DSH payments program in FFYs 2026 and 2027, provided for a 3.75% increase in the Medicare PFS rates in CY 2021 and allocates $30 billion for the purchase and administration of COVID-19 vaccines and related therapeutics. In addition, the CAA extended the temporary suspension of Medicare sequestration through March 31, 2021. The temporary suspension was subsequently extended through December 31, 2021, by HR 1868, which, to offset the cost of the suspension, extended Medicare sequestration through 2030. The Sequester Cuts Act further extended the temporary suspension of Medicare sequestration through March 31, 2022, and reduced the sequestration cuts for the period of April 1, 2022, through June 30, 2022, to 1%. The Sequester Cuts Act also delayed application of 4% cuts to Medicare and other federal programs resulting from the requirements of the PAYGO Act that were scheduled to go into effect in CY 2022 until CY 2023. On December 23, 2022, Congress adopted the CAA23, which reduces the Medicare sequestration cuts through CY 2024, and extends Medicare sequestration through 2032. The CAA23 also delays application of 4% cuts to Medicare and other federal programs mandated by the PAYGO Act that were scheduled to go into effect in CY 2023 and CY 2024 until CY 2025.

On March 11, 2021, the ARP was signed into law. Among other things, the ARP allocates approximately $70 billion for COVID-19 testing and vaccine efforts; provides $8.5 billion to reimburse rural healthcare providers, such as sole community hospitals, rural referral centers, rural health clinics, and providers located outside metropolitan statistical areas, for expenses and lost revenues attributable to COVID-19; provides incentives, in the form of temporary increases to the FMAP, to encourage states that have not expanded their Medicaid programs as permitted by the Affordable Care Act to do so; permits states to expand the availability and duration of Medicaid postpartum coverage; and temporarily expands the subsidies that are available to individuals who purchase insurance through the Exchanges.

Stimulus Payments

The Emergency Fund distributed approximately $43 billion to hospitals based on their 2018 net patient revenue. Additionally, since that time, the Emergency Fund has distributed more than $90 billion to a number of different types of healthcare providers, including participants in state Medicaid/CHIP programs, providers in areas particularly impacted by the COVID-19 outbreak, rural providers (including hospitals and rural health clinics), skilled nursing facilities, dentists, providers of services with lower shares of Medicare reimbursement or who predominantly serve Medicaid beneficiaries, and providers requesting reimbursement for the treatment of uninsured patients.

Payments made by the Emergency Fund to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, filing attestations acknowledging receipt of payments, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients, not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse, and submitting such reports as may be required by HHS regarding the provider's compliance with the terms and conditions of the Emergency Fund. Healthcare providers that received more than $10,000 from the Emergency Fund between April 10, 2020 through June 30, 2020 (the "***First Payment Received Period***") were required to submit a report on their use of those funds no later than September 30, 2021. We successfully submitted the required reports for all of our providers that received and retained payments from the Emergency Fund during First Payment Received Period prior to the deadline. However, we will be required to submit additional reports in the future for payments that were received and retained by our providers from the Emergency Fund after the end of the First Payment Received Period. The reporting requirements and guidance from HHS related to the Emergency Fund have been subject to frequent clarifications and revision, and there can be no assurance that we will not be required to submit additional reports or provide additional information related to the payments we received from the Emergency Fund in the future. In addition, HHS has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the Office of Inspector General of HHS (the "***OIG***"), will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, HHS temporarily expanded the CMS Accelerated and Advance Payment Program to a broad group of Medicare Part A and Part B providers. Under the expanded Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period.

We received a total of $991 million of Medicare advance payments under the CMS Accelerated and Advance Payment Program during the year ended December 31, 2020. During the year ended December 31, 2021, we fully repaid all Medicare advance payments, and we do not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program.

COVID-19 Waivers and Temporary Suspension of Certain Regulatory Requirements

In addition to the financial relief that has been provided by the federal government under the CARES Act and other legislation that has been passed by Congress, CMS and many state governments have also issued a number of waivers or temporarily suspended a number of healthcare facility licensure and reimbursement requirements in order to provide hospitals, skilled nursing facilities, and other types of healthcare providers with increased flexibility to meet the challenges that are being presented by the COVID-19 pandemic. For example, CMS has temporarily waived the enforcement of certain requirements of the Medicare hospital conditions of participation and the Stark law to enable hospitals to treat patients in temporary locations and to obtain services from physicians in a more efficient and timely manner. Likewise, many states have also suspended the enforcement of certain certificate of need and licensure requirements to ensure that hospitals and other healthcare providers have sufficient capacity to treat COVID-19 patients. Our facilities have utilized the waivers and regulatory flexibility that is being provided to the extent necessary to appropriately respond to the COVID-19 pandemic. On January 30, 2023, President Biden announced that his administration intends to end the COVID-19 public health emergency on May 11, 2023, which will result in termination of many of the flexibilities and waivers issued in response to the COVID-19 public health emergency that have not already been terminated.

CARES Act Tax Provisions

The CARES Act also provides for certain federal income tax changes, including an increase in the interest expense tax deduction limitation, the deferral of the employer portion of Social Security payroll taxes, refundable payroll tax credits, employee retention tax credits, net operating loss carryback periods, alternative minimum tax credit refunds and bonus depreciation of qualified improvement property. During the year ended December 31, 2020, we deferred cash payments of approximately $84 million related to Social Security payroll tax payments. During the year ended December 31, 2021, we fully repaid all previously deferred Social Security payroll taxes.

The federal income tax changes brought about by the CARES Act are complex and further guidance is expected. We may change our provision for income taxes and our deferred income taxes as our understanding of the CARES Act tax provisions evolves due to additional U.S. Department of Treasury guidance. Any such adjustments could materially impact our provision for income taxes and, as a result, our financial results in the relevant periods.

Fraud and Abuse Laws

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

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

Anti-kickback Statute

The federal Anti-kickback Statute is a criminal statute that generally prohibits the payment, receipt, offer or solicitation of anything of value, whether in cash or in kind, with the intent of generating referrals or orders, or recommending or arranging for services or items covered by a federal or state healthcare program. Violations of the Anti-kickback Statute are punishable by, among other things, imprisonment, criminal fines, substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation, damages equal to three times the total remuneration associated with the unlawful referrals or services, and/or possible exclusion from participating in Medicare, Medicaid or other governmental healthcare programs. Violations of the Anti-kickback Statute can also result in liability under the False Claims Act.

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

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

In 1998, the OIG published the Provider Self-Disclosure Protocol (which was subsequently replaced in 2013 and further amended in 2021 and renamed the Health Care Fraud Self-Disclosure Protocol) to establish a process for persons to voluntarily identify, disclose, and resolve instances of potential fraud involving federal healthcare programs and provide guidance on how to investigate this conduct, quantify damages, and report the conduct to OIG to resolve liability under OIG's civil monetary penalty authorities. We have a variety of financial relationships with physicians who refer patients to our facilities, including employment contracts, independent contractor agreements, professional service agreements, leases and joint ventures. We provide financial incentives to recruit physicians to relocate to communities served by our facilities. These incentives for relocation include minimum revenue guarantees and, in some cases, loans. The OIG is authorized to publish regulations outlining activities and business relationships that would be deemed not to violate the Anti-kickback Statute. These regulations are known as "safe harbor" regulations. Failure to comply with the safe harbor regulations does not, by itself, make conduct illegal, but instead the safe harbors delineate standards that, if complied with, protect conduct that might otherwise be deemed in violation of the Anti-kickback Statute. We intend for all our business arrangements to be in full compliance with the Anti-kickback Statute and seek to structure each of our arrangements with physicians to fit as closely as possible within an applicable safe harbor. However, not all of our business arrangements fit wholly within safe harbors, so we cannot guarantee that these arrangements will not be scrutinized by government authorities or, if scrutinized, that they will be determined to be in compliance with the Anti-kickback Statute or other applicable laws.

Eliminating Kickbacks in Recovery Act

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

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

Stark Law

The federal Stark law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship if those entities provide certain "designated health services" unless an exception applies. The Stark law also prohibits entities that provide designated health services reimbursable by Medicare and Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires entities to refund amounts received for items and services provided pursuant to a prohibited referral on a timely basis. "Designated health services" include, among other things, inpatient and outpatient hospital services, laboratory services and radiology services. A violation of the Stark law may result in (i) a denial of payment, (ii) substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation or circumvention scheme and (iii) exclusion from participation in the Medicare and Medicaid programs and other governmental healthcare programs. In addition, violations of the Stark law could also result in penalties under the False Claims Act.

There are ownership and compensation arrangement exceptions to the self-referral prohibition. There are also exceptions for many of the customary financial arrangements between physicians and facilities, including employment contracts, leases and recruitment agreements, and there is a "whole hospital exception," which allows a physician to make a referral to a hospital if, among other things, the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. The Affordable Care Act significantly modified the requirements of the whole hospital exception and placed a number of restrictions on the ownership structure, operations, and expansion of physician owned hospitals. Two of our facilities are subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations.

In recent years, CMS has issued a number of proposed and final rules modifying and/or clarifying the Stark law exceptions. For example, on November 20, 2020, HHS published two final rules related to the Anti-kickback Statute and the Stark law that are intended to reduce regulatory barriers to care coordination and ease unnecessary compliance burdens for physicians and other healthcare providers. Among other things, the rules create new Anti-kickback Statute safe harbors and Stark law exceptions for value-based and cyber-technology arrangements and provide new guidance and clarification as to how the Anti-kickback Statute and Stark law will be interpreted and enforced by the OIG and CMS, respectively. We cannot predict the impact that the final rules will have on our facilities and our operations or whether the recent trend toward reducing provider compliance burdens will continue in the future. We also anticipate that there will be further changes to the regulations that implement the Anti-kickback Statute and/or the Stark law, and those changes may require us to modify our activities.

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

False Claims Act

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

Changes in the Regulatory Environment

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

In addition to the changes mentioned above, the Affordable Care Act created False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. On February 11, 2016, CMS published a final rule that provides clarification around the meaning of overpayment identification and generally establishes a six-year lookback period for Medicare Part A and Part B providers and suppliers. However, on December 27, 2022, CMS issued a proposed rule that would, among other things, materially revise the meaning of overpayment identification, which, if adopted in its current form, could create uncertainty related to the timing of a provider's repayment obligations. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments, accurately prepare cost reports and timely resolve credit balances. In light of the provisions of FERA and the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law, including technical violations of certain fraud and abuse laws, and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

State Laws

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

Emergency Medical Treatment and Active Labor Act

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

On July 11, 2022, in response to an executive order issued by President Biden in the wake of the U.S. Supreme Court's Dobbs Decision that overturned the Roe Decision, HHS issued guidance on the applicability of EMTALA to the performance of abortion services when needed for emergency care. In its guidance HHS stated that EMTALA requires providers to provide stabilizing care to all individuals with an emergency medical condition, including providing abortion services when necessary, regardless of the state where they live. HHS also reiterated that EMTALA preempts directly conflicting state abortion laws that may restrict or ban abortions. A number of lawsuits have been filed challenging the enforceability of HHS's guidance in states with abortion laws. We cannot predict the outcome of these and other lawsuits, or how the federal and state government agencies will ultimately enforce EMTALA or related state laws in light of HHS's EMTALA guidance or the impact that such guidance will have on our operations or the cost of providing services in the communities we serve.

Administrative Simplification Provisions and Privacy and Security Requirements

We are subject to the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***") which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. Additionally, we are subject to the privacy, security and breach notification regulations promulgated under HIPAA and the Health Information Technology for Economic and Clinical Health Act (the "***HITECH Act***"), which are designed to protect the confidentiality, availability and integrity of protected health information ("***PHI***") and establish an array of patient rights with respect to such information. The HIPAA privacy, security and breach notification regulations apply to covered entities, which include health plans, healthcare clearinghouses, and healthcare providers that conduct certain standard transactions (such as billing insurance) electronically. In addition, certain provisions of the privacy, security and breach notification regulations apply to business associates, which are entities that perform certain functions or activities on behalf of covered entities that require access to or the use or disclosure of protected health information. In certain circumstances, a covered entity may be held liable for the actions of its business associate if HHS determines an agency relationship exists between the covered entity and the business associate under federal agency law.

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

HIPAA enforcement actions arise from audits, complaints, and breach notifications. Violations of the HIPAA regulations may result in criminal penalties and substantial civil monetary penalties subject to a limit for violations of the same requirement in a calendar year, based on the level of culpability associated with the violation. The civil monetary penalties are also subject to annual inflation adjustments. In addition, state attorneys general are authorized to bring civil actions seeking either injunction or damages up to $25,000 for violations of the same requirement in a calendar year in response to HIPAA violations that affect their state residents. HHS has the discretion in many cases to resolve HIPAA violations through informal means without the imposition of penalties. However, the HIPAA privacy, security and breach notification regulations have and will continue to impose significant costs on our facilities in order to comply with these standards. In recent years, enforcement of the HIPAA regulations has increased significantly, and we expect the increased level of enforcement to continue in the future.

Our facilities continue to remain subject to other applicable federal or state laws that are more restrictive than the HIPAA privacy and security regulations, which could impose additional penalties on us. For example, the federal government and some states impose laws governing the use and disclosure of health information pertaining to substance use disorder and/or mental health treatment that are more stringent than the rules that apply to healthcare information generally. In addition, the FTC uses its consumer protection authority to initiate enforcement actions against companies whose inadequate data security programs may expose consumers to fraud, identity theft and privacy intrusions, including the security programs of entities subject to the HIPAA regulations. Other state data privacy and security laws also may be applicable to certain data held by our facilities of residents of such states, such as the California Consumer Privacy Act of 2018, as amended by the California Privacy Rights Act of 2023, and the Virginia Consumer Data Protection Act, as well as other similar laws that are selected to go into effect in the future (for example, the Colorado Privacy Act, the Connecticut Data Privacy Act, and the Utah Consumer Privacy Act).

Corporate Practice of Medicine and Fee-Splitting

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

Facility Licensure, Certification, and Accreditation

All of our facilities must comply with various federal, state and local licensing and certification regulations and undergo periodic inspection by licensing agencies to certify compliance with such regulations. The initial and continued licensure of our facilities and certification to participate in government healthcare programs depends upon many factors including various state licensure regulations relating to quality of care, environment of care, equipment, services, staff training, personnel and the existence of adequate policies, procedures and controls. Federal, state and local agencies survey our facilities on a regular basis to determine whether the facilities are in compliance with regulatory operating and health standards and conditions for participating in government healthcare programs.

Most of our general acute care hospitals and IRFs maintain accreditation from private entities, such as The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities ("***CARF***"). The Joint Commission accredits a broad variety of healthcare organizations, including hospitals and behavioral health organizations. CARF accredits behavioral health organizations providing mental health and alcohol and drug use and addiction services, rehabilitation services, as well as opiate treatment programs, and other types of healthcare programs. These accreditation programs are intended generally to improve the quality, safety, outcomes and value of healthcare services provided by accredited facilities. Certain federal and state licensing agencies as well as many government and private healthcare payment programs require that providers be accredited as a condition of licensure, certification or participation. Accreditation is typically granted for a specified period, ranging from one to three years, and renewals of accreditation generally require completion of a renewal application and an on-site renewal survey.

The Controlled Substances Act and Drug Enforcement Administration ("***DEA***") regulations require every person who dispenses controlled substances to be registered with the DEA at each principal place of business or professional practice where the person dispenses controlled substances, subject to limited exceptions. Each hospital or clinic must hold a DEA registration at each location and may be subject to similar state registration requirements. In addition, our facilities are subject to a variety of federal and state statutes and regulations that govern operational issues related to pharmaceuticals and controlled substances, such as those related to packaging, storing, and dispensing of pharmaceutical drugs, inventory control and recordkeeping requirements for controlled substances, and other standards intended to prevent diversion of controlled substances. The DEA, the DOJ, HHS, and state boards of pharmacy have broad enforcement powers, may conduct audits and investigations and can impose substantial fines and other penalties, including revocation of registration.

Certificates of Need

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

Not-for-Profit Hospital Conversion Legislation

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

Environmental Regulation

Our healthcare operations generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Our operations, as well as our purchases and sales of healthcare facilities, are also subject to compliance with various other environmental laws, rules and regulations. Such compliance costs are not significant, and we do not anticipate that such compliance costs will be significant in the future. However, regulations limiting greenhouse gas emissions and energy inputs may increase in coming years, which may increase our costs associated with compliance, disrupt and adversely affect our operations and could materially adversely affect our financial performance.

Compliance Program

We maintain a company-wide ethics and compliance program designed to ensure that we maintain high standards of ethical conduct in the operation of our business and to meet or exceed applicable federal guidance and industry standards. We continually implement written policies and procedures for all of our employees to promote compliance with all applicable laws, regulations and Company policies and to encourage a "culture of compliance" within the Company and its facilities. The organizational structure of our ethics and compliance program includes oversight by our Board of Directors and compliance committees at the Company and facility levels. We have compliance officers and personnel at the Company level and at our facilities. Other features of our compliance program include initial and periodic ethics and compliance training, systems for identifying and tracking compliance issues (including databases and hotlines for employees to report, without fear of retaliation, any suspected legal or ethical violations), regular auditing and monitoring of compliance issues, including coding audits and reviews of our financial relationships with physicians, and prompt review and resolution of identified issues.

Our compliance program also oversees the implementation and monitoring of the standards set forth by HIPAA for privacy. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and oversight at the Company level.

Risk Management and Insurance

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("***SIR***") and deductible levels. At December 31, 2022, our SIR for professional liability claims is $15 million per claim at the majority of our acute care hospitals. Additionally, we participate in state-specific professional liability programs in Indiana, New Mexico and Pennsylvania. We have a $25,000 deductible for professional liability at each of our IRFs and behavioral health hospitals. At December 31, 2022, our deductible for workers' compensation claims at each of our acute care and behavioral health hospitals was $1 million per claim in all states in which we operate except for Montana and Washington. We participate in state-specific programs for our workers' compensation claims arising in these states. There is no deductible for workers' compensation claims at our IRFs. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

We also maintain directors' and officers', property, some professional liability and other types of insurance coverage with unrelated commercial carriers. Our directors' and officers' liability insurance coverage for current officers and directors is a program that protects us as well as the individual director or officer. We maintain property insurance through unrelated commercial insurance companies.

We operate a captive insurance company under the name Point of Life Indemnity, Ltd. This captive insurance company, which is licensed by the Cayman Islands Monetary Authority and is a wholly-owned subsidiary of Lifepoint, issues malpractice indemnity policies to some subsidiaries employing physicians and advanced practice providers.

Item 1A. ***Risk Factors.***

Any of the following risks could materially and adversely affect our business, financial condition, results of operations or cash flow. In addition, the risks described below are not the only risks that we face. The following information should be read in conjunction with "Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Report. Additional risks and uncertainties not currently known to us or those that we currently view to be immaterial could also materially and adversely affect our business, financial condition, results of operations or cash flow.

Risk Factor Summary

The following is a summary of the principal risks that could adversely affect our business, financial condition, results of operations or cash flow.

Business and Operational Risks

- Changes in reimbursement rates, methods or timing of payment by federal or state programs may reduce our Medicare or Medicaid payments and adversely affect our revenues, results of operations and cash flow.
- Changes to Medicaid supplemental payment programs may materially and adversely affect our revenues, results of operations and cash flow.
- Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may adversely affect our revenues, results of operations and cash flow.
- Uncertainty regarding the Affordable Care Act or future healthcare reform may adversely affect our business, financial condition, results of operations and cash flow.
- The evolving and ongoing COVID-19 global pandemic continues to affect our operations, business and financial condition, and the emergence and effects related to a future pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations and financial condition.
- We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations, or it could diminish the anticipated value of the acquired facility.
- We are subject to risks associated with outsourcing functions to third parties, including risks associated with the protection of patient data.
- We conduct a significant portion of our operations through joint ventures. We cannot provide assurances that relationships with our joint venture partners will remain strong, which could negatively affect our joint ventures, affiliations and other strategic alliances as well as our overall business.
- If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.
- Deterioration in the collectability of "patient due" accounts could adversely affect our revenues, results of operations and cash flow.
- Other hospitals and inpatient and outpatient facilities provide services similar to those which we offer. In addition, physicians and other healthcare practitioners provide services in their offices that could be provided in our facilities. These factors increase the level of competition we face and may therefore adversely affect our revenues, results of operations and cash flow.
- We may have difficulty acquiring or divesting facilities on favorable terms. Furthermore, our business could be negatively affected if acquisitions or divestitures are not successfully completed or if contingent liabilities materialize in connection with such transactions.
- If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results and cash flow could be negatively impacted.
- Under each of the 2021 Master Lease (defined below) and the Springstone Master Lease (defined below), a default with respect to one facility could cause a default under all of the facilities subject to the 2021 Master Lease or the Springstone Master Lease, respectively, which could have a material adverse effect on our business, financial condition, results of operations and cash flow.
- Because many of the facilities we operate are subject to long-term leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises.
- Many of the non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies intended to generate organic growth and improve operating results at our facilities.
- Our financial condition, results of operations and cash flow may be adversely affected by changing economic conditions.
- Supply chain issues of the medical supplies, equipment and pharmaceuticals used in our facilities could adversely affect our operating results.
- Our operations may be adversely impacted by the effects of climate change, extreme weather conditions, natural disasters such as hurricanes and earthquakes, hostilities or acts of terrorism and other criminal activities.

Credit and Liquidity Risks

- Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations or fund strategic initiatives, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments.
- Our debt agreements contain restrictions that will limit our flexibility in operating our business.
- We are dependent on cash flow generated by our subsidiaries to service our indebtedness.

- We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.
- Our ability to obtain, and the terms of any, financing or refinancing will be dependent on the condition of the financial markets and our financial condition and operating performance. Any inability to obtain refinancing as our debt matures could materially and adversely affect our financial condition.
- Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.
- Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.
- We may not be able to generate sufficient cash flow through operations or successfully access other capital resources to fund all of our capital expenditure programs and commitments.
- Our ability to utilize our net operating loss carryforwards ("***NOLs***") may be limited, and we may not be able to utilize our NOLs as a result of recent U.S. federal tax reform legislation.

Human Capital Risks

- Factors related to our employment of physicians could affect our financial performance.
- Our operations and ability to deliver healthcare services efficiently may be adversely affected by competition for staffing and the shortage of experienced physicians, nurses and other healthcare professionals.
- Increased labor costs due to inflation and competition for experienced physicians, nurses, qualified management and other healthcare professionals, including due to low unemployment levels and staffing shortages, could adversely affect our financial results.
- Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and subject to the terms of collective bargaining agreements.
- We are dependent on our executive management team and the loss of the services of one or more members of our executive management team could have a material adverse effect on our business.

Regulatory and Legal Risks

- We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may adversely affect our revenues, results of operations and cash flow.
- We may be subjected to actions brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the False Claims Act's "qui tam" or "whistleblower" provisions.
- We may be subjected to liabilities because of malpractice and other legal claims brought against our facilities or healthcare providers associated with, or employed by, our facilities or affiliated entities. If we become subject to these claims, we could be required to pay significant damages, which may not be covered by insurance.
- As a result of reviews of claims to Medicare and Medicaid for our services, we may experience delayed payments or incur additional costs and may be required to repay amounts already paid to us.
- Controls designed to reduce inpatient services may adversely affect our revenues, results of operations and cash flow.
- If we do not manage admissions in the IRFs that we operate or manage in compliance with a 60% threshold, reimbursement for services rendered by us in these facilities will be based upon less favorable rates.
- Certificate of need laws and regulations regarding licenses, ownership and operation may impair our future expansion in some states. In states without certificate of need laws, competing providers of healthcare services are able to expand and construct facilities without the need for significant regulatory approval.
- Failure to implement and use certified health information technology in an effective and timely manner could adversely affect our operations and result in reduced Medicare and Medicaid reimbursement and government enforcement actions.
- The industry emphasis on value-based purchasing and bundled payment arrangements may negatively affect our revenues.
- The implementation of participation and quality measurement requirements under the MACRA's Merit-Based Incentive Payment System may affect our revenues.
- If current or future laws or regulations force us or cause us to restructure our arrangements with physicians and other providers, we may incur additional costs, lose contracts and suffer a reduction in net revenue under existing contracts, and we may need to refinance our debt or obtain consent from our lenders.
- We care for a large number of vulnerable individuals with complex needs and any incident involving one or more of our patients or the failure by one or more of our facilities to provide appropriate care could adversely affect our business, financial condition, results of operations or cash flow.

Data Security and Privacy Risks

- A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.
- If access to our information systems or those provided by our third-party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.
- If we fail to comply with our obligations under license or technology agreements with third parties, we may be required to pay damages and we could lose license rights that are critical to our business.

Business and Operational Risks

Changes in reimbursement rates, methods or timing of payment by federal or state programs may reduce our Medicare or Medicaid payments and adversely affect our revenues, results of operations and cash flow.

For the years ended December 31, 2022, 2021 and 2020, approximately 57.1%, 56.1% and 55.7% of our revenues, respectively, related to patients participating in Medicare and Medicaid programs, collectively. Numerous factors could materially decrease, or delay timing of, Medicare and Medicaid payments to our facilities and, accordingly, adversely affect our revenues, results of operations and cash flow. These factors include statutory and regulatory changes, administrative rulings and determinations concerning patient and provider eligibility and requirements for utilization review. Furthermore, the Affordable Care Act and related federal laws provide for material scheduled reductions in the growth rate of Medicare and Medicaid program spending, including reductions in market basket updates and Medicare and Medicaid DSH funding. Additionally, a number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures or reform their Medicaid programs, including enrolling Medicaid recipients in managed care programs or converting to modified block grant funded programs. States also may impose additional taxes on hospitals to help finance the state's Medicaid programs.

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

MSPs are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and UPL payments. Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the additional costs incurred by hospitals in treating these patients. The total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law. Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars.

The Affordable Care Act called for significant reductions in Medicaid DSH funding to account for decreases in uncompensated care anticipated under the health insurance coverage expansion. Subsequent changes in the law have delayed the implementation of these reductions until FFY 2024. Reductions in Medicaid DSH payments may take place without increases in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

UPL programs have expanded in recent years and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs. We cannot predict whether MSP programs will continue, and, if continued, whether we will qualify for such programs, or guarantee that revenues recognized from these programs will not decrease.

Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may adversely affect our revenues, results of operations and cash flow.

The amounts we receive for services provided to patients are determined by a number of factors, including the payer mix of our patients and the reimbursement methodologies and rates utilized by our payers. We have seen shifts of patients from commercial and private insurance to Medicare and Medicaid programs and from "traditional" fee-for-service Medicare and Medicaid programs to managed Medicare and Medicaid programs. Reimbursement rates generally are lower for (i) Medicare and Medicaid beneficiaries than they are for patients whose care is covered by commercial and private insurance and (ii) managed Medicare and Medicaid beneficiaries than they are for traditional Medicare and Medicaid beneficiaries. Broad economic factors, including those resulting from the COVID-19 pandemic, inflationary pressures, supply chain disruptions, labor shortages, increased unemployment and underemployment rates and reduced consumer spending and confidence, may impact our revenue mix. We also experience demographic pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs. Our revenues, results of operations and cash flow may be adversely affected by these shifts.

In addition, our revenues from negotiated rates with HMOs, PPOs, insurance companies, employers and other private payers may decline based on renegotiations and the respective bargaining power of these parties. Also, consolidation among private payers may increase their bargaining power over fee structures. As a result, payers increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk related to paying for care provided. These changes include moving away from a percent of charge payment structure to a fixed payment for an episode of care, which typically reduces our payment rate and limits our ability to raise prices going forward. Furthermore, low-cost plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices, restrict or exclude our facilities or impose significantly higher cost sharing obligations for care provided by our facilities if they are classified in a disfavored tier. In addition, other healthcare providers, including some with greater financial resources, greater geographic coverage or a wider range of services, may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care plans to contract with us. As payments are reduced, if we are excluded from more payer networks or if the scope of services covered by payers is limited, there could be a material adverse effect on our revenues, results of operations and cash flow.

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

Uncertainty regarding the Affordable Care Act or future healthcare reform may adversely affect our business, financial condition, results of operations and cash flow.

The Affordable Care Act dramatically altered the U.S. healthcare system, and we have expended substantial cost and effort to prepare for and comply with the Affordable Care Act. The net effect of the Affordable Care Act on our business continues to be subject to a number of variables, including the law's complexity, its changing and often incomplete implementation of regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. Additionally, the Affordable Care Act has been the subject of numerous legal challenges and legislative efforts to delay, defund or repeal the implementation or amend significant provisions of the Affordable Care Act. We cannot predict the outcome of lawsuits regarding the implementation of various aspects of the Affordable Care Act and whether the U.S. Supreme Court will decide to hear additional cases related to the Affordable Care Act in the future. We also cannot predict the impact that the current or future Presidential administrations and Congresses will have on the implementation and enforcement of the provisions of the Affordable Care Act or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

The evolving and ongoing COVID-19 global pandemic continues to affect our operations, business and financial condition, and the emergence and effects related to a future pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations and financial condition.

The COVID-19 global pandemic has impacted and it may continue to affect our facilities, employees, patients, communities, business operations and financial performance, as well as the U.S. economy and financial markets. Although vaccines have been developed and distributed in the U.S., the length and severity of the COVID-19 pandemic continues to evolve and much of its impact remains unknown and difficult to predict because many of the driving factors are beyond our control, including the vaccination rates in the communities we serve, the number and severity of the variants and related subvariants of the virus that emerge, and the effectiveness of the vaccines against the virus and those variants and related subvariants.

Although we continue to take precautions to ensure we can continue providing quality care and safeguard the health and well-being of patients, employees, providers, volunteers and visitors in each community we serve, exposure to COVID-19 and variants of the virus has increased the cost of operating our facilities and has led to increased risks to doctors and nurses, which has caused staffing shortages and required us to utilize temporary healthcare practitioners and may further reduce our operating capacity. Certain of our facilities have experienced staffing shortages, and they could become overwhelmed by excessive demand, potentially preventing them from treating all patients who seek care. We also have experienced supply chain disruptions during the pandemic, including shortages and delays, as well as price increases in equipment, inventory, pharmaceuticals and medical supplies, particularly personal protective equipment (or PPE). Any staffing, equipment, inventory, pharmaceutical and medical supplies shortages may impact our ability to see, admit and treat patients. In addition, the impact of labor shortages across the healthcare industry may result in other healthcare facilities, such as nursing homes, limiting admissions, which may constrain our ability to discharge patients to such facilities and further exacerbate the demand on our resources, supplies and staffing.

As evidenced by the COVID-19 pandemic, the occurrence of a pandemic, epidemic, outbreak of an infectious disease or other public health crisis in an area in which we operate could adversely affect our operations and financial condition. In reaction to such a crisis or the fear of exposure to infection, patients might cancel elective procedures or fail to seek needed care at our facilities, which could result in reduced patient volumes and operating revenues, potentially over an extended period of time. Furthermore, a pandemic, epidemic or outbreak might adversely affect our operations by causing a temporary shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. Additionally, such a crisis could diminish the public trust in healthcare facilities, especially hospitals that fail to accurately or timely diagnose, or are treating (or have treated) patients affected by infectious diseases, and negatively affect the reputation at our facilities.

Although we have disaster plans in place and operate pursuant to infectious disease protocols, the extent to which the potential emergence of a pandemic, epidemic or outbreak would impact our business and operations is difficult to predict and would depend on many factors beyond our control, including the speed of the contagion, the development and implementation of effective preventative measures and possible treatments, the scope of governmental and other restrictions on travel and other activities, and public reactions to these factors.

We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations or it could diminish the anticipated value of the acquired facility.

We may be unable to timely and effectively integrate facilities that we acquire with our ongoing operations. Many of the facilities we have acquired had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced delays in improving the operating margins or effectively integrating the operations of our acquired facilities, and we may experience such delays in implementing operating procedures and systems in newly or future acquired facilities. Integrating an acquired facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow, distract management and other key personnel, negatively impact our ability to attract, retain and motivate current and prospective employees, subject us to increased regulatory oversight, and result in legal proceedings. Additionally, we may experience delays in reimbursement from governmental and third-party payers as a result of the change of ownership of our acquired facilities.

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

Facilities we have acquired or facilities we acquire in the future, may have unknown or contingent liabilities for historical activities or conditions, including liabilities for failure to comply with laws and regulations, retroactive payment adjustments or recoupments from payer and Emergency Fund audits, medical and general professional malpractice liabilities, unfunded pension liabilities, workers' compensation or other employee-related liabilities, previous tax or environmental liabilities, regulatory and compliance related liabilities, and unacceptable business or accounting practices. Although we endeavor to obtain contractual indemnification from sellers covering these matters in connection with some acquisitions, we have not obtained contractual indemnifications in connection with all of them, and any indemnification obtained from sellers may be insufficient to cover material claims or liabilities for past activities of acquired businesses and the sellers may have insufficient funds to satisfy any claims or liabilities for which we may otherwise be entitled to be reimbursed.

We typically retain and rely on existing local management teams at newly acquired facilities to implement changes to operating procedures and systems. Integrating local management teams can involve cultural and systems challenges that may demand a disproportionate share of our resources and senior management's attention, and we may experience turnover of providers and other key personnel. Our acquisitions have become, and may continue to become larger, and may occur in communities with competing facilities. As a result, the issues surrounding integration may become more complex, expensive and time-consuming and may have a greater impact on our financial performance when we experience delays or difficulties.

Our growth has placed, and will continue to place, increased demands on our management, operational and financial information systems and other resources. Furthermore, expansions into new geographic markets and diversification of services and service lines may require us to comply with new and unfamiliar legal and regulatory requirements, which could impose substantial obligations on us and our management, cause us to expend additional time and resources, and increase our exposure to penalties or fines for non-compliance with such requirements. To accommodate our past and anticipated future growth, and to compete effectively, we will need to continue to improve our management, operational and financial information systems and to expand, train, manage and motivate our workforce. Our personnel, systems, procedures or controls may not be adequate to support our operations in the future. Further, focusing our financial resources and management attention on the expansion and diversification of our operations may negatively impact our financial results. Any failure to improve our management, operational and financial information systems, or to expand, train, manage or motivate our workforce, could reduce or prevent our growth.

We are subject to risks associated with outsourcing functions to third parties, including risks associated with the protection of patient data.

We outsource selected business functions to third parties, including electronic health record software and data hosting, revenue cycle management, patient access, billing, cash collections, payment compliance and support services, project implementation, supply chain management, payroll system services and a portion of our cybersecurity management. We take steps to monitor and regulate the performance of the independent third parties to whom we delegate selected functions. Arrangements with third-party service providers may make our operations vulnerable if vendors fail to satisfy their obligations to us as a result of their performance, changes in their own operations, financial condition, or other matters outside of our control. We may also face legal, financial or reputational harm for the actions or omissions of such providers, including for violations of HIPAA and other privacy and security laws applicable to healthcare providers and the Cures Act information blocking regulations, and we may not have effective recourse against the providers for those harms. While we evaluate the information security programs and defenses of such third parties, we cannot be certain that our evaluations will identify all or any potential information security weaknesses, or that such third parties' information security protocols are or will be sufficient to withstand or adequately respond to a cyber-attack or other information security incident. The expanding role of third-party providers may also require changes to our existing operations and the adoption of new procedures and processes for retaining and managing these providers, as well as redistributing responsibilities as needed. Effective management, development and implementation of our outsourcing strategies are important to our business and strategy. If there are delays or difficulties in enhancing business processes or our third-party providers do not perform as anticipated, we may not fully realize on a timely basis the anticipated economic and other benefits of the outsourcing projects or other relationships we enter into with key vendors, which could result in substantial costs, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us. Terminating, transitioning or renegotiating arrangements with key vendors or failure to renegotiate on favorable terms could result in additional costs and a risk of operational delays, potential errors and possible control issues as a result of the termination or during the transition or renegotiation phase.

We conduct a significant portion of our operations through joint ventures. We cannot provide assurances that relationships with our joint venture partners will remain strong, which could negatively affect our joint ventures, affiliations and other strategic alliances as well as our overall business.

We are a party to a number of joint ventures, affiliations and other strategic alliances as part of our business strategy. We expect to enter into similar transactions in the future, including joint ventures where we may have a noncontrolling interest. Any changes in our relationships with our joint venture partners could disrupt ongoing business, negatively affect results of operations or cash flow and distract management and other key personnel. In the event of a material disagreement with any of our joint venture partners or the breach of any of our joint venture agreements, a joint venture may be subject to dissolution, unwinding or purchase of either party's interest, which could adversely affect our revenues, results of operations or cash flow, or result in reputational harm.

As a general matter, our joint venture partners may have investment and operational goals that are not aligned with our company-wide objectives, including the timing, terms and strategies for future growth and development opportunities, and we could reach an impasse on certain decisions, which may hinder our ability to pursue preferred strategies for growth and development, could require significant resources and attention from management and key employees to resolve and could have an adverse effect on our operations, cash flow and revenue growth. In addition, our joint venture relationships with not-for-profit partners and the agreements that govern these relationships are structured based on current provisions of the Internal Revenue Code of 1986, as amended (the "***Code***") (and the Treasury Regulations thereunder), published rulings by the Internal Revenue Service ("***IRS***"), as well as case law relevant to joint ventures between for-profit and not-for-profit entities. Material changes in these legal authorities could adversely affect our relationships with not-for-profit partners and related joint venture arrangements.

Furthermore, joint ventures in which we have a noncontrolling equity interest and noncontrolling investments may involve a lesser degree of control over business operations, thereby potentially increasing the financial, legal, operational and compliance risks associated with the joint venture or noncontrolling investment. We may be dependent on joint venture partners or management who may have business interests, strategies or goals that are inconsistent with ours. Business decisions or other acts or omissions of the joint venture partner or management may adversely affect the value of our investment, result in litigation or regulatory action against us or result in reputational harm to us. To the extent another party makes decisions that negatively impact the joint venture or internal control issues arise within the joint venture, we may have to take responsive or other actions or we may be subject to penalties, fines or other related actions for these activities.

If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.

As of December 31, 2022, we had approximately $3.9 billion of goodwill and other intangible assets and approximately $3.1 billion of property and equipment, net of accumulated depreciation. We expect to recover the carrying values of our goodwill and other long-lived assets through our future cash flows. We evaluate the carrying value of our goodwill at least annually, based on our fair value determined using a discounted cash flow analysis and consideration of certain market inputs, to determine whether it is impaired. We evaluate our long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows. If the carrying value of our goodwill or our long-lived assets is impaired, we may incur a material non-cash charge to earnings.

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

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

If we experience growth in self-pay volume and revenue, including increased acuity levels for uninsured patients and increases in co-payments and deductibles for insured patients, our revenues, results of operations and cash flow could be adversely affected. Although we have experienced a reduction in uninsured patients since 2014 as a result of the Affordable Care Act and the expansion of state Medicaid programs, we are unable to predict whether that trend will continue in light of the repeal of the penalties associated with the individual mandate, the cessation of the cost sharing reduction payments to insurers, the decision by some states not to expand their Medicaid programs, and the availability and utilization of employer-sponsored health plans. In addition, the risk of collection from insured patients (and the amounts due) has increased, and will likely continue to increase, as a result of more individuals being enrolled in insurance plans with high deductibles and high co-payments, including those purchased on the Exchanges. Furthermore, our ability to improve co-insurance collections and collections from self-pay patients may be limited by legislative developments, such as federal and state legislation designed to reduce "surprise billing," or by other regulatory or investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

An increase in the proportion of our accounts receivable being comprised of uninsured accounts and a deterioration in the collectability of these both insured and uninsured accounts could adversely affect our revenues, results of operations and cash flow. Even if the Affordable Care Act remains implemented in its current form, we may continue to experience bad debts and be required to provide uninsured discounts and charity care for patients who choose not to purchase coverage, are undocumented immigrants who are not permitted to enroll in the Exchanges or government healthcare programs or live in states that do not expand or maintain the expansion of their Medicaid programs.

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

Competition among hospitals and other healthcare service providers, including inpatient and outpatient facilities, has intensified in recent years. We also have acquired, and may continue to acquire, larger facilities in more concentrated population centers, which experience greater competition for healthcare services. We compete with other facilities, including larger tertiary and quaternary care centers located in metropolitan areas. Although the facilities with which we compete may be a significant distance away from our facilities, patients in our markets may migrate on their own to, may be referred by local providers to, or may be required by their health plan to travel to these facilities. Furthermore, some of the facilities with which we compete may offer more or different services than those available at our facilities, may have more advanced equipment or technology or may have a medical staff that is perceived to be better qualified. We also compete with facilities and health systems that are implementing physician and other provider alignment strategies, such as employing providers, acquiring physician practice groups and participating in ACOs or other clinical integration models, which may impact our competitive position. Also, many of the facilities that compete with our facilities are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions and are eligible to participate in the 340B Program. These facilities, in most instances, are also exempt from paying sales, property and income taxes and have the ability to issue tax-exempt bonds for financing.

Quality of care, value-based purchasing, and price transparency have also become significant trends and competitive factors in the healthcare industry. CMS makes public the performance data relating to multiple quality measures that facilities submit in connection with their Medicare payment. CMS also requires every Medicare participating hospital to establish and update annually a public online listing of the hospital's standard charges for items and services and has issued regulations that significantly increase hospital charge reporting requirements. If the publicly-available performance and charge data become a primary factor in where patients choose to receive care, and if competing facilities have lower charges or better results than our facilities on those measures, our revenues and/or patient volumes could decline.

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

We may have difficulty acquiring or divesting facilities on favorable terms. Furthermore, our business could be negatively affected if acquisitions or divestitures are not successfully completed or if contingent liabilities materialize in connection with such transactions.

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

The cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired facility's results of operations, allocation of purchase price, effects of subsequent legislation and limitations on rate increases. As part of our acquisition strategy, we may commit to making significant capital improvements at acquired facilities. Such improvements may be difficult to achieve in the anticipated timeframe, if at all, due to a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions.

Our ability to engage in certain acquisitions in several states may be limited due to exclusivity, non-competition and non-solicitation provisions that we have agreed to in connection with our joint ventures, leases and previous acquisitions and divestiture transactions. Additionally, certain acquisitions may require the consent of and collaboration with our joint venture partners based upon the applicable governing documents. If we cannot obtain the cooperation of our joint venture partners in certain instances, we may not be able to pursue these opportunities.

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

In recent years, the legislatures and attorneys general of several states have sought to exercise more active oversight authority regarding sales of facilities by tax-exempt entities. For example, as a condition to approving an acquisition involving a non-profit hospital, the state attorney general of a state in which an acquisition takes place may require us to maintain specific service lines or provide charity care at certain minimum levels for set periods of time after closing of the acquisition, regardless of profitability. Additionally, the federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive, and antitrust enforcement in the healthcare industry is currently a priority of the FTC and the DOJ, including with respect to hospital and physician practice acquisitions. This heightened scrutiny may increase the cost and difficulty, or prevent the completion, of transactions in the future. Our failure to acquire facilities consistent with our growth plans could prevent us from increasing our revenues.

We regularly evaluate the potential disposition of assets and facilities that may no longer help us attain our objectives. When we decide to sell assets or facilities, we may encounter difficulties in finding buyers or alternative exit strategies on acceptable terms or in a timely manner, which could delay the accomplishment of our strategic objectives. Certain of our facilities are subject to master leases which, in general, may make it more difficult for us to dispose of facilities or terminate facility leases subject to the terms of such master leases, including under the terms of our Master Lease Agreement, dated December 23, 2021, entered into with certain affiliates of Medical Properties Trust, Inc. ("***MPT***") (as amended from time to time, the "***2021 Master Lease***") and the Amended and Restated Master Lease, dated February 7, 2023, entered into with certain affiliates of MPT (as amended from time to time, the "***Springstone Master Lease***"). We may also dispose of assets or a facility at a price, or on terms, less desirable than we anticipated. In addition, we may experience greater dis-synergies than expected. After reaching an agreement with a buyer for the disposition of assets or a facility, we will be subject to satisfaction of pre-closing conditions as well as to necessary regulatory and governmental approvals on acceptable terms, which, if not satisfied or obtained, may prevent us from completing the transaction. Dispositions may also involve continued financial involvement in the divested facilities, such as through continuing equity ownership, guarantees, indemnities, transition service agreements or other financial and commercial obligations, and inability to avoid retention of certain regulatory and compliance risks. There can be no assurance that the anticipated benefits of our future divestiture strategies will be realized. Furthermore, we may be exposed to contingent liabilities in connection with completed divestitures. Finally, certain acquisition agreements and joint venture arrangements contain covenants that restrict our ability to dispose of certain facilities without first seeking consent of a joint venture partner or other third parties, which may affect our ability to take advantage of business opportunities that may be in our interest. If we do not realize the anticipated benefits of such divestitures, if contingent liabilities related to such divestitures materialize or if we are unable to divest certain properties on favorable terms or at all, this could have a material adverse effect on our results of operations and cash flow.

If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results and cash flow could be negatively impacted.

We have initiated a multi-year business initiative to standardize certain processes, policies and systems throughout our facilities, including migrating our multiple IT platforms to a smaller number of enterprise-wide systems solutions. If we do not allocate and effectively manage the resources necessary to build and sustain the proper IT infrastructure and implement standardized systems, or if we fail to achieve the expected benefits from this initiative, it may impact our ability to operate profitably and efficiently, as well as comply in a timely manner with changing regulatory requirements and with the requests of patients, payers and business partners. The failure to transition to these systems on time, or anticipate necessary readiness and training needs, could lead to business disruption and loss of revenue. In addition, the operating results of newly acquired facilities could be impacted if such facilities are not integrated on a timely basis into our new systems. The actions we take to resolve compliance or regulatory issues within acquired facilities may affect our revenue, results of operations or cash flow.

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

Under each of the 2021 Master Lease and the Springstone Master Lease, a default with respect to one facility could cause a default under all of the facilities subject to the 2021 Master Lease or the Springstone Master Lease, respectively, which could have a material adverse effect on our business, financial condition, results of operations and cash flow.

Upon certain defaults under each of the 2021 Master Lease and the Springstone Master Lease, even if such default relates to one facility under the 2021 Master Lease or the Springstone Master Lease, as the case may be, the applicable lessors may terminate the 2021 Master Lease or Springstone Master Lease in its entirety with respect to all of the facilities governed by such 2021 Master Lease or Springstone Master Lease, as the case may be. Under each of the 2021 Master Lease and the Springstone Master Lease, the portfolio of facilities supporting each of the 2021 Master Lease and the Springstone Master Lease is subject to financial covenants, including required minimum lease coverage and fixed charge coverage ratios. The failure to meet or obtain a waiver of such covenants or otherwise cure such non-compliance with such financial covenants in the 2021 Master Lease or the Springstone Master Lease in the future could result in an event of default under the 2021 Master Lease or the Springstone Master Lease, as the case may be.

Other events that could trigger a default under the 2021 Master Lease or the Springstone Master Lease if not cured within the time periods required by the 2021 Master Lease or the Springstone Master Lease, as the case may be, include, without limitation, (i) failure to pay rent or other amounts due under the 2021 Master Lease or the Springstone Master Lease, as the case may be, (ii) failure to comply with the non-financial covenants under the 2021 Master Lease or the Springstone Master Lease, as the case may be, (iii) the bankruptcy of any facility lessee under the 2021 Master Lease or the Springstone Master Lease or the guarantor of the facility lessees under the 2021 Master Lease or the Springstone Master Lease, as the case may be, (iv) termination of any licenses necessary for operation of a facility or required for certification under Medicare or Medicaid for any facility leased under the 2021 Master Lease or the Springstone Master Lease, as the case may be, (v) a change of control in violation of the 2021 Master Lease or the Springstone Master Lease, as the case may be, and (vi) a default under any material documents between any lessee of the facilities and any lessor of any facility leased under the 2021 Master Lease or the Springstone Master Lease, as the case may be. A default under the 2021 Master Lease or the Springstone Master Lease that results in a termination of the 2021 Master Lease or the Springstone Master Lease, as the case may be, would cause us to lose the ability to operate all of the facilities subject to the 2021 Master Lease or the Springstone Master Lease, respectively, and to incur substantial costs in restoring the premises, which could have a material adverse effect on our business, financial condition, results of operations and cash flow.

If the 2021 Master Lease or the Springstone Master Lease is terminated prior to its expiration because of a default and the lessor exercises its rights thereunder, in addition to losing the ability to operate our facilities, we may be liable for (i) damages and charges such as continued lease payments through the end of the lease term (or such shorter period as provided in the 2021 Master Lease or the Springstone Master Lease, as the case may be, or by law) and (ii) maintenance costs for the leased property leased under the 2021 Master Lease or the Springstone Master Lease, as the case may be. Upon termination of the 2021 Master Lease or the Springstone Master Lease, as the case may be, we will be obligated to restore the applicable premises to its original condition and repair all damage caused by the installation or removal of our personal property, ordinary wear and tear excepted. We also have restoration obligations with respect to certain casualty and condemnation events. In addition, upon termination of the 2021 Master Lease or the Springstone Master Lease, the lessor will have the option to purchase all of the applicable lessee's personal property at fair market value.

The 2021 Master Lease and the Springstone Master Lease are not cross-defaulted to one another.

Because many of the facilities we operate are subject to long-term leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises.

The rights to use many of our facilities are based upon long-term leases, including the 2021 Master Lease and the Springstone Master Lease. Pursuant to the terms of these leases, we are required to pay all rent due and comply with all other lessee obligations. As of December 31, 2022, the remaining term of these leases (including renewal options) generally ranged from less than one year up to 73 years. A pledge of our interest in some of these leases may also require the consent of the respective lessor and its lenders. As a result, we may not be able to sell, assign, transfer or convey our interest in certain facilities subject to such leases in the future absent consent of such third parties even if such transactions may be in our best interest. Most of the leases require that, upon the expiration or termination of the leases, we must surrender any improvements to the land to lessor. In addition, some of our leases include early termination provisions. We are typically responsible for all taxes, insurance, assessments and maintenance obligations under the leases. The leases also generally require the lessee to either reconstruct or restore the premises to its original condition following a casualty and to apply in a specified manner any proceeds received in connection therewith. In some leases, the lessor has the option to purchase some or all of the assets owned by us and used in connection with the operation of the applicable facility. Accordingly, failure to comply with the terms of such leases, the invalidity of or default or termination under such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises, which could have a material adverse effect on our business, financial condition, results of operations and cash flow.

Many of the non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies intended to generate organic growth and improve operating results at our facilities.

Many of the non-urban communities in which we operate continue to face challenging economic conditions, including high levels of unemployment and unfavorable demographic trends, which may impede our business strategies intended to generate organic growth and improve operating results at our facilities. These challenging economic conditions have been further exacerbated recently by inflationary pressures and the continuing impacts of the COVID-19 pandemic. The economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of large employers, especially manufacturing or similar facilities. These employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our facilities for care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or similar facilities located in or near many of the non-urban communities in which our facilities primarily operate, could cause affected employees to move elsewhere for employment or lose insurance coverage that was otherwise available to them.

When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to (i) defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for facilities, or (ii) purchase a high-deductible insurance plan or no insurance at all, which increases a facility's dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms, which are generally more costly settings for us to administer care.

Additionally, non-urban communities are experiencing a much slower rate of growth, if any, as compared to more concentrated population centers. As a result, we may experience payer mix pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs.

Our financial condition, results of operations and cash flow may be adversely affected by changing economic conditions.

A decline in economic conditions, such as recession, economic downturn, and/or inflationary conditions in the U.S. can adversely and negatively impact our patients in a manner that could adversely affect our financial condition, results of operations and cash flow. Further, broad economic factors in connection with a potential economic recession or slowdown, including increased unemployment rates, increased inflation rates and decrease in disposable income and wages, could also negatively affect our payer mix, increase the relative proportion of lower margin services we provide and reduce patient volumes, as well as diminish our ability to collect outstanding receivables. In addition, government actions intended to reduce inflation, including raising the federal funds rate, will increase our cost of borrowing, which in turn could make it more difficult to obtain financing for our operations or investments on favorable terms.

Supply chain issues of the medical supplies, equipment and pharmaceuticals used in our facilities could adversely affect our operating results.

We are dependent on various medical supplies, equipment and pharmaceuticals used in our facilities to conduct our operations. Supply chain issues, such as shortages, delivery delays, manufacturing disruptions, and other supply chain interruptions affecting such supplies, equipment and pharmaceuticals, and price increases of such supplies, equipment, pharmaceuticals and raw materials could adversely impact our results of operations.

Our operations may be adversely impacted by the effects of climate change, extreme weather conditions, natural disasters such as hurricanes and earthquakes, hostilities or acts of terrorism and other criminal activities.

Global climate change presents both immediate and long-term physical risks (such as extreme weather conditions) and risks associated with the transition to a low-carbon economy (such as regulatory or technology changes). These changes could result in, for example, temporary declines in the number of patients seeking our services, closures of our hospitals and related facilities, and supply chain disruptions, as well as increased costs of products, commodities and energy (including utilities), and disruptions in our information systems, which in turn could negatively impact our business and results of operations. In addition, certain of our operations and facilities are located in regions that may be disproportionately impacted by the physical risks of climate change (including hurricanes and flooding), and we face the risk of losses incurred as a result of physical damage to our hospitals and related facilities and business interruptions caused by such events. We maintain property insurance coverage to address the impact of physical damage to our facilities and for business interruption losses. However, such insurance coverage may be insufficient to cover all losses and we may experience a material, adverse effect on our results of operations that is not recoverable through our insurance policies. Additionally, if we experience a significant increase in climate-related events that result in material losses we may be unable to obtain similar levels of property insurance coverage in the future or at rates that are significantly higher than our current rates. Changes in consumer preferences and additional legislation and regulatory requirements, including those associated with the transition to a low-carbon economy, may increase costs associated with compliance, the operation of our facilities and supplies. Regulations limiting greenhouse gas emissions and energy inputs may also increase in coming years, which may adversely impact us through increased compliance costs for us and our suppliers and vendors.

Our operations are always subject to adverse impacts resulting from extreme weather conditions, natural disasters, hostilities or acts of terrorism or other criminal activities. Such events may result in a temporary decline in the number of patients who seek our services or in our employees' ability to perform their job duties. In addition, such events may temporarily interrupt our ability to provide our services. The occurrence of any such event and/or a disruption of our operations as a result may adversely affect our financial condition, results of operations and cash flow.

Credit and Liquidity Risks

Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations or fund strategic initiatives, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments.

We are a highly leveraged company. As of December 31, 2022, we had total outstanding debt of approximately $6.2 billion, excluding finance lease obligations and unamortized debt issuance costs. Our substantial indebtedness could have important consequences for the Lenders and Holders of our indebtedness. For example, it could:

- limit our ability to borrow money for our working capital, capital expenditures, debt service requirements, strategic initiatives or other purposes;
- make it more difficult for us to satisfy our obligations with respect to our indebtedness and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the agreements governing our indebtedness;
- require us to dedicate a substantial portion of our cash flow from operations to the payment of interest and the repayment of our indebtedness, thereby reducing funds available to us for other purposes;
- limit our flexibility in planning for, or reacting to, changes in our operations or business;
- make us more highly leveraged than some of our competitors, which may place us at a competitive disadvantage;
- make us more vulnerable to downturns in our business, our industry or the economy;
- restrict us from making strategic acquisitions, engaging in development activities, introducing new technologies or exploiting business opportunities;
- compel us to make non-strategic divestitures;
- limit, along with the financial and other restrictive covenants in our indebtedness, among other things, our ability to borrow additional funds or dispose of assets;
- prevent us from raising the funds necessary to repurchase all notes tendered to us upon the occurrence of certain changes of control, which failure to repurchase would constitute an event of default under the Indentures governing the Notes; or
- expose us to the risk of increased interest rates, as certain of our borrowings, including borrowings under the ABL Facility and the Term Loan Facility, are at variable rates of interest.

In addition, the Indentures and the Credit Agreements contain restrictive covenants that limit or will limit our ability to engage in activities that may be in our long-term best interest. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of substantially all of our existing and future indebtedness.

Our debt agreements contain restrictions that will limit our flexibility in operating our business.

The Indentures and the Credit Agreements contain, and any other existing or future indebtedness of ours would likely contain, a number of covenants that will impose significant operating and financial restrictions on us, including restrictions on our and our subsidiaries ability to, among other things:

- incur additional debt, guarantee indebtedness or issue certain preferred shares;
- pay dividends on or make distributions in respect of, or repurchase or redeem, our capital stock or make other restricted payments;
- prepay, redeem or repurchase certain debt;
- make loans or certain investments;
- sell certain assets;
- create liens on certain assets;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates;
- alter the businesses we conduct;
- enter into agreements restricting our subsidiaries' ability to pay dividends; and
- designate our subsidiaries as unrestricted subsidiaries.

As a result of these covenants, we will be limited in the manner in which we conduct our business, and we may be unable to engage in favorable business activities or finance future operations or capital needs.

In addition, the ABL Facility requires us to maintain a minimum fixed charge coverage ratio at any time when the average availability is less than the greater of $65 million and 10% of the lesser of the aggregate amount of revolving facility commitments and the borrowing base at such time. In that event, we must satisfy a minimum fixed charge ratio of 1.0 to 1.0. At December 31, 2022, we were in compliance with this financial maintenance covenant.

A failure to comply with the covenants under the Indentures, the Credit Agreements or any of our other future indebtedness could result in an event of default, which, if not cured or waived, could have a material adverse effect on our business, financial condition, results of operations and cash flow. In the event of any such default, the Lenders thereunder:

- will not be required to lend any additional amounts to us;
- could elect to declare all borrowings outstanding, together with accrued and unpaid interest and fees, to be due and payable and terminate all commitments to extend further credit;
- could require us to apply all of our available cash to repay these borrowings; or
- could effectively prevent us from making debt service payments on the Notes (due to a cash sweep feature under the ABL Facility).

Such actions by the Lenders could cause cross defaults under our other indebtedness. If we were unable to repay those amounts, the Lenders and Holders under the ABL Facility, the Term Loan Facility, the 6.75% Secured Notes and the 4.375% Secured Notes could proceed against the collateral granted to them to secure the ABL Facility, the Term Loan Facility or the 6.75% Secured Notes and the 4.375% Secured Notes, respectively. If any of our outstanding indebtedness under the ABL Facility, the Term Loan Facility, Notes or any of our other existing or future indebtedness were to be accelerated, there can be no assurance that our assets would be sufficient to repay such indebtedness in full.

We are dependent on cash flow generated by our subsidiaries to service our indebtedness.

We are a holding company with no operations and are dependent on our operating subsidiaries' cash flow and their ability to make such cash available to us to meet our financial obligations, including principal and interest payments related to the ABL Facility, the Term Loan Facility and the Notes. Unless they are guarantors of the indebtedness, our subsidiaries do not have any obligation to pay amounts due on such indebtedness or to make funds available for that purpose. Our subsidiaries may not be able to, or may not be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each subsidiary is a distinct legal entity and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries. While our debt agreements will limit the ability of our restricted subsidiaries to incur consensual restrictions on their ability to pay dividends or make other intercompany payments to us, these limitations are subject to certain qualifications and exceptions. In the event that we do not receive distributions from our subsidiaries, we may be unable to make required principal and interest payments on our indebtedness.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.

Our ability to pay principal and interest and to satisfy our other debt obligations will depend upon, among other things:

- our future financial and operating performance, which will be affected by prevailing economic, industry and competitive conditions and financial, business, legislative, regulatory and other factors, many of which are beyond our control; and
- our future ability to borrow under the ABL Facility, the availability of which depends on, among other things, the borrowing base and our complying with the covenants in the credit agreement governing the ABL Facility.

We cannot assure you that our business will generate cash flow from operations, or that we will be able to draw under the ABL Facility or otherwise, in an amount sufficient to fund our liquidity needs, including the payment of principal and interest on the ABL Facility, the Term Loan Facility and the Notes.

If our cash flows and capital resources are insufficient to service our indebtedness, we may be forced to reduce or delay capital expenditures, sell assets, seek additional capital or restructure or refinance our indebtedness, including the Notes and any indebtedness under the Credit Agreements. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations.

Our ability to obtain, and the terms of any, financing or refinancing will be dependent on the condition of the financial markets and our financial condition and operating performance. Any inability to obtain refinancing as our debt matures could materially and adversely affect our financial condition.

Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition and performance at such time. Disruptions or prolonged downturns in the financial markets may cause us to seek alternative sources of potentially less attractive financing or refinancing. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. In addition, the terms of existing or future debt agreements, including the ABL Facility, the Term Loan Facility and the Indentures, may restrict us from adopting some of these alternatives. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to dispose of material assets or operations to meet our debt service and other obligations. We may not be able to consummate those dispositions for fair market value or at all. Furthermore, any proceeds that we could realize from any such dispositions may not be adequate to meet our debt service obligations then due. The Sponsor and its affiliates have no continuing obligation to provide us with debt or equity financing. Our inability to generate sufficient cash flow to satisfy our debt obligations, or to refinance our indebtedness on commercially reasonable terms or at all, could result in a material adverse effect on our business, financial condition and results of operations and could negatively impact our ability to satisfy our obligations under our indebtedness.

If we cannot make scheduled payments on our indebtedness, we will be in default, and the Lenders under the Term Loan Facility and the Holders of the Notes could declare all outstanding principal and interest to be due and payable, the Lenders under the ABL Facility could terminate their commitments to loan money, our secured lenders (including the Lenders under the ABL Facility and the Holders of the Notes) could foreclose against the assets securing their loans and the Notes and we could be forced into bankruptcy or liquidation.

Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

Interest rates are highly sensitive to many factors that are beyond our control, including general economic conditions and policies of various governmental and regulatory agencies and, in particular, the Federal Reserve Board. If the Federal Reserve Board continues to increase the federal funds rate, which it has recently done in an effort to help counter inflation and has indicated that it may continue to do so, overall interest rates will likely rise. Interest rate increases would increase the interest costs on our borrowings under the ABL Facility and the Term Loan Facility, which have variable rates of interest and expose us to interest rate risk. Assuming the revolving credit facility is fully drawn, each 1% change in assumed blended interest rates would result in an approximately $40 million change in aggregate annual interest expense on indebtedness under the ABL Facility and the Term Loan Facility.

Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.

We and our subsidiaries may be able to incur substantial indebtedness in the future. Although the terms of the Credit Agreements and the Indentures contain restrictions on our and our subsidiaries' ability to incur additional indebtedness, these restrictions are subject to a number of important qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. As of December 31, 2022, we had $573 million available for additional borrowing under the ABL Facility (after giving effect to any letters of credit issued thereunder (which were approximately $53 million as of December 31, 2022)), all of which would be secured. In addition to the Notes and our borrowings under the Credit Agreements, the covenants under any other existing or future debt instruments could allow us to incur a significant amount of additional indebtedness and, subject to certain limitations, such additional indebtedness could be secured. The more leveraged we become, the more we, and in turn our security holders, will be exposed to certain risks described above under "—Our debt agreements contain restrictions that will limit our flexibility in operating our business."

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

We require substantial capital resources to fund our growth strategy and ongoing capital expenditure programs, including capital expenditure programs for renovation, expansion and construction at our facilities and the addition of equipment and technology at our facilities. We often commit to significant capital expenditures well in advance of the time these expenditures will be made. Additionally, we are subject to annual capital expenditure commitments in connection with several of our facilities. At December 31, 2022, we estimated our total remaining annual capital expenditure commitments to be approximately $573 million. The majority of this amount represents long-term commitments that are computed as a percentage of revenues at the applicable facility. Our cash flows and available capital resources may be insufficient to fund our capital expenditure programs and commitments, and we may be forced to reduce or delay planned and required capital expenditures. Additionally, we may experience delays or impediments in satisfying the schedule for capital expenditures and these commitments because of a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions, adverse weather conditions, shortages of labor or materials or other unforeseen problems or delays. The failure to satisfy our capital expenditure commitment obligations could also damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities, lessors or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions. Additionally, as a result, if our cash flows and available capital resources are not sufficient to fund all of our anticipated capital expenditures, it may be necessary for us to give priority to contractual capital expenditure commitment obligations over other elective capital expenditure programs.

Our ability to utilize our NOLs may be limited, and we may not be able to utilize our NOLs as a result of recent U.S. federal tax reform legislation.

As of December 31, 2022, we had federal NOLs of approximately $106 million with an indefinite carryforward period and subject to annual usage limitations under Section 382 of the Code. In addition, we had state and local NOLs of approximately $2 billion that expire at various dates between 2023 and 2042 or have an indefinite carryforward period. To the extent available and not otherwise utilized, we intend to use any NOLs to reduce the applicable federal and state corporate income tax liability associated with our operations. However, our ability to utilize our NOLs is based on the extent to which we generate future taxable income and on prevailing corporate income tax rates, and we cannot provide any assurance as to when and to what extent we will generate sufficient future taxable income to realize our deferred tax assets, whether in whole or in part. Furthermore, the utilization of our NOLs may become subject to an annual limitation under Section 382 of the Code (and similar state provisions) in the event of certain cumulative changes in the ownership interest of significant shareholders in excess of 50 percent over a three-year period. This could limit the amount of NOLs that can be utilized annually to offset taxable income. The amount of the annual limitation is determined based on the value of a company immediately prior to the ownership change. Subsequent ownership changes may further affect the limitation in future years. For these reasons, our ability to utilize our NOLs may be limited.

Human Capital Risks

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

Our subsidiaries employ a large number of physicians. Physician employment by health systems and healthcare facilities, where permissible, is a trend in the industry and has become more common as a result of actual and potential reductions in payment amounts for physician services and increasing operating costs to physicians. Employed physicians generally present more direct risks to us than those presented by independent members of our hospitals' medical staffs, such as risks of unsuccessful physician integration, challenges associated with physician practice management and compliance risks arising from the increased billing and coding activities associated with the employment of physicians, the possibility of legal claims under federal and state employment law, and governmental scrutiny of physician employment arrangements. Employed physicians also require us to incur additional expenses, such as increased salary and benefit costs, medical malpractice expense and rent expense. Payments received by us for services provided by our employed physicians, the physicians to whom our facilities have provided recruitment assistance, and the physician members of our medical staffs could be adversely affected as physician payment methodologies move toward pay-for-performance similar to what hospital payment models are doing. The combination of payment cuts, potential liabilities and increased expenses could have an adverse effect on our results of operations and cash flow.

Our operations and ability to deliver healthcare services efficiently may be adversely affected by competition for staffing and the shortage of experienced physicians, nurses and other healthcare professionals.

The success of our business operations and the efficiency with which we deliver healthcare services depends on the number and quality of our physicians and other healthcare providers such as nurses, pharmacists and lab technicians, and management and other non-physician personnel responsible for the day-to-day operations of each of our facilities. Our ability to recruit and retain quality providers and personnel in turn depends on several factors, including the actual and perceived quality of services furnished by our facilities, our ability to meet demands for new technology, our ability to identify and communicate with providers who want to practice in our communities and our ability to provide competitive financial compensation packages. In many markets, the availability of nurses and other medical support personnel has been a significant operating issue to healthcare providers, including at certain of our facilities. The COVID-19 pandemic has exacerbated workforce competition and shortages, both of which appear to be continuing beyond the duration of the pandemic. This may result in personnel turnover, require us to enhance wages and benefits to recruit and retain management, nurses and other medical support personnel, recruit personnel from foreign countries, and hire more expensive temporary or contract personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified physicians, nurses and other medical support staff, and management and non-physician personnel, or to control our labor costs could have a material adverse effect on our revenues, results of operations and cash flow.

Federal and state laws and regulations may impact our ability to hire and retain and increase our costs of employing qualified physicians, nurses and other medical support personnel. For example, a significant portion of the providers serving our facilities are native to countries other than the U.S. Our ability to recruit such providers and their ability and willingness to remain and work in the U.S. are impacted by immigration laws and regulations. Changes in immigration or naturalization laws, regulations, or procedures may adversely affect our ability to hire or retain providers and may adversely affect our costs of doing business or our ability to deliver services in our communities. In addition, the states in which we operate have adopted or could adopt mandatory nurse staffing ratios, or could increase mandatory nurse staffing ratios. State-mandated nurse staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. Also, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the federal physician self-referral law (commonly referred to as the Stark law), the Anti-kickback Statute, state anti-kickback and self-referral statutes, and related regulations. The Stark law requires, among other things, that recruitment assistance can only be provided to physicians who meet certain geographic and practice requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit physicians currently in practice in the community beyond recruitment costs actually incurred by them. All arrangements with physicians must also be fair market value and commercially reasonable. In addition, some of the states in which we operate limit or restrict our ability to enter into non-compete agreements or enforce restrictive covenants with physicians we employ, which may impact our ability to hire and retain qualified physicians in those states. Also, on January 5, 2023, the FTC issued a proposed rule that would ban employers from imposing post-termination non-competes on its workers (whether employees or independent contractors), subject to certain exceptions, and require employers to rescind existing non-competes and actively inform workers that they are no longer in effect. The proposed rule may not apply to non-profit hospitals, which could create a competitive disadvantage for us in our hiring and retention efforts. The FTC's proposed rule follows President Biden's July 9, 2021 executive order in which the administration encouraged the FTC to ban or limit non-compete agreements. Although we cannot predict whether the FTC's proposed rule will be adopted in its current form, any limitation or ban on our ability to enter into non-compete agreements with employed or contracted physicians, nurses and other medical support personnel may impact our ability to hire and retain qualified physicians, nurses and other medical support personnel and may adversely affect our costs of doing business or our ability to deliver services in our communities.

In addition to these legal requirements, there is competition from other communities and facilities for these providers, and this competition continues after the provider is practicing in one of our communities. For example, integrated ACOs and other kinds of "narrow" provider networks or organizations may exclude our providers from their plans' networks of healthcare providers. These contracting networks often organize hospitals, providers and ancillary healthcare providers into exclusive networks involving fewer healthcare providers. If our affiliated providers are excluded from such networks, we may have difficulty recruiting new providers or retaining existing providers.

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

Increased labor costs due to inflation and competition for experienced physicians, nurses, qualified management and other healthcare professionals, including due to low unemployment levels and staffing shortages, could adversely affect our financial results.

Our success depends on the ability of our facilities to attract and retain experienced physicians, nurses, qualified management and other healthcare professions such as pharmacists and lab technicians, and we compete with other healthcare providers in recruiting and retaining these positions. Significant increases in labor costs due to inflation and the shortage of experienced physicians, nurses, management and other healthcare professionals may have an adverse impact on our business, financial condition, results of operations and cash flow. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue, which has been exacerbated by the COVID-19 pandemic and inflationary pressures. This shortage has required, and may continue to require us, to enhance wages and benefits to recruit and retain nurses and other medical support personnel, recruit personnel from foreign countries, and utilize more expensive temporary personnel. If we fail to attract and retain experienced physicians, nurses, qualified management and other healthcare professionals, our ability to conduct our business operations effectively, our overall operating results and cash flow could be harmed.

Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and subject to the terms of collective bargaining agreements.

Increased or ongoing labor union activity could adversely affect our labor costs or otherwise adversely impact us. Several of our facilities, including those in which we have a non-controlling interest, have unionized employees. When a new collective bargaining agreement with a union must be negotiated, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur, and our operations could be disrupted or our labor costs increased as a result of these disruptions. Our labor costs also could increase significantly if a substantial number of other employees at our facilities unionize. If our labor costs increase, we may not be able to raise our payer rates sufficiently or commensurately in order to offset these increased costs. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained.

The terms of the collective bargaining agreements also set forth certain requirements related to the respective facility's employment practices, seniority, hours of work, overtime, holidays, use and redemption of paid time off, extended illness bank, vacation scheduling, compensation, pay practice, health and non-health benefits, leaves of absence, grievance procedures, disability accommodations and the facility's drug and alcohol policies. If these facilities fail to fulfill any of these requirements, it could result in discussions with union representatives or the filing of a grievance that could be costly and time-consuming for those facilities. Furthermore, the terms of the collective bargaining agreements constrain our flexibility with respect to these and other employee issues. The inability to negotiate future collective bargaining agreements on favorable terms with these employees or with other unionized employees could have a material adverse effect on our business, financial condition, results of operations and cash flow.

We are dependent on our executive management team and the loss of the services of one or more members of our executive management team could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our executive management team. In addition, we depend on the ability of our executive officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our executive management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our executive management team, we could experience a significant disruption in our operations and failure of the affected facilities to adhere to their respective business plans.

Regulatory and Legal Risks

We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may adversely affect our revenues, results of operations and cash flow.

All participants in the healthcare industry are required to comply with numerous overlapping laws and regulations at the federal, state and local government levels. These laws and regulations require that healthcare facilities and providers meet various requirements, including those relating to relationships with referral sources, the adequacy and quality of medical care, inpatient admission criteria, privacy and security of health information, standards for equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, the use and storage of pharmaceuticals and controlled substances and other standards intended to prevent diversion of controlled substances, compliance with building codes and environmental protection, among other matters. Many of the laws and regulations applicable to the healthcare industry are complex and may be violated inadvertently, and there are numerous enforcement authorities, including CMS, the OIG, the DOJ, the DEA, state attorneys general, and contracted auditors, as well as private plaintiffs.

There are also heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. Recent enforcement actions have focused on, among other things, financial arrangements between hospitals and providers, billing for services without adequately documenting the medical necessity for such services and billing for services outside the coverage guidelines for such services. Hospital services, IRF services and certain other ancillary services that our facilities provide, such as physical therapy services, continue to be focal areas of the OIG and other governmental fraud and abuse programs, as described in the OIG Work Plan. Dealing with investigations can be time and resource consuming and can divert management's attention from the business. Any such investigation or settlement could increase our costs or otherwise have an adverse effect on our business. In addition, because of the potential for large monetary exposure under the False Claims Act, which provides for treble damages and substantial civil monetary penalties for each separate false claim or statement, healthcare providers often resolve allegations without admissions of liability for significant and material amounts to avoid the uncertainty of damages and penalties that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree, settlement agreement or corporate integrity agreement. These additional requirements can result in significant additional and ongoing expenditures. Given the significant size of actual and potential settlements, it is expected that the government will continue to devote substantial resources to investigating healthcare facility and provider compliance with the healthcare payment rules and fraud and abuse laws. Over the past several years, certain of our facilities have received inquiries and subpoenas from various governmental agencies regarding these matters, and we are also subject to various claims and lawsuits relating to these and other matters.

The laws and regulations with which we must comply continually change. In the future, different interpretations or enforcement of these laws and regulations could subject our business practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws and regulations, many of these laws and regulations are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable laws and regulations. If we fail to comply with applicable laws and regulations, we could suffer substantial civil or criminal penalties, including the loss of our licenses to operate our facilities or loss of our ability to participate in the Medicare, Medicaid and other governmental programs.

Additionally, we are subject to a variety of different federal, state and local employment and wage and hour laws. While we strive to comply with those laws, if we fail to do so, we may be subject to lawsuits by governmental authorities or private plaintiffs (including employee class action lawsuits). In addition, the IRS and/or state taxing authorities may successfully challenge positions taken on our tax returns.

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

Finally, we communicate with patients, with prior consent, through short message service ("***SMS***") text messages. While we obtain consent from these individuals to send text messages and limit the content of those messages, federal or state regulatory authorities or private litigants may claim that the notices and disclosures we provide, form of consents we obtain, or our SMS texting practices are not adequate or violate applicable law. In addition, we must ensure that our SMS texting practices comply with regulations and agency guidance under the Telephone Consumer Protection Act (the "***TCPA***"), a federal statute that protects consumers from unwanted telephone calls, faxes and text messages, HIPAA, and all applicable state data privacy and security laws and regulations. While we strive to adhere to strict policies and procedures that comply with the TCPA, the Federal Communications Commission, as the agency that implements and enforces the TCPA, may disagree with our interpretation of the TCPA and impose penalties and other consequences for noncompliance. Determination by a court or regulatory agency that our SMS texting practices violate the TCPA could subject us to civil penalties and could require us to change some portions of our business. Even an unsuccessful challenge by patients or regulatory authorities of our activities could result in adverse publicity and could require a costly response from and defense by us.

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

The False Claims Act prohibits healthcare facilities and providers, as well as other entities or individuals from, among other things, knowingly submitting false claims for payment to the federal government, or knowingly causing the submission of such claims. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are generally entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. We are required to provide information to our employees and certain contractors about state and federal false claims laws and whistleblower provisions and protections. Defendants found to be liable under the False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus substantial civil monetary penalties, that are subject to annual inflation adjustments, for each separate false claim.

There are many potential bases for liability under the False Claims Act, including reckless or intentional acts or omissions. The government has used the False Claims Act to prosecute Medicare and other government healthcare program violations such as coding errors, billing for services not provided, submitting false cost reports, falsely certifying meaningful use of certified health information technology, and providing care that is not medically necessary or that is substandard in quality. The Affordable Care Act also (i) created potential False Claims Act liability for failing to report and repay identified overpayments within sixty (60) days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later, and (ii) provided that claims submitted in connection with patient referrals that result from violations of the Anti-kickback Statute constitute false claims for the purposes of the False Claims Act. Violations of the Stark law can result in False Claims Act liability, as well. In addition, a number of states have adopted their own false claims and whistleblower provisions whereby a private party may file a civil lawsuit in state court.

Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws, many of these laws are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable fraud and abuse laws.

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

We may be subjected to medical malpractice lawsuits and other legal actions arising out of the operations of our facilities and the activities of our employed or affiliated providers, including regulatory proceedings and private litigation (including employee class action lawsuits) concerning our application of various federal and state labor laws, rules and regulations governing a variety of workplace wage and hour issues. As a matter of policy, we typically notify patients of any potential harms they may have suffered at our facilities, regardless of whether such notifications are required by law and notwithstanding our uncertainty as to the severity of such harms or whether they even took place. This may lead to class actions or other multi-plaintiff lawsuits or whistleblower reports. These actions may involve large claims and significant defense costs and, if we or our facilities are found liable, any judgments against us may be material. Furthermore, some states in which we operate do not impose caps on non-economic malpractice damages and, even in the states that have imposed caps on such damages, litigants may seek recoveries under alternative theories of liability that might not be subject to such caps. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement whether or not we believe we are liable. Amounts we pay to settle any of these matters also may be material.

Although we maintain professional and general liability insurance with unrelated commercial insurance carriers, each individual plaintiff's claim is generally subject to a deductible or SIR insurance program administered in-house by our risk department with assistance from our insurance brokers. As a result, we are effectively self-insured for claims or portions of claims that are less than our deductible or SIR amounts and for claims or portions of claims that are not covered by insurance or exceed policy limits. Any successful claim against us that is within our deducible or SIR amounts or that is not covered by insurance or exceeds our policy limits could have an adverse effect on our financial condition, results of operations or cash flow.

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

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

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare and Medicaid for payment for our services. These post-payment reviews may increase as a result of government cost-containment initiatives, including, without limitation, enhanced medical necessity reviews for patients admitted as inpatients to general acute care hospitals for certain procedures and audits of claims under the RAC programs to detect overpayments not identified through existing claims review mechanisms. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those claims most likely to contain overpayments, such as incorrectly coded services, short stays, incorrect payment amounts, non-covered services and duplicate payments. The claims review strategies used by the RACs generally include a review of high dollar claims, including, for example, inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals.

In addition, CMS and the states use UPICs to perform post-payment audits of claims and identify Medicare and Medicaid overpayments. Third party audits or investigations of Medicare or Medicaid claims could result in increases or decreases in operating revenues to be recognized in periods subsequent to when the related services were performed, which may have a material adverse effect on our results of operations and cash flow.

Controls designed to reduce inpatient services may adversely affect our revenues, results of operations and cash flow.

Over the last several years, payers have instituted policies and procedures to reduce or limit the use of inpatient services. Controls imposed by Medicare, Medicaid, and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for payment are properly filed. In the hospital context, these provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by QIOs, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of the MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. QIOs may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider that is in substantial noncompliance with quality standards be excluded from participation in the Medicare program.

Utilization review is also a requirement of most non-governmental managed care organizations and other third-party payers. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Additionally, in some states in which we operate, commercial third-party payers and Medicaid managed care plans have instituted policies that retroactively limit or deny patient coverage for emergency department and certain other services provided at hospitals or services provided at other inpatient facilities if the payers believe the services could have been provided in less expensive settings. For example, such payers are increasingly seeking to pay relatively low "triage fees" for patients seen in emergency departments when the payers retrospectively determine the patients' treatment did not qualify as an emergency service. Significant limits on the scope of services reimbursed or on the amounts paid for such services may adversely affect our revenues, results of operations and cash flow.

If we do not manage admissions in the IRFs that we operate or manage in compliance with a 60% threshold, reimbursement for services rendered by us in these facilities will be based upon less favorable rates.

IRFs and ARUs are subject to a Medicare requirement that 60% or more of the patients admitted to the facilities have one or more specific conditions in order to qualify for reimbursement under the IRF PPS. If that compliance threshold is not maintained, the IRFs and ARUs will be reimbursed by Medicare at IPPS rates applicable to acute care hospitals. That likely would lead to reduced revenue in the IRFs and ARUs that we operate or manage and also may lead customers of IRFs and ARUs to attempt to renegotiate the terms of their contracts or terminate their contracts. Our inability to appropriately manage admissions in our IRFs and ARUs in compliance with applicable thresholds could have a material adverse effect on our business, financial position, results of operations and cash flow.

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

Some states require prior approval for the purchase, construction and expansion of healthcare facilities, based on the state's determination of need for additional or expanded healthcare facilities or services. Certain states in which we operate facilities require a certificate of need for the purchase, construction or expansion of hospital facilities, capital expenditures exceeding a prescribed amount, changes in bed capacity or services, or for other hospital-related activities. We may not be able to obtain certificates of need required for expansion activities or to effectively compete with competing healthcare providers in the future. In addition, all of the states in which we operate facilities require hospitals, other healthcare facilities, and most healthcare providers to maintain one or more licenses. If we fail to obtain any required certificate of need or license, our ability to operate or expand operations in those states could be impaired.

In the states in which we operate that do not require certificates of need for the purchase, construction and expansion of hospital facilities, competing healthcare facilities face lower regulatory barriers to entry and expansion. If competing healthcare entities are able to purchase, construct or expand healthcare facilities without the need for regulatory approval, we may face decreased market share and revenues in those markets.

Failure to implement and use certified health information technology in an effective and timely manner could adversely affect our operations and result in reduced Medicare and Medicaid reimbursement and government enforcement actions.

The federal government has adopted laws and regulations intended to promote the adoption of health information technology, advance the interoperability of medical record systems, and support the access, exchange, and use of electronic health information. For example, under the Medicare Promoting Interoperability Programs (formerly the Medicare EHR Incentive Program), eligible hospitals, critical access hospitals and eligible professionals that do not successfully demonstrate meaningful use of certified electronic health record technologies every year (absent a hardship exception) may be subject to a downward payment adjustment under Medicare. In addition, health information technology that is certified by CMS is subject to an annual certification process. While we generally have no control over whether the health information technology we have implemented will continue to maintain CMS certification, we routinely monitor and evaluate our health information technology for compliance with the applicable CMS certification standards. Failure of our health information technology to maintain CMS certification could result in reduced Medicare and Medicaid reimbursement. Also, the Cures Act and its implementing regulations impose regulatory obligations, including new Medicare conditions of participation on hospitals and critical access hospitals, related to the access and exchange of electronic health information and prohibit information blocking, which includes any practice that is unreasonable and likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information, by healthcare providers and certain other entities, unless required by law or otherwise permitted by an exception in the applicable regulations. Failure to comply with these requirements could subject us to financial penalties or other disincentives or reputational damage. Complying with these and future initiatives related to healthcare technology and interoperability may also require us to change our operations or incur additional costs related to investments in information technology and EHR system software upgrades, and our payers may not adequately reimburse us for these costs and investments.

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

There is a trend in the healthcare industry toward value-based purchasing of healthcare services and bundled payment arrangements. Value-based purchasing programs include both public reporting of quality data and payment limitations tied to the incidence of preventable adverse events or the quality and efficiency of care provided by facilities. For example, Medicare, Medicaid and many large commercial payers may require facilities to report certain quality data to receive full payment updates or avoid payment reductions. They may also impose payment reductions in connection with HACs and excessive readmissions for certain conditions designated by HHS. Our revenue may be negatively impacted by the application of one or more of these measures. Bundled payment arrangements generally set target payment amounts for all healthcare services provided to patients during particular episodes of care. They are intended to create incentives for physicians, hospitals and other providers to work together to provide higher quality and more coordinated care at a lower cost. We currently participate in a few ACOs as well as a number of bundled payment programs, and we expect value-based purchasing programs, including programs that condition payment on patient outcome measures, to become more common and to involve a higher percentage of our payment amounts. We are unable at this time to predict how this trend will affect our results of operations and cash flow, but it could negatively affect our revenues.

The implementation of participation and quality measurement requirements under the MACRA's Merit-Based Incentive Payment System may affect our revenues.

Under MACRA, CMS updates payment rates for physician and practitioner services on an annual basis, and implements the QPP that rewards value and outcomes through participation in traditional MIPS, an APM program, or, beginning with the 2023 performance year, MVPs. MIPS measures provider performance under four categories: quality, improvement activities, promoting interoperability and cost, and annually establishes a point threshold for each category and overall performance. The results of the measurement are used to establish a positive, negative, or neutral payment adjustment for the physician or practitioner for claims that are submitted two years after the applicable MIPS measurement period. The MIPS adjustment has a more significant impact on payment for physician and practitioner services than the annual inflationary update to the Medicare PFS.

Physicians participate in traditional MIPS unless they are participants of specific forms of APM report MVPs, are newly enrolled in Medicare, or see a low volume of Medicare patients (i.e., no more than 200 Medicare Part B patients in a calendar year, 200 covered professional services to Medicare Part B patients, or $90,000 in charges for Medicare Part B professional services). Groups or eligible clinicians who choose not to participate and fall within specified circumstances may request an exception through a hardship application and incur no MIPS impact on Medicare payments. CMS permits hardship applications, including, in the 2022 performance year, hardships based on circumstances arising from COVID related operational issues, through which clinicians can request reweighing of any or all performance categories if they encounter an extreme and uncontrollable circumstance or a public health emergency. MIPS eligible clinicians or Group Practices are subject to a sliding scale payment adjustment of minus to plus 9% per claim in CY 2022 and beyond. In addition, MIPS eligible clinicians with exceptional performance may receive up to 10% bonus payment from $500 million specifically allocated for this purpose through the end of CY 2024. MIPS is a budget neutral program, and, as a result, any upward payment adjustments that are made for highly performing clinicians are offset by downward payment adjustments for others. Providers participating in an APM may be eligible for more advantageous adjustments under MIPS (or avoid any negative adjustment) and receive a 5% bonus. At this time, we have limited participation in APMs.

If an eligible clinician has not been satisfactorily participating in MIPS (and is not qualified to participate in an APM), his or her claims for Medicare Part B services are likely to be subject to negative payment adjustments in CY 2022 (which was based on CY 2020 performance) and CY 2023 (which was based on CY 2021 performance). For participating eligible clinicians that meet or exceed the MIPS threshold or APM requirements, claims for payment are likely to be subject to positive adjustments as well as a share of an additional pool of bonus payments. At this time, and as CMS continues to modify MIPS payment policies, it is unclear how MIPS will impact our overall physician payments under the Medicare program. If we have not timely and effectively implemented policies and procedures, quality programs and appropriate clinician contracting to ensure compliance with MACRA and other QPP requirements, we would experience a negative effect on future revenues related to Medicare Part B claims.

MACRA requires that CMS publish each eligible clinician's MIPS score and performance category scores on its Physician Compare website. Publishing of MIPS scores could have an adverse reputational effect on us if our employed physicians have low scores or scores that are lower than those of the other clinicians in the relevant communities.

If current or future laws or regulations force us or cause us to restructure our arrangements with physicians and other providers, we may incur additional costs, lose contracts and suffer a reduction in net revenue under existing contracts, and we may need to refinance our debt or obtain consent from our lenders.

A number of laws impact our relationships with our physicians and other providers. There is a risk that state authorities in some jurisdictions may find that our contractual relationships with our physicians violate laws prohibiting the corporate practice of medicine and fee-splitting. These laws generally prohibit the practice of medicine by lay entities or persons and are intended to prevent unlicensed persons or entities from interfering with or inappropriately influencing the physician's professional judgment. They may also prevent the sharing of professional services income with non-professional or business interests. In states that have enacted corporate practice of medicine and fee-splitting prohibitions, we believe that we have structured our physician contracts in an effort to remain compliant with such laws. A regulatory agency, however, could still make a determination that our arrangements constitute a corporate practice of medicine or fee splitting violation. A review or action by regulatory authorities or the courts could force us to terminate or modify our contractual relationships with physicians and affiliated medical groups or revise them in a manner that could be materially adverse to our business.

In addition, we have also entered into a number of joint venture arrangements with physicians and other potential sources of referrals (e.g., hospitals and hospital operators) that are subject to state and federal fraud and abuse laws, including the Anti-kickback Statute and False Claims Act. See "—We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may reduce our revenues and profitability." To the extent applicable, regulatory agencies may view these transactions as prohibited arrangements that must be restructured, or discontinued, or for which we could be subject to other significant penalties, including debarment, suspension or exclusion from state and federal government healthcare programs. Although compliance programs can mitigate the risk of investigation and prosecution for violations of these laws, the risks cannot be entirely eliminated. Any action against us for violation of these laws, even if we successfully defend against it, could cause us to incur significant legal expenses and loss of revenue from those joint ventures and divert our management's attention from the operation of our business.

We care for a large number of vulnerable individuals with complex needs and any incident involving one or more of our patients or the failure by one or more of our facilities to provide appropriate care could adversely affect our business, financial condition, results of operations or cash flow.

Many of our patients, including those in our behavioral health facilities, have complex medical conditions or special needs, are vulnerable and often require a substantial level of care and supervision. There is a risk that one or more patients could be harmed by one or more of our employees, either intentionally, through negligence or by accident. Further, individuals cared for by us have in the past engaged, and may in the future engage, in behavior that results in harm to themselves, our employees or to one or more other individuals, including members of the public. Further, because many of the patients we treat, including those in our behavioral health facilities, suffer from severe mental health and chemical dependency disorders, patient incidents, including deaths, sexual abuse, assaults and theft, occur from time to time. If one or more of our facilities experiences an adverse patient incident or is found to have failed to provide appropriate patient care, loss of accreditation, license revocation or other adverse regulatory action could be taken against us. Any such patient incident or adverse regulatory action could result in damage to our reputation, governmental investigations, judgments or fines and could adversely affect our business, financial condition, results of operations or cash flow.

Data Security and Privacy Risks

A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

We rely extensively on our information systems and certain systems operated by us and third-parties to manage clinical, financial and employee data, communicate with our patients, payers, vendors and other third parties and summarize and analyze operating results. These systems are at risk from cybersecurity attacks, ransomware attacks, denial-of-service attacks, and other intrusions, including attempts to gain unauthorized access to and theft of our confidential data, misuse, corruption or destruction of confidential data and damage, disruptions or shutdowns of these systems due to viruses, malware, ransomware, malicious code, employee error or malfeasance, and other electronic security breaches. Our systems, which transmit and store sensitive and confidential data, including personally identifiable information ("***PII***") and other PHI of our patients, employees and others, and our proprietary and confidential business performance and other data, will continue to be a target for attempts to gain unauthorized access and data theft due to the valuable nature of the information they contain, as well as at risk for accidental exposure. In addition, certain third-party medical devices and equipment are used at our facilities, and may be vulnerable to cybersecurity attacks or other breaches which could negatively impact our systems or our patients.

Cybersecurity breaches and other unauthorized access to our data can sometimes be difficult to discern, and any delays in detection may lead to increased harm. Such attacks or breaches are common in the healthcare sector and could result in the compromise of health information or other data subject to protection by HIPAA and other laws and regulations or disrupt our IT systems or business. There can be no assurance that we will not be subject to material cyber-attacks or security breaches in the future, or that the preventive actions we take to reduce the risk of such incidents and protect our IT and data will be sufficient. We continue to develop our cybersecurity practices and controls to protect our systems. However, regardless of the nature, extent and timing of our actions, these measures may not prevent security breaches. If our services are subject to cyber-attacks that impair or deny the ability of patients to access our services, current and potential patients may become unwilling to provide us the information necessary for them to become users of our services or may curtail or stop using our services. As cyber-threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures and to investigate and remediate any information security vulnerabilities. As we are subjected to cyber-attacks and possible security breaches in the future, this could have an adverse impact on our business, reputation, financial condition and results of operations, as well as expose us to class action lawsuits and regulatory investigation, action, and penalties. We also cannot be sure that our existing insurance coverage will continue to be available on acceptable terms or will be available in sufficient amounts to cover one or more large claims related to a security breach, or that the insurer will not deny coverage as to any future claim.

The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. If, in spite of our security and compliance efforts we or any of our business associates were to experience a breach, loss, or other compromise of PHI or PII, such event could disrupt our operations, result in increased data protection costs, damage our reputation, or result in regulatory penalties, legal claims and civil or criminal liability under HIPAA and other state and federal laws, which could have a material adverse effect on our results of operations. In addition, failure to comply with state and federal data breach notification and reporting laws could result in additional regulatory penalties, legal claims and civil or criminal liability, which could have a material adverse effect on our financial condition, results of operations and cash flow.

If access to our information systems or those provided by our third-party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

Our business depends heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and to develop new systems in order to keep pace with continuing changes in information processing technology. In addition to our own systems, we rely on multiple third-party providers of financial, clinical, supply chain, patient accounting and network information services and, as a result, we face operational challenges in maintaining multiple provider platforms and facilitating the interface of such systems with one another. The third-party providers may not have appropriate controls to protect confidential information. We do not control the information systems of third-party providers, and in some cases we may have difficulty accessing information archived on third-party systems, which could subject us to liability for failure to respond to legal, regulatory or payer obligations or information requests. Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, flood, hurricane, telecommunications failure, terrorist attack or other catastrophic event. If these systems fail or are interrupted, if our access to these systems is limited in the future or if providers develop systems more appropriate for more urban healthcare markets and not suited for our facilities, our operations could suffer.

We intend to expand our operations, including by acquiring more facilities, which will require us to integrate and transition certain existing information systems. In addition, as new information systems are developed in the future, we will need to integrate them into our existing systems. Evolving industry and regulatory standards, such as the HITECH Act, HIPAA and EHR meaningful use regulations, also may require changes to our information systems in the future. System conversions are costly, time consuming and disruptive for providers, staff and, in some cases, patients. If such conversions occurred on a large scale or if we are unable to properly integrate other information systems or expand or update our current information systems, the costs and disruptions could have a material adverse effect on our revenues, results of operations and cash flow.

If we fail to comply with our obligations under license or technology agreements with third parties, we may be required to pay damages and we could lose license rights that are critical to our business.

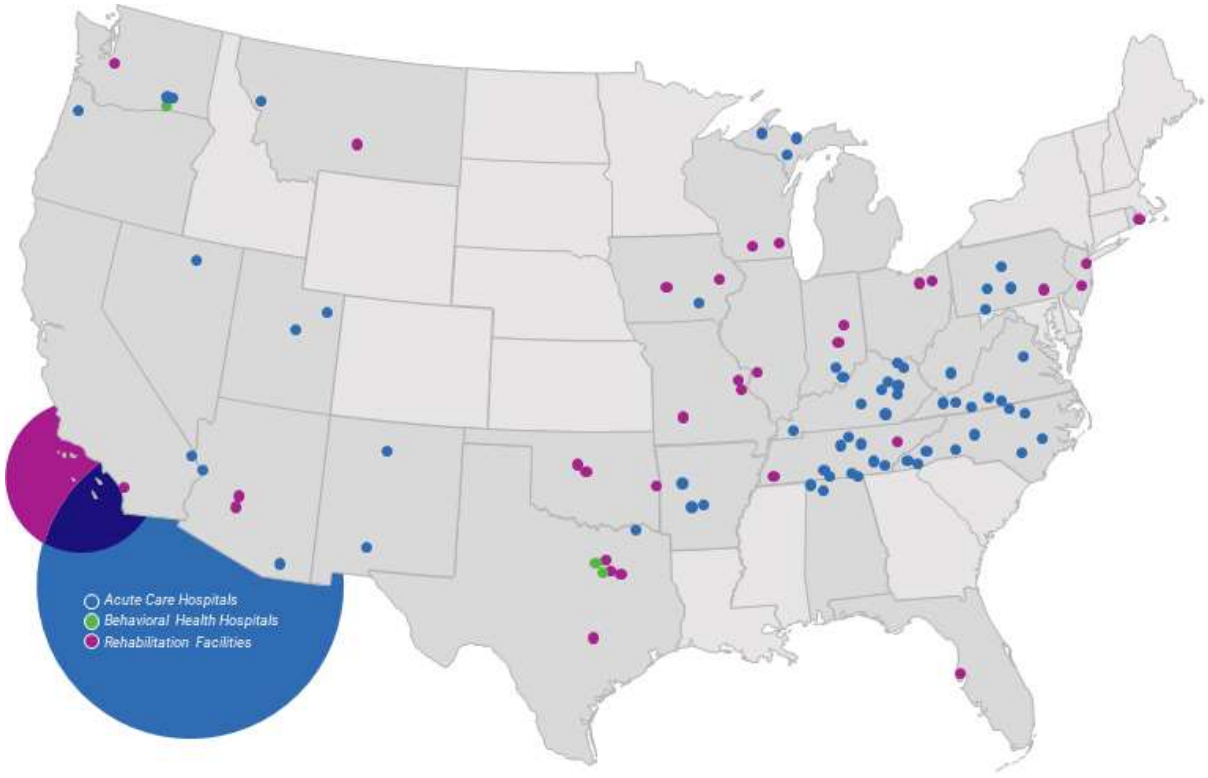
We license certain intellectual property, including technologies and software from third parties, that is important to our business, and in the future we may enter into additional agreements that provide us with licenses to valuable intellectual property or technology. If we fail to comply with any of the obligations under our license agreements, we may be required to pay damages and the licensor may have the right to terminate the license. Termination by the licensor would cause us to lose valuable rights, and could prevent us from selling our solutions and services, or adversely impact our ability to commercialize future solutions and services. Our business would suffer if any current or future licenses terminate, if the licensors fail to abide by the terms of the license agreement, if the licensors fail to enforce licensed intellectual property against infringing third parties, if the licensed intellectual property are found to be invalid or unenforceable, or if we are unable to enter into necessary license agreements on acceptable terms or at all. Any of the foregoing could have an adverse effect on our business, financial condition, or results of operations and cash flow.

Item 2. ***Properties.***

The following tables and map present certain information with respect to our consolidated facilities as of December 31, 2022:

Service Line	Facilities	Licensed Beds	States
Acute Care	62	8,487	22
Inpatient Rehabilitation [(a)]	31	1,617	19
Behavioral Health	3	154	2
	96	10,258	28

(a) Excludes two non-consolidated IRFs.



Facilities

Facility Name	City	Service Line	Licensed Beds
Alabama			
North Alabama Medical Center	Florence	Acute Care	263
Shoals Hospital	Muscle Shoals	Acute Care	198
Arizona			
Canyon Vista Medical Center	Sierra Vista	Acute Care	100
Dignity Health East Valley Rehabilitation Hospital	Chandler	Inpatient Rehabilitation	50
Dignity Health East Valley Rehabilitation Hospital - Gilbert	Gilbert	Inpatient Rehabilitation	40
Havasu Regional Medical Center	Lake Havasu City	Acute Care	171
Valley View Medical Center	Fort Mohave	Acute Care	84
Arkansas			
Mercy Rehabilitation Hospital Fort Smith	Ft. Smith	Inpatient Rehabilitation	50
National Park Medical Center	Hot Springs	Acute Care	163
Saline Memorial Hospital	Benton	Acute Care	177
St. Mary's Regional Medical Center	Russellville	Acute Care	170

Facility Name	City	Service Line	Licensed Beds
California			
Palomar Health Rehabilitation Institute	Escondido	Inpatient Rehabilitation	52
Florida			
Tampa Rehabilitation Hospital	Tampa	Inpatient Rehabilitation	80
Illinois			
Anderson Rehabilitation Institute	Edwardsville	Inpatient Rehabilitation	34
Indiana			
Clark Memorial Hospital	Jeffersonville	Acute Care	236
Community Rehabilitation Hospital	Indianapolis	Inpatient Rehabilitation	60
Community Rehabilitation Hospital South	Greenwood	Inpatient Rehabilitation	44
Scott Memorial Hospital	Scottsburg	Acute Care	25
Iowa			
Mercy Iowa City Rehabilitation Hospital	Coralville	Inpatient Rehabilitation	40
MercyOne Clive Rehabilitation Hospital	Clive	Inpatient Rehabilitation	50
Ottumwa Regional Health Center	Ottumwa	Acute Care	217
Kentucky			
Bluegrass Community Hospital	Versailles	Acute Care	25
Bourbon Community Hospital	Paris	Acute Care	58
Clark Regional Medical Center	Winchester	Acute Care	79
Fleming County Hospital	Flemingsburg	Acute Care	25
Georgetown Community Hospital	Georgetown	Acute Care	75
Jackson Purchase Medical Center	Mayfield	Acute Care	107
Lake Cumberland Regional Hospital	Somerset	Acute Care	295
Meadowview Regional Medical Center	Maysville	Acute Care	100
Spring View Hospital	Lebanon	Acute Care	75
Michigan			
UP Health System - Bell	Ishpeming	Acute Care	25
UP Health System - Marquette	Marquette	Acute Care	222
UP Health System - Portage	Hancock	Acute Care	96
Missouri			
Mercy Rehabilitation Hospital Springfield	Springfield	Inpatient Rehabilitation	60
Mercy Rehabilitation Hospital St. Louis	Chesterfield	Inpatient Rehabilitation	90
Mercy Rehabilitation Hospital South	St. Louis	Inpatient Rehabilitation	50
Montana			
Community Medical Center	Missoula	Acute Care	151
The Rehabilitation Hospital of Montana	Billings	Inpatient Rehabilitation	34
Nevada			
Northeastern Nevada Regional Hospital	Elko	Acute Care	75
New Jersey			
Atlantic Rehabilitation Institute	Madison	Inpatient Rehabilitation	38
New Mexico			
Los Alamos Medical Center	Los Alamos	Acute Care	47
Memorial Medical Center of Las Cruces	Las Cruces	Acute Care	199
North Carolina			
Central Carolina Hospital	Sanford	Acute Care	137
Frye Regional Medical Center	Hickory	Acute Care	355
Harris Regional Hospital	Sylva	Acute Care	86
Haywood Regional Medical Center	Clyde	Acute Care	153
Maria Parham Medical Center	Henderson	Acute Care	205
Person Memorial Hospital	Roxboro	Acute Care	98
Rutherford Regional Medical Center	Rutherfordton	Acute Care	143
Swain County Hospital	Bryson City	Acute Care	48
Wilson Medical Center	Wilson	Acute Care	384

Facility Name	City	Service Line	Licensed Beds
Ohio			
University Hospitals Avon Rehabilitation Hospital	Avon	Inpatient Rehabilitation	50
University Hospitals Rehabilitation Hospital	Beachwood	Inpatient Rehabilitation	50
Oklahoma			
Mercy Rehabilitation Hospital Oklahoma City	Oklahoma City	Inpatient Rehabilitation	66
Mercy Rehabilitation Hospital Oklahoma City South	Oklahoma City	Inpatient Rehabilitation	36
Oregon			
Willamette Valley Medical Center	McMinnville	Acute Care	60
Pennsylvania			
Conemaugh Memorial Medical Center	Johnstown	Acute Care	539
Lancaster Rehabilitation Hospital	Lancaster	Inpatient Rehabilitation	59
Meyersdale Medical Center	Meyersdale	Acute Care	20
Miners Medical Center	Hastings	Acute Care	25
Nason Medical Center	Roaring Spring	Acute Care	45
St. Mary Rehabilitation Hospital	Langhorne	Inpatient Rehabilitation	50
Rhode Island			
Rehabilitation Hospital of Rhode Island	North Smithfield	Inpatient Rehabilitation	82
Tennessee			
Baptist Memorial Rehabilitation Hospital	Germantown	Inpatient Rehabilitation	53
Knoxville Rehabilitation Hospital	Knoxville	Inpatient Rehabilitation	57
Riverview Regional Medical Center	Carthage	Acute Care	35
Southern Tennessee Regional Health System - Lawrenceburg	Lawrenceburg	Acute Care	99
Southern Tennessee Regional Health System - Pulaski	Pulaski	Acute Care	95
Southern Tennessee Regional Health System - Sewanee	Sewanee	Acute Care	46
Southern Tennessee Regional Health System - Winchester	Winchester	Acute Care	152
Starr Regional Medical Center - Athens	Athens	Acute Care	190
Starr Regional Medical Center - Etowah	Etowah	Acute Care	88
Sumner Regional Medical Center	Gallatin	Acute Care	167
Trousdale Medical Center	Hartsville	Acute Care	25
Texas			
Central Texas Rehabilitation Hospital	Austin	Inpatient Rehabilitation	50
Paris Regional Medical Center	Paris	Acute Care	154
Texas Rehabilitation Hospital of Arlington	Arlington	Inpatient Rehabilitation	40
Texas Rehabilitation Hospital of Fort Worth	Fort Worth	Inpatient Rehabilitation	66
Texas Rehabilitation Hospital of Keller	Keller	Inpatient Rehabilitation	36
WellBridge Healthcare Greater Dallas	Plano	Behavioral Health	48
WellBridge Healthcare Fort Worth	Fort Worth	Behavioral Health	48
Utah			
Ashley Regional Medical Center	Vernal	Acute Care	39
Castleview Hospital	Price	Acute Care	39
Virginia			
Clinch Valley Medical Center	Richlands	Acute Care	175
Fauquier Health	Warrenton	Acute Care	210
Sovah Health - Danville	Danville	Acute Care	250
Sovah Health - Martinsville	Martinsville	Acute Care	220
Twin County Regional Hospital	Galax	Acute Care	141
Wythe County Community Hospital	Wytheville	Acute Care	100
Washington			
CHI Franciscan Rehabilitation Hospital	Tacoma	Inpatient Rehabilitation	60
Lourdes Health - Medical Center	Pasco	Acute Care	95
Lourdes Health - Counseling Center	Pasco	Behavioral Health	58
Trios Health - Southridge Hospital	Kennewick	Acute Care	111

Facility Name	City	Service Line	Licensed Beds
West Virginia			
Raleigh General Hospital	Beckley	Acute Care	300
Wisconsin			
Pro Health Rehabilitation Hospital of Wisconsin	Waukesha	Inpatient Rehabilitation	40
UW Health Rehabilitation Hospital	Madison	Inpatient Rehabilitation	50
			10,258

We own or lease and operate medical office buildings, clinics and other ancillary properties in conjunction with many of our hospitals. These medical office buildings and clinics are primarily occupied by physicians who practice at our hospitals. Additionally, we lease office space in Brentwood, Tennessee and Louisville, Kentucky for our HSC. All of our facilities are suitable for their respective uses and are generally adequate for our present needs.

Item 3. ***Legal Proceedings.***

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

The information set forth under "Legal Proceedings and General Liability Claims" in Note 13 to our accompanying consolidated financial statements included elsewhere in this Report, is incorporated herein by reference.

Item 4. ***Mine Safety Disclosures*****.**

Not applicable.

PART II

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

All of our equity securities are held by Holdings, an indirect subsidiary of DSB Parent L.P., a Delaware limited partnership (the "***Parent***"). As of December 31, 2022, our Sponsor and certain co-investors beneficially owned approximately 97.4% of the capital units of the Parent with the remaining approximate 2.6% owned by our or our affiliates' current or former directors, members of management, employees and certain other service providers, and/or our affiliates. Because our equity securities are privately held, there is no established public trading market for our equity securities.

Equity Compensation Plan Information

Refer to Note 12 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by the Parent to certain of our current and former service providers.

Recent Sales of Unregistered Securities

There have been no recent sales of unregistered equity securities of the Company within the period covered by this Report.

Item 6. [Reserved.]

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

The following is management's discussion and analysis of our financial condition and results of operations for the years ended December 31, 2022 and December 31, 2021. We recommend that you read this discussion together with our accompanying consolidated financial statements and related notes included elsewhere in this Report.

Refer to "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations" in our Annual Report for the year ended December 31, 2021 for management's discussion and analysis of changes in financial condition and results of operations as of and for the years ended December 31, 2021 and 2020.

Overview

We are a leading provider of healthcare serving patients, clinicians, communities and partner organizations across the healthcare continuum. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a growing diversified healthcare delivery network, which at December 31, 2022 was comprised of 62 community hospital campuses, 31 IRFs, three behavioral health facilities, and additional sites of care that include ARUs, outpatient centers and post-acute care facilities. As of December 31, 2022, we operated 96 healthcare facilities in 28 states throughout the U.S. with approximately 10,000 licensed beds and approximately 50,000 dedicated employees.

We seek to fulfill our mission of *making communities healthier*® and strive to create places where people choose to come for healthcare, physicians and providers want to practice and employees want to work. Additionally, we are committed to upholding our core values, which are champion patient care; do the right thing; embrace individuality; act with kindness; and make a difference together. Together, our shared mission, vision and values guide our work and unite our employees across our organization.

We generated revenues of $8,020 million and $8,937 million for the years ended December 31, 2022 and 2021, respectively. For the years ended December 31, 2022 and 2021, approximately 57.1% and 56.1% of our revenues, respectively, related to patients participating in Medicare and Medicaid programs, collectively. Payments made to our facilities pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payers, together with certain limited services provided to Medicare recipients, to generate an operating profit. The healthcare industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payers. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our facilities.

Developments, Trends and Operating Environment

Springstone Transaction

On August 26, 2022, we entered into a definitive agreement with (i) entities affiliated with MPT and (ii) BH EIK Management, LP, a management company owned by certain members of the executive leadership team ("***Springstone Management***") of Springstone Health Opco, LLC ("***Springstone***"), to acquire a majority ownership interest in Springstone from Springstone Management and to acquire a promissory note issued by Springstone to an affiliate of MPT (the "***Springstone Transaction***"). Springstone is a national behavioral health provider with 18 behavioral health hospitals and 35 outpatient locations across nine states. Pursuant to the Springstone Transaction, MPT will continue to own the majority of Springstone's real estate locations, subject to the Springstone Master Lease, and retain a noncontrolling interest in Springstone, subject to a put/call agreement. The Springstone Transaction was consummated on February 7, 2023, upon which certain of our subsidiaries entered into the Springstone Master Lease and we funded $230 million in cash to complete the transaction. For additional information regarding the Springstone Transaction, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Cornerstone Behavioral Health El Dorado

On January 20, 2023, we acquired Cornerstone Behavioral Health El Dorado ("***El Dorado***"), a 54-bed behavioral health facility located in Tucson, Arizona for $35 million (the "***El Dorado Transaction***"). For additional information regarding the El Dorado Transaction, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Everest Rehabilitation

On January 24, 2023, a wholly-owned, indirect subsidiary of ours entered into a definitive agreement with entities affiliated with Everest Rehabilitation Hospitals, LLC ("***Everest***"), to acquire four IRFs (the "***Operational IRFs***") located in Arkansas, Texas, and Ohio (the "***Operational IRF Transaction***") for an aggregate purchase price of approximately $38 million. The closing of the Operational IRF Transaction was consummated on March 1, 2023. Additionally, in connection with the closing of the Operational IRF Transaction, certain of our affiliated entities entered into a definitive agreement with entities affiliated with Everest to acquire six IRFs that Everest is currently developing in Texas and Florida (the "***Developing IRFs***") for an aggregate purchase price of approximately $60 million. We anticipate closing our acquisition of the Developing IRFs on a rolling basis beginning in the third or fourth quarter of 2023. For additional information regarding the Operational IRF Transaction and the Developing IRFs, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

De Novo IRF Openings

We commenced the operations of four de novo IRFs during 2022. The results of operations of these four IRFs are excluded from the classification of "same-facility" in the forthcoming discussion and analysis of our results of operations for the years ended December 31, 2022 and 2021. Refer to the table below for additional details.

Facility Name	Location	Opening Date	Licensed Beds
Dignity Health East Valley Rehabilitation Hospital - Gilbert	Gilbert, Arizona	December 21, 2022	40
Mercy Rehabilitation Hospital South	St. Louis, Missouri	December 6, 2022	50
Saint Thomas Rehabilitation Hospital (a)	Nashville, Tennessee	June 14, 2022	40
Tampa Rehabilitation Hospital	Tampa, Florida	May 17, 2022	80

(a) We hold a noncontrolling ownership interest in Saint Thomas Rehabilitation Hospital and have accounted for it as an equity investment in accordance with Accounting Standards Codification ("***ASC***") 323, "Investments – Equity Method and Joint Ventures" ("***ASC 323***").

Kindred Transaction

On June 18, 2021, we entered into the Kindred Purchase Agreement for us and/or one or more affiliated assignees to acquire, directly or indirectly, Kindred, a leading specialty hospital company that operates facilities providing post-acute care, rehabilitation services and behavioral health services throughout the U.S. The Kindred Transaction closed on December 23, 2021. Upon the closing of the Kindred Transaction, a new healthcare company was established operating under the name ScionHealth, which is separate from Lifepoint. For additional information regarding the Kindred Transaction, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Divestitures

Effective May 1, 2022, we sold Colorado Plains Medical Center ("***Colorado Plains***"), a 50 bed acute care facility located in Fort Morgan, Colorado, and Western Plains Medical Complex ("***Western Plains***"), a 99 bed acute care facility located in Dodge City, Kansas, to an unrelated third party. The results of operations of Colorado Plains and Western Plains are excluded from the classification of "same-facility" in the forthcoming discussion and analysis of our results of operations for the years ended December 31, 2022 and 2021. For additional information regarding our recent divestitures, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Ongoing Impact of COVID-19

While we continue to diagnose and treat COVID-19 patients in our facilities, the prevalence and widespread impact of the virus has decreased both across our organization and the country at large. Our focus continues to be on protecting our patients, our people and our communities by managing this infectious disease according to standard infection prevention and control protocols and guidance from the CDC. Our internal COVID-19 taskforce, which was established during the early stages of the pandemic, continues to carefully monitor any trends that may impact the organization and meets on an ad hoc basis to address the specific needs of our facilities.

We initially implemented during the early stages of the COVID-19 pandemic and have continued to retain a number of health and safety measures to protect our patients, providers, employees, volunteers and visitors. These include monitoring local COVID-19 infection and hospitalization trends, adhering to stringent infection control protocols, maintaining rigorous cleaning and disinfection practices, and regularly assessing crucial supplies, among others.

Our evaluation of the measures taken across our health system in response to COVID-19 is ongoing and additional updates to our policies, procedures and operations could occur as best practices continue to evolve. Furthermore, our facilities are located across a wide geographic range of communities, which may require us to modify measures we take at specific facilities based on local conditions, including the severity of COVID-19 and any variants of the virus in the community served by a facility and changes in state and local executive orders that may restrict certain services or activities.

Taking into account the COVID-19 pandemic and other factors, the U.S. economy has recently experienced general inflationary pressures, significant disruptions to global supply networks, and an extremely competitive labor market, including staffing shortages and increases to expenses related to staffing. We have incurred, and may continue to incur, certain increased expenses arising from the pandemic and these economic conditions, including additional labor, supply chain, capital and other expenditures. While we have implemented cost containment and other measures to try to counteract these developments, we may be unable to fully offset these increases in our costs and otherwise effectively respond to supply disruptions.

Legislative and Regulatory Developments in Response to COVID-19

Numerous legislative and regulatory actions, including the CARES Act and related stimulus legislation, have been taken in an attempt to provide businesses, including healthcare providers, with relief from and to combat the negative effects of the COVID-19 pandemic.

Under the CMS Accelerated and Advance Payment Program as expanded by the CARES Act, we received a total of $991 million of Medicare advance payments during the year ended December 31, 2020, which we fully repaid in the year ended December 31, 2021. We do not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program, and although we have previously repaid or declined funds that are available to us and our facilities under the CARES Act and related stimulus legislation, we cannot predict if we will need to seek such funds in the future, and we cannot assure you that we will be able to access such funds in a timely manner or at all.

In addition to the financial relief that has been provided by the federal government under the CARES Act and other legislation that has been passed by Congress, CMS and many state governments have also issued a number of waivers or temporarily suspended a number of healthcare facility licensure and reimbursement requirements in order to provide hospitals, skilled nursing facilities, and other types of healthcare providers with increased flexibility to meet the challenges that are being presented by the COVID-19 pandemic. For example, CMS has temporarily waived the enforcement of certain requirements of the Medicare hospital conditions of participation and the Stark law (as defined in this Report) to enable hospitals to treat patients in temporary locations and to obtain services from physicians in a more efficient and timely manner. Likewise, many states have also suspended the enforcement of certain certificate of need and licensure requirements to ensure that hospitals and other healthcare providers have sufficient capacity to treat COVID-19 patients. Our facilities have utilized the waivers and regulatory flexibility that are being provided to the extent necessary to appropriately respond to the COVID-19 pandemic. On January 30, 2023, President Biden announced that his administration intends to end the COVID-19 public health emergency on May 11, 2023, which will result in termination of many of the flexibilities and waivers issued in response to the COVID-19 public health emergency that have not already been terminated.

The CARES Act also provides for certain federal income tax changes, including an increase in the interest expense tax deduction limitation, the deferral of the employer portion of Social Security payroll taxes, refundable payroll tax credits, employee retention tax credits, net operating loss carryback periods, alternative minimum tax credit refunds and bonus depreciation of qualified improvement property. During the year ended December 31, 2020, we deferred cash payments of approximately $84 million related to Social Security payroll tax payments, which we fully repaid during the year ended December 31, 2021.

Healthcare Reform Efforts

In recent years, Congress has passed a number of laws, including the Affordable Care Act, that are intended to effect major changes in the U.S. healthcare system. The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The net effect of the Affordable Care Act, as currently adopted, on our business continues to be subject to a number of variables, including the law's complexity, its changing and often incomplete implementation of regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. While the U.S. Supreme Court rejected the most recent challenge to constitutionality of the Affordable Care Act, we cannot predict the outcome of other lawsuits that are still pending in lower courts regarding the implementation of various aspects of the Affordable Care Act or whether the U.S. Supreme Court will decide to hear future cases. Additionally, we cannot predict the impact that the current or future Presidential administrations and Congresses will have on the implementation and enforcement of the provisions of the Affordable Care Act or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

Refer to "Part I, Item 1. Business—Healthcare Reform" included in this Report for more information about the Affordable Care Act.

Competitive and Structural Environment

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

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

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

In addition to competitive concerns, many of our communities are experiencing slow growth, and in some cases, population losses. We believe this trend has occurred mainly as a result of challenging economic conditions in the non-urban communities where our facilities primarily operate, which are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves. In addition, other economic factors, including, the recent economic downturn resulting from the COVID-19 pandemic, rising inflation and, potentially, self-rationing of healthcare services, have made it more difficult to increase the number of patients who seek care at many of our facilities.

Regulatory Environment

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

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

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

In light of the provisions of the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

Revenue Sources

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

Medicare and Medicaid Reimbursement

Revenues from governmental payers, such as Medicare and Medicaid, are controlled by complex rules and regulations that stipulate the amount a healthcare provider is paid for providing healthcare services. We must comply with these rules and regulations to continue to be eligible to participate in the Medicare and Medicaid programs. These rules and regulations are subject to frequent changes as a result of legislative and administrative action and annual payment adjustments on both the federal and the state levels. In addition, Medicare payment methodologies have been, and are expected to continue to be, revised significantly based on cost containment and policy considerations.

For more information about Medicare and Medicaid reimbursement matters, refer to “Part I, Item 1. Business—Sources of Revenue” included in this Report.

Physician & Non-Physician Practitioner Services

We employ an increasing number of physicians and non-physician practitioners, such as physician assistants and nurse practitioners, in our hospital markets. Medicare pays us for services provided by our employed physicians and non-physician practitioners under the PFS system. MACRA, which was adopted in 2015, significantly changed how CMS determines the annual updates to the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased annually by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the Bipartisan Budget Act of 2018, were increased by 0.25% for CY 2019. PFS payment rates are scheduled to remain at their CY 2019 levels through CY 2025. In addition, MACRA also established the QPP for incentivizing physician and practitioner care that meets certain value, quality, cost, and performance criteria, and, beginning in CY 2019, amounts paid to physicians and practitioners under the PFS are subject to adjustment through the QPP and participation in either MIPS or an APM. For more information, refer to "Part I, Item 1. Business—Sources of Revenue—Medicare Physician Fee Schedule" included in this Report.

HMOs, PPOs and Other Private Insurers

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

Self-pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities have experienced in prior years, which included increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. We cannot predict how administrative or judicial interpretations, legislative actions or any other modifications to the Affordable Care Act that may be implemented or adopted, such as the cessation of cost sharing reduction payments or the repeal of the individual mandate, may impact our self-pay revenues.

Surprise Billing Regulations

On December 21, 2020, Congress adopted legislation that is intended to limit the "surprise" medical bills that are often received by individuals receiving emergency and certain other services (such as anesthesia services) from out-of-network providers. Effective as of January 1, 2022, the No Surprises Act prohibits, among other things, out-of-network providers from balance billing patients for emergency care services that are provided by out-of-network facilities or at in-network facilities by out-of-network providers. The No Surprises Act also generally prohibits out-of-network providers from billing patients for non-emergency medical treatment unless the provider first notifies the patient of the provider's network status and estimated charges and the patient agrees to be financially liable for the additional amounts. Violations of the No Surprises Act are punishable by civil monetary penalties of up to $10,000, and the No Surprises Act may be enforced by both the state and federal governments. We cannot predict how the No Surprises Act will be implemented or enforced. We also cannot predict the amounts that will be received by our facilities and our employed providers for out-of-network services, whether the No Surprises Act will impact the in-network payment rates that are offered by third-party payers and the willingness of those payers to enter into participation agreements with us and our facilities in the future, or the costs we will incur in complying with the requirements of the No Surprises Act. For more information, see "Business—Sources of Revenues—Surprise Medical Billing" included elsewhere in this Report —Item 1.

Price Transparency

Transparency in healthcare pricing has become a focal point for CMS, Congress, and many state legislatures. For example, effective as of January 1, 2021, hospitals generally are required to post their standard charges prominently on a publicly available website. Although we continue to evaluate, and are taking proactive steps in response to, the legislative and regulatory developments regarding price transparency, we cannot predict how existing regulations will be implemented or interpreted or whether any other requirements will be imposed on providers and health plans. We also cannot predict what affect the public disclosure of hospitals' or insurance providers' negotiated rates will have on our future negotiations with payers or the effect that the disclosure of pricing information by healthcare providers and health plans will have on our patient volumes and revenues. For more information, see "Business—Sources of Revenues—Price Transparency" included elsewhere in this Report—Item 1.

Results of Operations

Certain Definitions

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

Adjusted EBITDA. EBITDA adjusted to exclude unusual items and other adjustments required or permitted in calculating debt covenant compliance under the Indentures governing the Notes and/or the Credit Agreements. We believe that this inclusion of supplementary adjustments to EBITDA applied in presenting Adjusted EBITDA are appropriate to provide additional information to investors about the impact of certain non-cash, non-recurring or unusual items that we do not expect to continue or to continue at the same level in the future and other items.

Admissions. The total number of patients admitted to our facilities for inpatient treatment.

Case mix index. Refers to the acuity or severity of illness of an average patient at our acute care facilities.

Consolidated. Consolidated information includes the results of all facility operations and corporate overhead costs, including the results of our new facility openings and our completed divestitures through the date of disposal during the applicable periods.

EBITDA. Earnings before interest, taxes, depreciation and amortization.

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

Outpatient factor. The sum of gross inpatient revenue and gross outpatient revenue divided by gross inpatient revenue.

Patient days. The total number of days of care provided to patients admitted to our facilities for inpatient treatment.

Same-facility. Same-facility information includes the results of the same facilities operated during the entire three months and years ended December 31, 2022 and 2021, as if the Kindred Transaction had occurred on January 1, 2021. Same-facility information excludes the results of the Artemis Business, as well as our newly opened facilities and our completed divestitures.

Summary

The following table summarizes our consolidated results of operations for the years ended December 31, 2022 and 2021 (dollars in millions):

	Years Ended December 31,			
	2022		2021	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 8,020	100.0 %	$ 8,937	100.0 %
Salaries and benefits	4,016	50.1	4,176	46.7
Supplies	1,243	15.5	1,505	16.8
Other operating expenses, net	2,039	25.4	2,245	25.1
Government stimulus income	(14)	(0.2)	(17)	(0.2)
Depreciation and amortization	323	4.0	345	3.9
Interest expense, net	480	6.0	466	5.2
Transaction-related costs	46	0.6	86	1.0
Other non-operating (gains) losses, net	(8)	(0.1)	19	0.2
	8,125	101.3	8,825	98.7
(Loss) income before income taxes	(105)	(1.3)	112	1.3
Provision for (benefit from) income taxes	100	1.3	(27)	(0.3)
Net (loss) income	(205)	(2.6)	139	1.6
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(66)	(0.8)	(9)	(0.1)
Net (loss) income attributable to Lifepoint Health, Inc.	$ (271)	(3.4) %	$ 130	1.5 %

Revenues

The following table summarizes our key revenue metrics on a consolidated basis for the years ended December 31, 2022 and 2021:

	Years Ended December 31,		Increase	% Increase
	2022	2021	(Decrease)	(Decrease)
Number of facilities (at end of period) (a)	96	96		
Revenues (in millions)	$ 8,020	$ 8,937	$ (917)	(10.3)%
Patient days	1,541,709	1,524,403	17,306	1.1 %
Admissions	248,646	284,918	(36,272)	(12.7)%
Equivalent admissions	636,886	734,730	(97,844)	(13.3)%
Revenues per equivalent admission	$ 12,593	$ 12,164	$ 429	3.5 %
Case mix index	1.47	1.49	(0.02)	(1.3)%
Total surgeries	306,655	380,293	(73,638)	(19.4)%
Emergency department visits	1,275,070	1,606,668	(331,598)	(20.6)%

(a) Excludes two non-consolidated IRFs accounted for as equity method investments in accordance with ASC 323.

For the year ended December 31, 2022, our consolidated revenues decreased $917 million, or 10.3%, to $8,020 million compared to $8,937 million for the prior year. The decrease in our consolidated revenues was primarily attributable to the impact of the Kindred Transaction, including the transfer of the Artemis Business and acquisition of the Knight Transferred Business, as well as our acute care facility divestitures completed during 2021 and 2022. Refer to *"Supplemental Results of Operations on a Same-Facility Basis"* included elsewhere in this Report for a more comparable analysis of our key revenue metrics.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2022 and 2021 (dollars in millions):

	Years Ended December 31,			
	2022		2021	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,227	40.2 %	$ 3,368	37.7 %
Medicaid	1,353	16.9	1,645	18.4
HMOs, PPOs and other private insurers	3,030	37.8	3,691	41.3
Self-pay	57	0.7	55	0.6
Other (a)	338	4.2	156	1.8
Revenue from contracts with customers	8,005	99.8	8,915	99.8
Rental income	15	0.2	22	0.2
Revenues	$ 8,020	100.0 %	$ 8,937	100.0 %

(a) Includes revenues from managed ARUs and ancillary goods and services.

Salaries and Benefits

For the year ended December 31, 2022, our consolidated salaries and benefits expense was $4,016 million, or 50.1% of revenues, compared to $4,176 million, or 46.7% of revenues, for the prior year. The decrease in our salaries and benefits expense was primarily attributable to $112 million of accelerated stock-based compensation expense recognized in the prior year and the transfer of the Artemis Business in connection with the Kindred Transaction, and our acute care facility divestitures completed during 2021 and 2022, partially offset by the impact of wage inflation and increases in the rate and utilization of contract labor across the majority of our markets. For additional information regarding our accounting for stock-based compensation, refer to Note 12 to our accompanying consolidated financial statements included elsewhere in this Report.

Supplies

For the year ended December 31, 2022, our consolidated supplies expense was $1,243 million, or 15.5% of revenues, compared to $1,505 million, or 16.8% of revenues, for the prior year. The decrease in our supplies expense was primarily a result of the transfer of the Artemis Business in connection with the Kindred Transaction, as well as our acute care facility divestitures completed during 2021 and 2022.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the year ended December 31, 2022, our consolidated other operating expenses were $2,039 million, or 25.4% of revenues, compared to $2,245 million, or 25.1% of revenues, for the prior year. The decrease in our other operating expenses was primarily a result of the transfer of the Artemis Business in connection with the Kindred Transaction, our acute care facility divestitures completed during 2021 and 2022 and investment income recognized during the current year in connection with the receipt of a dividend from a non-consolidated cost method investment, partially offset by increases in professional fees and contract services resulting from inflation across the majority of our markets during the current year as compared to the prior year.

Government Stimulus Income

As a result of the adverse impact of the COVID-19 pandemic on our business, we received stimulus payments from the Emergency Fund established under the CARES Act. For the years ended December 31, 2022 and 2021, we recognized $14 million and $17 million, respectively, of stimulus payments as other income. For additional information regarding the CARES Act and related financial impact, refer to Note 1 to our accompanying consolidated financial statements included elsewhere in this Report.

Depreciation and Amortization

For the year ended December 31, 2022, our consolidated depreciation and amortization expense was $323 million, or 4.0% of revenues, compared to $345 million, or 3.9% of revenues, for the prior year. The decrease in our depreciation expense was primarily attributable to the impact of the Kindred Transaction, including the transfer of the Artemis Business and acquisition of the Knight Transferred Business, as well as our acute care facility divestitures completed during 2021 and 2022.

Interest Expense, Net

For the year ended December 31, 2022, our consolidated interest expense was $480 million, or 6.0% of revenues, compared to $466 million, or 5.2% of revenues, for the prior year. The increase in our interest expense was primarily attributable to rising variable interest rates during the current year, partially offset by the discontinuation of finance lease amortization in connection with certain of our acute care facility divestitures completed during 2021 and 2022. For a further discussion of our debt and corresponding interest expense, refer to Notes 3 and 10 to our accompanying consolidated financial statements included elsewhere in this Report.

Transaction-Related Costs

For the years ended December 31, 2022 and 2021, we recognized transaction and advisory-related costs of $46 million and $86 million, respectively, primarily in connection with the Kindred Transaction, the Springstone Transaction and other business development activities. For additional information regarding our business development activities, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Other Non-Operating (Gains) Losses, Net

For the year ended December 31, 2022, we recognized a net other non-operating gain of $8 million, primarily comprised of gains related to our divestitures of Colorado Plains and Western Plains and the repurchase of a portion of our 9.75% Unsecured Notes, partially offset by losses recognized in connection with miscellaneous disposals of property and equipment. For the year ended December 31, 2021, we recognized a net other non-operating loss of $19 million, primarily comprised of net gains and losses recognized in connection with our recent hospital divestitures, as well as other miscellaneous disposals of property and equipment. For additional information regarding our recent divestitures, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Income Taxes

For the years ended December 31, 2022 and 2021, we recognized a provision for income taxes of $100 million and a benefit from income taxes of $27 million, respectively. For a further discussion of our income taxes, refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report.

Noncontrolling Interests

For the years ended December 31 2022 and 2021, we recognized net income attributable to noncontrolling interests and redeemable noncontrolling interests of $66 million and $9 million, respectively. The increase in our net income attributable to noncontrolling interests and redeemable noncontrolling interests was primarily attributable to the impact of the Kindred Transaction, including the transfer of the Artemis Business and acquisition of the Knight Transferred Business.

Non-GAAP Measures

Supplemental Results of Operations on a Same-Facility Basis

The following table summarizes our key supplemental results of operations for the three months and years ended December 31, 2022 and 2021 on a same-facility basis as if the Kindred Transaction had occurred on January 1, 2021. GAAP does not allow for such a combination of results of operations; however, we believe this information is useful in evaluating our financial performance.

	Three Months Ended December 31,		Increase (Decrease)	% Increase (Decrease)
	2022	2021		
Number of facilities (at end of period) (a)	93	93		
Revenues (in millions)	$ 2,024	$ 2,108	$ (84)	(4.0)%
Patient days	379,934	411,486	(31,552)	(7.7)%
Admissions	62,027	63,619	(1,592)	(2.5)%
Equivalent admissions	161,038	152,966	8,072	5.3 %
Revenues per equivalent admission	$ 12,567	$ 13,779	$ (1,212)	(8.8)%
Case mix index	1.46	1.53	(0.07)	(4.6)%
Total surgeries	76,311	77,099	(788)	(1.0)%
Emergency department visits	333,836	311,665	22,171	7.1 %

	Years Ended December 31,		Increase	% Increase
	2022	2021	(Decrease)	(Decrease)
Number of facilities (at end of period) (a)	86	86		
Revenues (in millions)	$ 7,889	$ 8,108	$ (219)	(2.7)%
Patient days	1,480,239	1,563,114	(82,875)	(5.3)%
Admissions	242,772	254,237	(11,465)	(4.5)%
Equivalent admissions	628,514	625,517	2,997	0.5 %
Revenues per equivalent admission	$ 12,551	$ 12,962	$ (411)	(3.2)%
Case mix index	1.47	1.49	(0.02)	(1.3)%
Total surgeries	305,705	307,120	(1,415)	(0.5)%
Emergency department visits	1,269,197	1,240,081	29,116	2.3 %

(a) Excludes two non-consolidated IRFs accounted for as equity method investments in accordance with ASC 323.

The decrease in our same-facility revenues for the three months and year ended December 31, 2022 compared to the same periods last year was attributable to decreases in revenues per equivalent admission of 8.8% and 3.2%, respectively, partially offset by increases in equivalent admissions of 5.3% and 0.5%, respectively. Our same-facility revenues per equivalent admission for the three months and year ended December 31, 2022 were negatively impacted by expected changes to certain governmental reimbursement programs, including declining COVID add-on payments and the return of Medicare sequestration, as well as changes in acuity, service mix and payer mix. The increase in our same-facility equivalent admissions for the three months and year ended December 31, 2022 was attributable to increases in emergency department visits and outpatient volumes as compared to the same periods last year.

EBITDA and Adjusted EBITDA

The following table presents a reconciliation of net (loss) income to EBITDA and Adjusted EBITDA prepared in accordance with the calculations set forth in the Indentures and the Credit Agreements for the three months ended December 31, 2022 and 2021 and the twelve months ended December 31, 2022 and September 30, 2022 (in millions):

	Three Months Ended December 31,		Twelve Months Ended December 31,	September 30,
	2022	2021	2022	2022
Net (loss) income	$ (167)	$ 108	$ (205)	$ 70
Interest expense, net	135	114	480	458
Income taxes	81	(61)	100	(42)
Depreciation and amortization	84	85	323	324
EBITDA	133	246	698	810
Transaction-related costs (a)	19	33	46	60
Facility lease expense (b)	(12)	(20)	(45)	(53)
One-time costs, non-cash and non-recurring items (c)	42	2	107	67
Subtotal	182	261	806	884
Pro forma run rate adjustments (d)	62	43	301	221
Adjusted EBITDA	$ 244	$ 304	$ 1,107	$ 1,105

(a) Represents the exclusion of certain transaction-related expenses, including costs associated with the Springstone Transaction and the Kindred Transaction, as well as other business development activities occurring during the applicable periods. For additional information regarding our business development activities, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

(b) Represents cash interest expense in connection with certain finance leases. Pursuant to the terms of our financial covenants contained in our debt agreements, we are required to consider cash interest expense on facility-related finance leases within the calculation of Adjusted EBITDA.

(c) Represents the exclusion of certain one-time costs, non-cash and non-recurring items, including, but not limited to, incremental operating expenses associated with the COVID-19 pandemic, litigation-related expenses, facility pre-opening costs and start-up related expenses, employee severance and other restructuring charges, the elimination of EBITDA associated with facilities that have been divested, differences between cash payments and reported rent expense for facility operating leases, stock-based compensation expense, gains and losses related to hospital divestitures and other disposals of property and equipment, as well as other non-operational items.

(d) Represents the estimated pro forma EBITDA impact attributable to various strategic initiatives and investments as permitted by our debt agreements. Such items primarily consist of (i) new or expanded service lines, newly opened or constructed facilities and other strategic investments; (ii) our recently announced 2023 acquisitions, including the Springstone Transaction, the El Dorado Transaction and the Everest Operational IRF Transaction; (iii) our IRF and behavioral health de novo pipeline; and (iv) unrealized savings associated with various cost reduction initiatives across our business, including supply chain, revenue cycle management and other functional areas.

Leverage

The following table illustrates our indebtedness and certain leverage ratios prepared in accordance with the calculations set forth in the Indentures and the Credit Agreements as of and for the twelve months ended December 31, 2022 and September 30, 2022 (dollars in millions):

	December 31, 2022	September 30, 2022
Cash and cash equivalents	$ 395	$ 475
ABL Facility	$ -	$ -
Term Loan Facility	3,215	3,215
6.75% Secured Notes	600	600
4.375% Secured Notes	600	600
Total Secured Debt (a)	$ 4,415	$ 4,415
Net Secured Debt (a)	$ 4,020	$ 3,940
9.75% Unsecured Notes	$ 1,270	$ 1,320
5.375% Unsecured Notes	500	500
Total Debt (a)	$ 6,185	$ 6,235
Net Debt (a)	$ 5,790	$ 5,760
Adjusted EBITDA	$ 1,107	$ 1,105
Total Secured Debt (a) / Adjusted EBITDA	3.99x	4.00x
Net Secured Debt (a) / Adjusted EBITDA	3.63x	3.57x
Total Debt (a) / Adjusted EBITDA	5.59x	5.64x
Net Debt (a) / Adjusted EBITDA	5.23x	5.21x

(a) Excludes finance lease obligations, which are not considered indebtedness for purposes of calculating the ratios set forth in the Indentures and the Credit Agreements, as well as unamortized debt issuance costs.

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash generated by operations and borrowings under the ABL Facility. Our primary uses of cash are working capital requirements, debt service requirements and capital expenditures. Based on our current level of operations and available cash, we believe our cash flows from operations, combined with availability under the ABL Facility, will provide sufficient liquidity to fund our current obligations, projected working capital requirements, debt service requirements and capital spending requirements over the next twelve months. We cannot assure you, however, that our business will generate sufficient cash flows from operations or that future borrowings will be available to us under the ABL Facility, which is subject to a borrowing base, in an amount sufficient to enable us to pay principal and interest on the ABL Facility, the Term Loan Facility and the Notes, or to fund other liquidity needs. Our ability to do so depends on prevailing economic conditions, many of which are beyond our control. In addition, upon the occurrence of certain events, such as a change of control, we could be required to repay or refinance our indebtedness. We cannot assure you that we will be able to refinance any of our indebtedness on commercially reasonable terms or at all. Any future acquisitions, joint ventures or other similar transactions will likely require additional capital, and there can be no assurance that any such capital will be available to us on acceptable terms or at all. Any refinancing of our indebtedness could be at higher interest rates and may require us to comply with more onerous covenants that could further restrict our business operations. See "Item 1A, Risk Factors—Credit and Liquidity Risks" included elsewhere in this Report.

The following table presents summarized cash flow information for the years ended December 31, 2022 and 2021 (in millions):

	2022	2021
Net cash provided by (used in) operating activities	$ 82	$ (590)
Net cash used in investing activities	(138)	(1,034)
Net cash used in financing activities	(402)	(176)
Change in cash and cash equivalents	$ (458)	$ (1,800)

Operating Activities

When adjusted to exclude the impact of the repayments of Medicare advance payments and deferred payroll taxes in connection with the CARES Act during 2021, our net cash provided by operating activities for the years ended December 31, 2022 and 2021 was $82 million and $485 million, respectively. The decrease in our net cash provided by operating activities on such adjusted basis was primarily attributable to lower net income and differences in the amount and timing of various working capital accounts, partially offset by the receipt of a dividend related to a non-consolidated cost method investment.

Investing Activities

We invested $227 million and $274 million in purchases of property and equipment for the years ended December 31, 2022 and 2021, respectively. Refer to "—Capital Expenditures" below for further information.

During the year ended December 31, 2022, we received cash proceeds of $135 million in connection with the sale of Colorado Plains and Western Plains. Additionally, during the year ended December 31 2022, certain of our subsidiaries invested approximately $47 million for an aggregate $50 million principal amount of ScionHealth's senior secured term loan.

In connection with the Kindred Transaction, we transferred cash of $946 million to ScionHealth and received cash of $71 million associated with the Knight Transferred Business, resulting in a net cash outflow of $875 million for the year ended December 31, 2021. Additionally, during the year ended December 31, 2021, we received cash proceeds of $119 million in connection with our recent divestitures.

For a further discussion of the Kindred Transaction and our recent divestitures, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Financing Activities

On June 3, 2022, the Executive Committee of the Board of Directors of the Company authorized the repurchase of up to $200 million aggregate principal amount of the Notes (the "***Notes Repurchase Program***"). Our net cash used in financing activities for the year ended December 31, 2022 primarily consisted of repurchases of a portion of our 9.75% Unsecured Notes in connection with our Notes Repurchase Program, distributions to our joint venture partners and a cash distribution to our Parent to fund the repurchase of certain previously issued profit interest units and capital units held by certain of our former employees. Additionally, our net cash used in financing activities for the year ended December 31, 2022 included payments to terminate the finance lease obligations related to one of our acute care facilities that we continue to operate and Western Plains.

Our net cash used in financing activities for the year ended December 31, 2021 includes a $93 million cash distribution to the Parent to partially fund the repurchase of certain previously issued Units and capital units, primarily held by certain of our former employees, as well as certain of our current employees, executives, and directors, in addition to distributions to certain joint venture partners, and payments made under finance lease arrangements.

Capital Expenditures

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

The following table summarizes our capital expenditures as a percentage of revenues and as a percentage of depreciation expense for the years ended December 31, 2022 and 2021 (dollars in millions):

	2022		2021	
	Amount	% of Revenues	Amount	% of Revenues
Capital expenditures	$ 227	2.8 %	$ 274	3.1 %
Depreciation expense	$ 323		$ 344	
Ratio of capital expenditures to depreciation expense	70.3 %		79.7 %	

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

Capital Resources

ABL Facility

Effective November 16, 2018, we entered into the ABL Facility in an aggregate principal amount of $800 million with a maturity of five years. As of December 31, 2022, we had no borrowings outstanding under the ABL Facility and approximately $53 million in letters of credit outstanding primarily related to the self-insured retention level of our general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements. Amounts available for borrowing under the ABL Facility were approximately $573 million as of December 31, 2022.

On January 27, 2023, we entered into an Incremental Assumption and Amendment Agreement No. 2, which amended and restated the ABL Facility. The ABL Facility, as amended and restated, has a stated maturity of five years; provided, that if more than $200 million aggregate principal amount of the Notes or the Term Loan Facility remain outstanding 91 days before the stated maturity thereof, then the ABL Facility will mature and the commitments under the facility will terminate on such date. The ABL Facility, as amended and restated, continues to provide revolving availability of $800 million, with a $150 million letter of credit sub-facility and a $40 million swingline sub-facility.

On February 6, 2023, we borrowed $250 million under the ABL Facility in order to fund the Springstone Transaction, El Dorado Transaction and Everest Operational IRF Transaction as discussed further in Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Availability under the ABL Facility continues to be subject to a borrowing base that is based on a specified percentage of eligible accounts receivable. Borrowings under the ABL Facility continue to be subject to the satisfaction of customary conditions, including the absence of a default and the accuracy of representations and warranties. For further information regarding the ABL Facility, including certain restrictive covenants and such amendment and restatement, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Term Loan Facility

Effective November 16, 2018, we entered into the Term Loan Facility, which is a senior secured term loan credit facility with a maturity of seven years. As of December 31, 2022, approximately $3,215 million was outstanding on the Term Loan Facility. For further information regarding the Term Loan Facility, including certain restrictive covenants and our optional prepayments and incremental borrowings made in 2020, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

6.75% Secured Notes

On April 13, 2020, we issued the 6.75% Secured Notes in an aggregate principal amount of $600 million with a maturity of five years. For further information regarding the 6.75% Secured Notes, including certain restrictive covenants, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

4.375% Secured Notes

On February 13, 2020, we issued the 4.375% Secured Notes in an aggregate principal amount of $600 million with a maturity of seven years. For further information regarding the 4.375% Secured Notes, including certain restrictive covenants, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

9.75% Unsecured Notes

On November 16, 2018, we issued the 9.75% Unsecured Notes in an aggregate principal amount of $1,425 million with a maturity of eight years. During year ended December 31, 2022, we repurchased $155 million aggregate principal amount of the 9.75% Unsecured Notes in connection with our Notes Repurchase Program. For further information regarding the 9.75% Unsecured Notes, including certain restrictive covenants, and our Notes Repurchase Program, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

5.375% Unsecured Notes

On December 4, 2020, we issued the 5.375% Unsecured Notes in an aggregate principal amount of $500 million with a maturity of eight years. For further information regarding the 5.375% Unsecured Notes, including certain restrictive covenants, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

We monitor the capital markets and our capital structure and make changes from time to time, with the goal of maintaining financial flexibility, preserving or improving liquidity and/or achieving cost efficiency. From time to time, we may elect to repurchase amounts of our outstanding debt for cash through open market repurchases or privately negotiated transactions with certain of our debt holders, although there is no assurance we will do so.

Liquidity and Capital Resources Outlook

We continue to have ongoing capital commitments in connection with several of our facilities. At December 31, 2022, we estimated our total remaining capital expenditure commitments to be approximately $573 million. The majority of this amount represents long-term commitments that are computed as a percentage of revenues at the applicable facility. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the ABL Facility.

Our business strategy contemplates the selective acquisition of additional hospitals and other healthcare service providers, and we regularly review potential acquisitions. These acquisitions may, however, require additional financing. Our primary sources of liquidity are cash flows provided by our operations and our borrowings available under the ABL Facility. We believe that our internally generated cash flows and borrowing availability under the ABL Facility will be adequate to service existing debt, finance internal growth and fund capital expenditures and small to mid-size hospital acquisitions over the next twelve months and into the foreseeable future prior to maturity dates of our outstanding debt. Certain larger hospital acquisitions may, however, require additional financing.

Inflation

The healthcare industry is labor-intensive. Wages and other expenses increase during periods of inflation and when labor shortages in marketplaces occur. In addition, suppliers pass along rising costs to us in the form of higher prices. Private insurers pass along their rising costs in the form of lower reimbursement to us. Our ability to pass on these increased costs in increased rates is limited because of increasing regulatory and competitive pressures and the fact that the majority of our revenues are fee-based. Accordingly, inflationary pressures could have a material adverse effect on our results of operations. Additionally, there is uncertainty surrounding the impact of any monetary policy changes taken by the U.S. Federal Reserve and other central banks to address the structural risks associated with inflation.

Contractual Obligations and Material Cash Requirements

We have certain material contractual obligations which are recorded as liabilities in our consolidated financial statements, primarily including:

- long-term debt obligations (refer to "—Capital Resources" above and to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report); and
- finance and operating lease obligations (refer to Note 7 to our accompanying consolidated financial statements included elsewhere in this Report).

Additionally, we have certain other material cash requirements related to items that are not recognized as liabilities in our consolidated financial statements, primarily including:

- capital expenditure commitments (refer to "—Capital Expenditures" above and to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report);
- shared centralized resource model arrangements with various third parties to provide certain nonclinical business functions to us, including payroll, supply chain management and revenue cycle management;
- information technology services, including, but not limited to, financial, clinical, patient accounting and other information services;
- diagnostic imaging equipment maintenance and bio-medical services; and
- other minimum commitments to purchase miscellaneous goods or services under non-cancelable contracts.

Adoption of Recently Issued Accounting Standards

None.

Critical Accounting Estimates

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

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

Our critical accounting estimates include the following areas:

- Revenue recognition and accounts receivable;
- Goodwill impairment analysis;
- Accounting for income taxes;
- Reserves for self-insurance claims; and
- Accounting for CARES Act stimulus payments.

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

Revenue Recognition and Accounts Receivable

We recognize revenues in the period in which performance obligations are satisfied. Generally, we bill patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. Amounts we receive for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, HMOs, PPOs and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in our financial statements are recorded at the net consideration to which we expect to be entitled to receive in exchange for providing patient care.

Approximately 95.6%, 98.0% and 98.0% of our patient revenues recognized during the years ended December 31, 2022, 2021 and 2020, respectively, related to discounted charges, which were comprised of the following sources (as a percentage of our revenues):

	2022	2021	2020
Medicare	40.2 %	37.7 %	38.6 %
Medicaid	16.9 %	18.4 %	17.1 %
HMOs, PPOs and other private insurers	37.8 %	41.3 %	41.6 %
Self-pay	0.7 %	0.6 %	0.7 %

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

We monitor our processes for calculating contractual allowances through:

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

Medicare and Medicaid

The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e. gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under the Medicaid program's prospective reimbursement systems, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates.

Discounts for retrospectively cost-based revenues are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under these programs are subject to adjustment based on administrative review and audit by third-party intermediaries, which can take several years to resolve completely.

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

HMOs, PPOs and Other Private Insurers

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

The process of determining the allowance requires us to estimate the amount expected to be received based on payer contract provisions, historical collection data as well as other factors and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts for managed care plans would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third-party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. We evaluate these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. We estimate the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that we utilize include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that we expect to collect. Because we provide care to patients regardless of their ability to pay, we have determined that the differences between the amounts we bill based on gross or discounted charges and the amounts we expect to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and we account for this variable consideration in accordance with the provisions of ASC 606. Self-pay accounts receivable are written off after collection efforts have been followed in accordance with our policies.

Goodwill Impairment Analysis

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired businesses. Our goodwill included in our consolidated balance sheet as of December 31, 2022 was $3.8 billion. Refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report for a detailed roll forward of changes in our goodwill during the years ended December 31, 2022 and 2021.

In accordance with ASC 350, "Intangibles — Goodwill and Other" (**"*ASC 350*"**) goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment on October 1. Prior to the Kindred Transaction, we historically determined that our consolidated business comprised a single reporting unit for goodwill impairment testing purposes. Due to the significance of the Kindred Transaction and the impact on our management team and business operations, we re-evaluated our reporting units in accordance with ASC 280, "Segment Reporting" ("***ASC 280***") and ASC 350 during 2022 and determined that we are now comprised of two distinct reporting units (i) acute hospital operations and (ii) rehabilitation hospital operations.

For the annual impairment evaluation, we estimate fair values of our reporting units utilizing both a discounted cash flow ("***DCF***") analysis and a guideline public company analysis considering observable market data of the Company's industry peers. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates, profitability and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing the Company's assumptions. The cash flows employed in the DCF analysis are based on the Company's most recent financial budgets and business plans and, when applicable, various growth rates and profitability for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the reporting unit.

If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. Refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report for further discussion of the results of our annual goodwill impairment evaluation procedures.

Accounting for Income Taxes

Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or subsequently increase or decrease this allowance, we must include an adjustment as part of the income tax provision in our results of operations. Our deferred tax asset balances in our consolidated balance sheets were $488 million and $504 million as of December 31, 2022 and 2021, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $305 million and $197 million as of December 31, 2022 and 2021, respectively.

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

The first step in determining the deferred tax asset valuation allowance is identifying reporting jurisdictions where we have a history of tax and operating losses or are projected to have losses in future periods as a result of changes in operational performance. We then determine if a valuation allowance should be established against the deferred tax assets for that reporting jurisdiction. The second step is to determine the amount of the valuation allowance. We will generally establish a valuation allowance equal to the net deferred tax asset (deferred tax assets less deferred tax liabilities) related to the jurisdiction identified in step one of the analysis. In certain cases, we may not reduce the valuation allowance by the amount of the deferred tax liabilities depending on the nature and timing of future taxable income attributable to deferred tax liabilities.

In assessing tax contingencies, we apply the provisions of ASC 740, "Income Taxes". We apply the recognition threshold and measurement of a tax position taken or expected to be taken in a tax return and follow the guidance on various matters such as derecognition, interest, penalties and disclosure. We classify interest and penalties as a component of income tax expense. During each reporting period, we assess the facts and circumstances related to recorded tax contingencies. If tax contingencies are no longer deemed probable based upon new facts and circumstances, the contingency is reflected as a reduction of the provision for income taxes in the current period.

Our deferred tax assets exceeded our deferred tax labilities by $286 million as of December 31, 2022, excluding the impact of valuation allowances. Historically, we have not produced federal taxable income, and in connection with the Lifepoint/RCCH Merger, we became highly leveraged. As such, we believe it is likely that a significant component of our deferred tax assets will not be realized and thus have established a valuation allowance against these deferred tax assets as of December 31, 2022. In addition, we have subsidiaries with a history of tax losses in certain state jurisdictions, and, based upon those historical tax losses, we have assumed that the subsidiaries would not be profitable in the future for those states' tax purposes. If our assertion regarding the future profitability of those subsidiaries would have been different, then our deferred tax assets would be understated by the amount of the state valuation allowance of $153 million at December 31, 2022. During the year ended December 31, 2021, we reduced our valuation allowance by $163 million as a result of the transfers and utilization of certain net deferred tax assets and liabilities between us and ScionHealth.

Reserves for Self-Insurance Claims

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding SIR and deductible levels. At December 31, 2022, our SIR for professional liability claims is $15 million per claim at the majority of our acute care hospitals. Additionally, we participate in state-specific professional liability programs in Indiana, New Mexico and Pennsylvania. We have a $25,000 deductible for professional liability at each of our IRFs and behavioral health hospitals. At December 31, 2022, our deductible for workers' compensation claims at each of our acute care and behavioral health hospitals was $1 million per claim in all states in which we operate except for Montana and Washington. We participate in state-specific programs for our workers' compensation claims arising in these states. There is no deductible for workers' compensation claims at our IRFs. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

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

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

Our reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. Our reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. We have discounted our reserves for self-insured claims to their present value using a discount rate of 1.8% at December 31, 2022, 1.6% at December 31, 2021, and 1.7% at December 31, 2020. We select a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

The following table provides information regarding our reserves for self-insured claims at December 31, 2022 and 2021 (in millions):

	2022	2021
Undiscounted	$ 308	$ 308
Discounted (as reported)	$ 293	$ 295

As of December 31, 2022 and 2021, our reserves for self-insurance claims did not include any significant amounts for settled and unpaid claims. Our average lag time between the settlement and payment of a self-insured claim ranges from 1 to 2 weeks.

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

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

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

Ultimately, from an actuarial standpoint, the sensitivity in the estimates of reserves for self-insured claims is reflected in the various actuarial confidence levels. Our best estimate of our reserves for self-insured claims utilizes an actuarial central estimate, which employs a statistical confidence level that approximates 50%. Higher statistical confidence levels, while not representative of our best estimate, reflect reasonably likely outcomes upon the ultimate resolution of related claims. Using a higher statistical confidence level would increase the estimated reserves for self-insured claims. At a 75% statistical confidence level, our estimated reserve would increase by $32 million. Changes in our estimates of reserves for self-insured claims are non-cash charges and accordingly, do not impact our liquidity or capital resources.

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of our quarterly and semi-annual actuarial calculations resulted in changes to our reserves for self-insured claims for prior years. For the years ended December 31, 2022 and 2021 our related self-insured claims expense increased by $5 million and $13 million, respectively.

Accounting for CARES Act Stimulus Payments

For the years ended December 31, 2022 and 2021, respectively, we recognized $14 million and $17 million of stimulus payments as other income under the caption "Government stimulus income" in our accompanying consolidated statements of operations included elsewhere in this Report. Payments made by the Emergency Fund and the ARP rural program to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, filing attestations acknowledging receipt of payments, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients, not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse, and submitting such reports as may be required by HHS regarding the provider's compliance with the terms and conditions of the Emergency Fund. Healthcare providers that received more than $10,000 from the Emergency Fund between April 10, 2020 through June 30, 2020 (the "***First Payment Received Period***"), were required to submit a report on their use of those funds no later than September 30, 2021. We successfully submitted the required reports for all of our providers that received and retained payments from the Emergency Fund during First Payment Received Period prior to the deadline. However, we will be required to submit additional reports in the future for payments that were received and retained by our providers from the Emergency Fund after the end of the First Payment Received Period. The reporting requirements and guidance from HHS related to the Emergency Fund have been subject to frequent clarifications and revision, and there can be no assurance that we will not be required to submit additional reports or provide additional information related to the payments we receive from the Emergency Fund in the future. In addition, HHS has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the OIG of HHS, will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

We have accounted for the stimulus payments received as a government grant related to income in a manner consistent with International Accounting Standards 20, "Accounting for Government Grants and Disclosure of Government Assistance" ("***IAS 20***"). In accordance with IAS 20, government grants are recognized either as other income or a reduction to a related expense when there is reasonable assurance that the grant will be received, and the entity will comply with any conditions attached to the grant. There is currently limited, and sometimes changing, guidance available regarding the accounting treatment of funds that have been received by us and our facilities under the CARES Act and the related stimulus legislation. This lack of guidance requires us to apply professional judgement and make certain estimates and assumptions with respect to the presentation, amount and timing of our recognition of stimulus received under the CARES Act. For additional information regarding the CARES Act and related financial impact, refer to "Part I, Item 1. Business—Government Regulation—Legislative and Regulatory Developments in Response to COVID-19" and Note 1 to our accompanying consolidated financial statements included elsewhere in this Report.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk.***

Market Risk

Market risk is defined as the risk of loss resulting from changes in market prices as a result of changes in interest rates, credit and liquidity or general economic conditions. Our principal market risks in the ordinary course of business are credit risk, liquidity risk and interest rate risk. We currently do not have direct exposure to either market risk from trading activities or foreign currency exchange rate risk.

Credit Risk

We define credit risk as the risk that amounts payable by uninsured patients and remaining patient responsibility amounts (deductibles and co-payments) for patient accounts where the primary insurance carrier has paid the amounts covered by the applicable agreements will not be paid. The provision for doubtful accounts relates primarily to amounts due directly from patients. While we have experienced a reduction in uninsured patients, the risk of collection from insured patients and the amounts due, may increase as more individuals are enrolled in insurance plans with larger deductibles and/or co-payments, including those purchased on insurance exchanges.

Liquidity Risk

We define liquidity risk as the risk that we will not meet our payment obligations in a timely manner or the risk that market conditions or institution-specific events may reduce our ability to raise funds from market counterparties. An adverse institution-specific event such as a major loss that causes a perceived or actual deterioration in our financial condition or an adverse systemic event could affect our funding liquidity.

Interest Rate Risk

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. As of December 31, 2022, we had total outstanding debt of approximately $6.2 billion, excluding finance lease obligations and unamortized debt issuance costs, of which approximately $3.2 billion, or 51.6%, was subject to variable rates of interest. If the interest rate on our variable rate long-term debt outstanding as of December 31, 2022 were to increase by 100 basis points during any annual period, our cash flows would be negatively impacted by approximately $32 million.

Item 8. ***Financial Statements and Supplementary Data.***

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

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

None.

Item 9A. ***Controls and Procedures.***

The information that would be required to be disclosed under Part II, Item 9A of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

Item 9B. ***Other Information.***

None.

Item 9C. ***Disclosure Regarding Foreign Jurisdictions that Prevent Inspections.***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance*****.**

The following table provides information regarding our executive officers and the members of our Board of Directors (ages as of March 2, 2023):

Name	Age	Position(s)
David M. Dill	54	President, Chief Executive Officer, Director and Chairman
Michael S. Coggin	53	Executive Vice President and Chief Financial Officer
Jennifer C. Peters	51	Executive Vice President, General Counsel
Terry W. Terrill, Jr.	56	Executive Vice President, Human Resources
Jason Zachariah	45	Executive Vice President, Chief Operating Officer
Aaron Lewis	39	Executive Vice President, Growth and Integrated Solutions
Norman Brownstein	79	Director
Nell Buhlman	56	Director
Christine Cahill	28	Director
Christopher J. Christie	60	Director
Maxwell David	32	Director
Holly McMullan	46	Director
Matthew H. Nord	43	Director
Eric L. Press	57	Director
Wendell Pritchett	58	Director
G. Rodney Wolford	76	Director

David M. Dill became our Chief Executive Officer upon consummation of the Lifepoint/RCCH Merger. Prior to the consummation of the Lifepoint/RCCH Merger, Mr. Dill served in various roles at Legacy Lifepoint as President since January 2011 and as Chief Operating Officer since April 2009. Mr. Dill served as Executive Vice President from February 2008 to January 2011. Mr. Dill joined Legacy Lifepoint in July 2007 as Chief Financial Officer and continued to serve in that role until April 2009. From March 2006 until Mr. Dill joined Legacy Lifepoint, he served as executive vice president of Fresenius Medical Care North America and as chief executive officer of one of two U.S. divisions of Fresenius Medical Care Services, a wholly owned subsidiary of Fresenius Medical Care AG & Co. KGaA. Mr. Dill previously served as executive vice president, chief financial officer and treasurer of Renal Care Group, Inc., a publicly-traded dialysis services company, from November 2003 until Renal Care Group, Inc. was acquired by Fresenius Medical Care in March 2006. From 1996 to November 2003, Mr. Dill served in various finance and accounting roles with Renal Care Group, Inc. Mr. Dill served as a member of the board of directors of Psychiatric Solutions, Inc., a behavioral health services company, from 2005 until 2010. Mr. Dill is a former chairman of the board for the Federation of American Hospitals ("***FAH***") and currently serves as a member of the FAH's board and Executive Committee. He is also chair of the board of directors for the Nashville Health Care Council, serves as a director on the boards of R1 RCM and the American Heart Association's Greater Southeast Affiliate and is a member of the board of trustees for the Murray State University Foundation and the Montgomery Bell Academy.

Michael S. Coggin became our Executive Vice President and Chief Financial Officer upon consummation of the Lifepoint/RCCH Merger. Prior to the consummation of the Lifepoint/RCCH Merger, Mr. Coggin served in various roles at Legacy Lifepoint as Executive Vice President, Chief Financial Officer and Chief Accounting Officer, since September 2016. From December 2008 until September 2016, Mr. Coggin served as Senior Vice President and Chief Accounting Officer of Legacy Lifepoint. From September 2007 until December 2008, Mr. Coggin served as chief financial officer of Specialty Care Services Group, a multi-service line healthcare provider primarily focused on providing perfusion and auto-transfusion services to hospitals. Mr. Coggin was a senior vice president in the finance, accounting and internal audit groups of Renal Care Group, Inc. from April 2004 until its acquisition by Fresenius Medical Care AG & Co. KGaA in March 2006. Following the acquisition, Mr. Coggin provided finance and accounting oversight for business units within the East Division of Fresenius. Prior to that time, Mr. Coggin was an audit manager at KPMG Peat Marwick in Nashville, Tennessee.

Jennifer C. Peters became our Executive Vice President and General Counsel upon consummation of the Lifepoint/RCCH Merger. Prior to the consummation of the Lifepoint/RCCH Merger, Ms. Peters served as Legacy Lifepoint's General Counsel since April 2017 and Corporate Secretary since June 2017. Prior to that, Ms. Peters served as senior vice president and chief operations counsel of Legacy Lifepoint, where she was responsible for overseeing the Company's operations lawyers and contract management team to ensure consistent legal guidance across all operational units. Prior to joining Legacy Lifepoint in November 2013, Ms. Peters served as general counsel, secretary and chief compliance officer for Simplex Healthcare from October 2010 through November 2013. Ms. Peters has also served as vice president and associate general counsel at Community Health Systems. In addition, Ms. Peters has experience as a hospital administrator.

Terry W. "Sonny" Terrill, Jr. joined the Company in April 2019 as Executive Vice President, Human Resources. Mr. Terrill is responsible for providing leadership in developing and executing human resources strategies in support of the overall business plan and strategic direction of the organization. Mr. Terrill has three decades of HR experience, including executive coaching, full-cycle talent management and management of large-scale system and organizational integration. Before joining the Company, he served in a number of leadership roles, most recently as executive vice president, chief human resources officer for BrightSpring Health from August 2017 to March 2019 and human resources officer for CIGNA- HealthSpring from May 2005 to August 2017. He is also a Six Sigma Black Belt.

Jason Zachariah was promoted to Executive Vice President, Chief Operating Officer in June 2022. Prior to his current role, Mr. Zachariah served as President, Integrated Solutions upon consummation of the Kindred Transaction in December 2021. Before joining Lifepoint, he served as president and chief operating officer of Kindred, where he led the company's hospital division, rehabilitation services and behavioral health operations until consummation of the Kindred Transaction. Prior to that, he served as president of Kindred's rehabilitation services and in various roles in the company's hospital division, including chief operating officer and executive director for the division's California/Arizona district. From 2003 until Mr. Zachariah joined Kindred, he served as a Senior Sales Representative at GlaxoSmithKline Pharma GmbH.

Aaron Lewis was promoted to Executive Vice President, Growth and Integrated Solutions in June 2022. Prior to his current role, Mr. Lewis served as Senior Vice President, Care Continuum and Business Transformation, and previously served the Company as Senior Vice President, Physician Enterprise and Strategic Growth. Before joining Lifepoint Health, Mr. Lewis served in multiple roles for RCCH HealthCare Partners, including Senior Vice President of Strategic Growth and Vice President, Operations and Strategic Alignments. Prior to his RCCH tenure, he held operational and development roles with Vanguard Health Systems, after beginning his career in investment banking for Merrill Lynch.

Norman Brownstein became our Director in April 2016. Mr. Brownstein is the founding member and chairman of the board of the law firm of Brownstein Hyatt Farber Schreck, LLP. Mr. Brownstein is nationally recognized for his extensive experience in real estate law, commercial transactions and public policy advocacy, which spans the economic spectrum, extending to telecommunications, financial services, agriculture, tax and healthcare interests. Mr. Brownstein's firm is one of the leading lobbying firms in the U.S. Mr. Brownstein serves on the board of directors of National Jewish Health and the Simon Wiesenthal Center, and during the past five years has also served as a director of Ardent Healthcare Services. Mr. Brownstein received a B.S. from the University of Colorado and a J.D. from the University of Colorado Law School.

Nell Buhlman became our Director in March 2022. Ms. Buhlman is the Chief Administrative Officer and Head of Strategy for Press Ganey Forsta, an international company that works with health systems to optimize the healthcare experience for patients, consumers, and staff. In her role, Nell has responsibility for enterprise growth and client strategy for provider, payer, life sciences and healthcare consumer solutions in the U.S. and abroad. Ms. Buhlman joined Press Ganey in 2010. Prior to the company's 2022 merger with Forsta, Ms. Buhlman served as Press Ganey's Chief Operating Officer, Chief Strategy Officer, Senior Vice President for Clinical Solutions, and Vice President for Product Strategy. Ms. Buhlman is a Board Member for the Hospital for Consumptives of Maryland (Eudowood Foundation), serves on the Parent Advisory Council for the Greater Baltimore Medical Center, and is an Executive in Residence for the Johns Hopkins Carey Business School. She also serves as a trustee for the WPW Foundation, a charitable organization that provides grants to nonprofits serving vulnerable women and children. Ms. Buhlman holds a Bachelor of Arts degree from Connecticut College and an MBA from Johns Hopkins Carey Business School.

Christine Cahill became our Director in March 2022. Ms. Cahill is a Principal in Apollo Global Management's Private Equity business, having joined in 2018. Prior to that time, Ms. Cahill was a member of the Investment Banking Division of Goldman Sachs. Ms. Cahill serves on the board of directors of Lune Holdings (parent of Kem One) and ScionHealth. Ms. Cahill graduated from Harvard University with a B.A. in Economics.

Christopher J. Christie became our Director in December 2018. Mr. Christie served two terms as Governor of New Jersey from 2010 to 2018. Prior to that, Mr. Christie served as U.S. Attorney for the District of New Jersey from 2002 to 2008. During his governorship, Mr. Christie chaired the President's Commission on Combating Drug Addiction and the Opioid Crisis in 2017. He currently serves as a legal and political commentator for ABC News. Mr. Christie is a graduate of the University of Delaware and Seton Hall University School of Law.

Maxwell David became our Director in December 2018. Mr. David is a Principal in Apollo Global Management's Private Equity business, having joined in 2014. Prior to that time, Mr. David was a member of the Investment Banking division of Bank of America Merrill Lynch. Mr. David serves on the board of directors of ScionHealth, 25m Health, CareerBuilder, and Newfi and previously served on the board of directors of AmeriHome. Mr. David graduated cum laude from Dartmouth College.

Holly McMullan became our Director in December 2018. She is the Global Head of Consultant Relations, Partner in the Client and Product Solutions (CPS) group at Apollo. Prior to joining Apollo in 2008, Ms. McMullan was Senior Vice President at Pequot Capital Management where she was responsible for U.S. sales coverage of institutions and consultants. Prior to Pequot, Ms. McMullan was with Guggenheim Partners, Bear Stearns and Robertson Opportunity Capital. She holds her MBA with a concentration in Finance from the McCombs School of Business at The University of Texas at Austin and a BA (honors) in International Business from Sheffield Hallam University, Sheffield, UK. She currently serves on the advisory boards of Capital Creek Partners, McCombs School of Business Advisory Council, New York for McCombs and the Hicks Muse Private Equity Research Center at The University of Texas at Austin.

Matthew H. Nord has been our Director since the consummation of Apollo's acquisition of RCCH in December 2015 and served as Chairman of the Board from December 2018 until September 2021. Mr. Nord is a Partner and Co-Head of Private Equity at Apollo, where he oversees the firm's private equity strategy and has led numerous investments across technology, healthcare and business services. Mr. Nord serves on Apollo's diversity, equity and inclusion committee and is a member of Apollo Women Empower (AWE). Mr. Nord is on the board of directors of TD Synnex, West Technology Group, ScionHealth and Tenneco. Prior to joining Apollo in 2003, Mr. Nord was a member of the Investment Banking division of Salomon Smith Barney Inc. Mr. Nord graduated summa cum laude from the University of Pennsylvania's Wharton School of Business with a BS in Economics. He also serves on the Montefiore Health System Board of Trustees, the Board of Advisors of the University of Pennsylvania's Stuart Weitzman School of Design and the Board of the Rock and Roll Hall of Fame Foundation.

Eric L. Press has been our Director since Apollo's acquisition of RCCH in December 2015. Mr. Press is a Partner at Apollo, having joined in 1998. In his time with Apollo, he has been involved in many of the firm's investments in basic industrials, metals, lodging/gaming/leisure and financial services. Prior to joining Apollo, Mr. Press worked at the law firm of Wachtell, Lipton, Rosen & Katz, specializing in mergers, acquisitions, restructurings and related financing transactions. Prior thereto, Mr. Press was a consultant with The Boston Consulting Group, a management consulting firm focused on corporate strategy. Mr. Press serves on the boards of directors of ADT Inc., Knight Health Holdings, LLC (d/b/a ScionHealth), and Apollo Commercial Real Estate Finance, Inc. He previously served on the boards of directors of Lottomatica S.p.A. (f/k/a Gamenet Group S.p.A.), Princimar Chemical Holdings, LLC, PlayAGS, Inc., Triton Maritime III Corp., Triton Maritime IV Corp, Rodeph Sholom School and Constellis Holdings, Inc. He graduated magna cum laude from Harvard College, with an A.B. in economics, and Yale Law School, where he was a Senior Editor of the Yale Law Journal.

Wendell Pritchett became our Director in September 2022. Dr. Pritchett serves as the James S. Riepe Presidential Professor of Law and Education at the University of Pennsylvania. He served as Provost of the University from 2017 to 2021 and as Interim President in 2022. Between 2009 and 2014, Dr. Pritchett served as Chancellor and Professor of Law and History at Rutgers University-Camden. Dr. Pritchett also sits on the Boards of the publicly traded companies Toll Brothers and Clarivate, as well as several nonprofit organizations, including College Unbound, the Philadelphia Foundation, Reinvestment Fund, and Public Health Management Corporation. He holds a B.A. in Political Science from Brown University, earned his J.D. from Yale Law School and his PhD from the University of Pennsylvania.

G. Rodney Wolford became a Director upon consummation of the RegionalCare/Capella Merger in April 2016. Mr. Wolford, beginning his career as a CPA, has over 40 years of wide-ranging experience in the healthcare industry, having served in leadership roles with healthcare providers, suppliers, consulting firms, associations and insurers. Among his executive positions, Mr. Wolford served as chief executive officer of Alliant Healthcare (now Norton Healthcare, Inc.) in Louisville, Kentucky, Sterling Diagnostic, a worldwide manufacturer of x-ray film, Forhealth Technologies, the inventor of the first robot dedicated to hospital IV production, and a senior executive of Blue Cross Tennessee. Mr. Wolford currently serves on the boards of Atlanta based D4C Dental Brands, Liberate Medical, Chairman of Parasight Systems and as a fund manager of Bluegrass Angel Venture Funds. During the past five years, Mr. Wolford has also served as a director of Haven Behavioral, Laboratory Supply Company and VetCor.

Code of Ethics

Our Board expects its members, as well as our officers and employees, to act ethically at all times and to acknowledge in writing their adherence to the policies comprising our Code of Conduct, which is known as "Common Ground," and, as applicable, our Code of Ethics for Senior Financial Officers and Chief Executive Officer.

Board Structure

The Board consists of 11 directors. The Board has the following standing committees: audit; compensation; nominating and governance; compliance; quality; and executive. In addition, the board of directors of the Parent company also has a compensation committee that administers equity-based compensation plans in which our managers, officers, employees, consultants and directors participate. Apollo has the power to control us and our affairs and policies, including the designation of a majority of the members of our Board and the appointment of management.

Committees of our Board of Directors

The Board has adopted written charters for each of the following standing committees:

Audit Committee

The current members of our audit committee are Messrs. Wolford and Pritchett. Ms. Buhlman serves as an interim member of our audit committee. Mr. Wolford is the interim chairman of our audit committee. The principal duties and responsibilities of our audit committee are to assist the Board in overseeing:

- the integrity of our financial statements;
- the independent auditor's qualifications, independence and performance;
- the performance of our internal audit function; and
- our compliance with certain legal, ethical and regulatory requirements.

The audit committee has the authority to conduct or authorize investigations into or studies of matters within its scope of responsibilities. It also has the authority to retain and determine funding for independent legal, accounting or other advisors (without seeking Board approval) as it determines necessary or appropriate to carry out its duties and responsibilities.

Our Board has determined that Mr. Wolford is an "audit committee financial expert" within the meaning of applicable SEC regulations.

Compensation Committee

The current members of our compensation committee are Messrs. Nord and Press. Mr. Press is the chair of our compensation committee. The principal duties and responsibilities of our compensation committee are as follows:

- approving the non-equity-based compensation of our officers, directors and key employees;
- administering our non-equity-based compensation plans; and
- making recommendations to the Parent for the equity-based compensation of the Parent and its subsidiaries' officers, directors, employees and other service providers.

Nominating and Governance Committee

The current members of our nominating and governance committee are Messrs. Christie and Press. Mr. Press is the chair of our nominating and governance committee. The principal duties and responsibilities of our nominating and governance committee are as follows:

- to assist the Board in identifying individuals qualified to serve as members of the Board and/or its committees; and
- other duties and responsibilities that our Board may delegate to the nominating and governance committee.

Compliance Committee

The current members of our compliance committee are Mr. Wolford and Ms. Buhlman. Mr. Wolford is the chair of our compliance committee. The compliance committee is responsible for overseeing our legal and regulatory compliance program, including certain healthcare and regulatory compliance matters that affect us and our business operations.

Quality Committee

The current members of our quality committee are Messrs. Brownstein, David, Dill, and Pritchett and Ms. McMullan. Mr. Dill is the chair of our quality committee. The quality committee is responsible for monitoring and evaluating the adequacy and effectiveness of our quality of care and patient safety programs and initiatives.

Executive Committee

The current members of our executive committee are Messrs. David, Nord and Press. Mr. Nord is the chair of our executive committee. The principal duties and responsibilities of our executive committee are as follows:

- to advise and counsel the Chief Executive Officer regarding company matters; and
- to take such actions as are necessary due to their urgent or highly confidential nature, or where convening the Board is impracticable, subject to certain limitations.

Item 11. ***Executive Compensation.***

The information that would be required to be disclosed under Part III, Item 11 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

The information that would be required to be disclosed under Part III, Item 12 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

Executive Compensation

Employment Agreements

In connection with the consummation of the Lifepoint/RCCH Merger, we entered into an employment agreement with each of Messrs. Dill and Coggin and Ms. Peters. We later entered into an employment agreement with Mr. Terrill effective April 8, 2019. Following the consummation of the Kindred Transaction, we assumed an employment agreement with Mr. Zachariah. Each of the aforementioned employment agreements were amended and restated effective May 18, 2022. Mr. Zachariah's employment agreement was again amended and restated effective June 20, 2022, and we also entered into an employment agreement with Mr. Lewis effective June 20, 2022.

Each applicable executive's employment agreement contains an indefinite term of employment. Each employment agreement established the applicable executive's annual base salary at the time (the annual base salary in the employment agreements for each of Messrs. Dill, Coggin, Terrill, Zachariah and Lewis and Ms. Peters is currently set at $1,500,000, $700,000, $525,000, $850,000, $500,000 and $600,000 respectively), and his or her eligibility to receive an annual bonus with the target bonus for each fiscal year determined annually by our board of directors or our compensation committee. Pursuant to his or her respective employment agreement, Mr. Dill's target bonus is at least 150% of base salary, and each of Messrs. Coggin's, Zachariah's, Terrill's and Lewis' and Ms. Peters' target bonus is at least 100% of base salary with a maximum of 200% of base salary. The actual bonus payable to each applicable executive is based upon the level of achievement of annual Company and individual performance objectives, as determined by the board of directors or our compensation committee.

In the event of the executive's termination without cause (other than due to death or disability) or resignation for good reason, the executive shall be entitled to receive: (i) unpaid prior year's bonus; (ii) if the termination occurs after the second quarter of a fiscal year, a pro rata bonus for the year of termination based upon achievement of performance criteria; (iii) a severance payment equal to 1.5x (or, for Mr. Dill, 2x) the sum of the executive's annual base salary and target bonus, payable in substantially equal installments for 18 months (or, for Mr. Dill, 24 months) following termination; and (iv) up to 12 months of health benefits continuation; provided, however, that in the case of a termination without cause (other than due to death or disability) or a resignation for good reason following a change in control, Mr. Dill, Mr. Coggin and Ms. Peters shall receive a lump sum payment equal to 3x the sum of the executive's annual base salary and target bonus in lieu of the payment described in clause (iii) above and Messrs. Zachariah, Lewis and Terrill shall receive a lump sum payment equal to 1.5x the sum of the executive's annual base salary and target bonus in addition to the payment described in clause (iii) above.

Each applicable executive is subject to a (i) 12-month post-termination non-competition covenant relating to competitors of the Company, (ii) 12-month post-termination non-solicitation covenant in respect of our employees, consultants, clients, customers and similar business relationships of the Company and (iii) perpetual confidentiality and non-disparagement covenants.

Retention Bonus and Severance Payments

On June 26, 2022, we entered into a separation and consulting agreement with Victor Giovanetti, our former President of Hospital Operations. Pursuant to the terms of the agreement, Mr. Giovanetti received severance benefits equal to (i) $2,280,000, paid in substantially equal installments for an 18 month period and (ii) up to 24 months of health benefits continuation. Mr. Giovanetti also became eligible for an equity repurchase as described below in the section titled "Equity Repurchase." Finally, Mr. Giovanetti agreed to provide consulting services to the company until December 31, 2022, with a consulting fee based on an annual fee of $750,000. The separation and consulting agreement was amended and restated on June 28, 2022 to correct certain typographical errors in the original agreement.

Nonqualified Deferred Compensation

After freezing the Lifepoint Hospitals Deferred Compensation Plan and RCCH HealthCare Partners Deferred Compensation Plan at the end of 2020, the Company established a new nonqualified deferred compensation plan effective January 1, 2021 in which certain Company executives and employees participate. Also, certain former Kindred executives and employees, including Mr. Zachariah, who are now Company executives and employees, participate in a separate nonqualified deferred compensation plan that replicates the former Kindred Deferred Compensation Plan. Plan participants may defer a portion of their salary and bonuses. Currently, the Company does not make any matching or other contributions to the nonqualified deferred compensation plans. The timing and form of payments are based on the terms of the applicable plan and deferral elections made by participants.

Parent Capital Units and Profits Units

Certain of our and our affiliates' executives, employees, consultants, directors and other service providers have been granted profits units and/or purchased or otherwise acquired capital units in the Parent.

The profits units provide the recipients with the opportunity to share in our future appreciation, subject to vesting. In general, for grants to non-directors, 33.34% of the profits units vest in substantially equal installments on the last day of each of the first twenty (20) calendar quarters commencing on or after the applicable grant date and the remaining 66.66% of the profits units vest based on the achievement of certain investment returns to our Sponsor. The profits units we typically grant to directors on an annual basis generally vest on a time basis, on the date that is six months and one day from the date of grant. In addition, the time-vested profits units and the director profits units will vest in full on a sale of the Company.

The capital units and profits units are generally subject to the terms and condition set forth in the applicable award agreements or subscription agreements, as the case may be, and in the partnership agreement of the Parent, including, but not limited to, customary transfer restrictions, redemption rights, drag-along rights, tag-along rights, and preemptive rights.

Equity Repurchases

From time to time, the Parent repurchases previously issued profits units and capital units held by certain of our former and current service providers, including executive officers and directors. Additionally, transactions involving the Parent may impact the units held by such former and current service providers. Refer to Note 12 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by the Parent to our service providers and additional information regarding our accounting for stock-based compensation.

Director Retainers and Fees

Certain members of our Board of Directors are entitled to receive annual retainers and fees in accordance with our director compensation policy in connection with their service on our Board.

Management Agreement

In connection with the Lifepoint/RCCH Merger, we entered into a Management Consulting Agreement (as amended, the "***Management Agreement***") with an affiliate of our Sponsor relating to the provision of certain management consulting and advisory services. In exchange for the provision of such services, we currently pay a non-refundable quarterly management fee of approximately $2 million. The Management Agreement will terminate on the earlier of (i) the eighth anniversary of July 25, 2021, (ii) the consummation of any transaction or series of transactions, whether or not related, as a result of which New Holders (as defined in the Management Agreement) become the beneficial owner, directly or indirectly, of more than 90% of our equity and voting securities and (iii) such earlier date as is mutually agreed upon. Our payment obligations under the Management Agreement may be subject to deferral to the extent such obligations would otherwise violate any prohibitions or limitations under our then existing indebtedness. Furthermore, we may be required to reimburse such affiliate of our Sponsor for all out-of-pocket expenses, including legal fees and expenses, incurred by such affiliate and its affiliates and each of their representatives in the connection with the performance of its obligations under the Management Agreement or the Transaction Fee Agreement (as defined below), including expenses incurred in connection with the transactions contemplated by the agreement governing the Lifepoint/RCCH Merger (the "***Merger Agreement***") and any Underwritten Offering or Change of Control (as defined in the Merger Agreement).

Transaction Fee Agreement

In connection with the Lifepoint/RCCH Merger, we entered into a transaction fee agreement (as amended, the "***Transaction Fee Agreement***") with an affiliate of our Sponsor relating to the provision of certain preparation services in support of the Lifepoint/RCCH Merger. The Transaction Fee Agreement will terminate automatically upon the termination of the Management Agreement. As consideration for these transaction preparation services, we paid a nonrefundable fee of $55 million in full to an affiliate of our Sponsor upon the closing of the Lifepoint/RCCH Merger. In addition, if we, or certain of our parent entities or controlled affiliates, consummate an acquisition (including of assets or equity interests) of any business or entity, we are also required to pay to an affiliate of our Sponsor a success fee equal to 1% of the aggregate enterprise value (i) paid or provided by or to the Company Group (as defined in the Transaction Fee Agreement) or us or (ii) otherwise indicated by such acquisition. Furthermore, we may be required to reimburse such affiliate of our Sponsor for all out-of-pocket expenses, including legal fees and expenses, incurred by such affiliate and its affiliates and each of their representatives in the connection with the performance of its obligations under the Transaction Fee Agreement, including expenses incurred in connection with the transactions contemplated by the Merger Agreement.

Participation of Apollo Global Securities, LLC

Apollo Global Securities, LLC is an affiliate of our Sponsor and received a portion of the gross spread as an initial purchaser in the sale of the Notes. Apollo Global Securities, LLC or one of its affiliates also participated as an arranger in respect of the Term Loan Facility and the ABL Facility, for which it received customary fees.

Transition Services Agreements and Other Agreements with ScionHealth

In connection with the Kindred Transaction, we have entered into a number of transition services agreements and other ancillary agreements with ScionHealth and its subsidiaries. For the year ended December 31, 2022, in connection with the TSAs, we were reimbursed by ScionHealth for certain costs incurred on their behalf of $61 million, and paid ScionHealth $3 million for certain costs incurred on our behalf. In addition, we and ScionHealth are party to a number of commercial services agreements, pursuant to which we provide ScionHealth with therapy services, rehabilitation unit and behavioral health unit management, consulting and development services, among other commercial services.

On January 20, 2023, ScionHealth acquired Cornerstone Healthcare Group Holding, Inc., a Delaware corporation ("***Cornerstone***"), which operates 15 specialty hospitals, eight senior living locations, and Cornerstone Behavioral Health El Dorado ("***El Dorado***") (the "***Cornerstone Transaction***"). Immediately following ScionHealth's acquisition of Cornerstone on January 20, 2023, we paid $35 million in cash to acquire El Dorado, a 54 bed behavioral health facility located in Tucson, Arizona, from ScionHealth (the "***El Dorado Transaction***").

In connection with the Cornerstone Transaction and the El Dorado Transaction, we entered into a number of transition services agreements and other ancillary agreements with ScionHealth and its subsidiaries pursuant to which (i) we provide certain transition services to ScionHealth to support the businesses acquired by ScionHealth in connection with the Cornerstone Transaction and (ii) ScionHealth provides certain transition services to us to support El Dorado, including leasing certain employees to us through the first quarter of 2023.

Investments Related to Lifepoint Forward Innovation Strategy

In connection with our Lifepoint Forward innovation strategy, we have made investments of cash and contributions of existing investments and securities into certain unconsolidated but affiliated entities owned by us, Parent, ScionHealth and other affiliated entities (collectively, "***Forward Health Ventures***"). Forward Health Ventures, in turn makes targeted and strategic investments in new and existing early-stage enterprises primarily focused on developing meaningful solutions to enhance quality, increase access to care, and improve value across our enterprise, including a significant focus on digital health capabilities that span the healthcare continuum. In exchange for our investments of cash and contributions of existing investments and securities, Forward Health Ventures has issued to us noncontrolling equity interests and perpetual cumulative preferred instruments.

At December 31, 2022, in the aggregate, our cost method investment in Forward Health Ventures totaled $53 million. In addition to our cost method investment in Forward Health Ventures, we also have entered into management and administrative services arrangements with Forward Health Ventures and commercial arrangements with certain underlying early-stage enterprises, including pilot and services agreements and a revolving credit facility that we provide to one of these enterprises. The revolving credit facility provides for loans up to approximately $8 million, has a 5-year maturity (or earlier upon our demand) and bears interest at 9.00%. At December 31, 2022, $6 million was drawn and outstanding.

Item 14. *Principal Accounting Fees and Services*.

The Audit Committee has appointed Ernst & Young LLP as our independent registered public accounting firm. Services provided to us by Ernst & Young LLP in fiscal 2022 are described below.

Audit Fees. The aggregate audit fees billed by Ernst & Young LLP for professional services rendered for the audit of our annual consolidated financial statements and services that are normally provided by the independent registered public accounting firm in connection with statutory and regulatory filings totaled approximately $4 million for each of the years 2022 and 2021.

Audit-Related Fees. The aggregate fees billed by Ernst & Young LLP for assurance and related services other than those described under "Audit Fees" were nominal for 2022 and $2 million for 2021.

Tax Fees. The aggregate fees billed by Ernst & Young LLP for professional services rendered for tax compliance, tax advice and tax planning were approximately $1 million for each of the years 2022 and 2021.

All Other Fees. There were no fees billed by Ernst & Young LLP for products or services other than those described above in 2022 or 2021.

PART IV

Item 15. ***Exhibits, Financial Statement Schedules*.**

(a) The following documents are filed as part of this Report:

1. *Consolidated Financial Statements*:

2. *Financial Statement Schedule*: All schedules for which provision is made in the applicable accounting regulations of the SEC are omitted because they either are not required under the related instructions, are inapplicable, or the required information is shown in the consolidated financial statements or notes thereto.

3. *Exhibits*: The exhibits required by Item 601 of Regulation S-K that would be disclosed under Part IV, Item 15 of an annual report on Form 10-K filed with the SEC have been omitted as permitted pursuant to Section 4.02(a) of the Indentures.

Ernst & Young LLP
222 2nd Avenue South
Suite 2100
Nashville, TN 37201

Tel: (615) 252 2000
Fax: (615) 242 9128
ey.com

Report of Independent Auditors

Board of Directors and Shareholders of
Lifepoint Health, Inc.

Opinion

We have audited the consolidated financial statements of Lifepoint Health, Inc., which comprise the consolidated balance sheets as of December 31, 2022 and 2021, and the related consolidated statements of operations, comprehensive (loss) income, equity and cash flows for each of the three years in the period ended December 31, 2022, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2022 and 2021, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2022 in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements. In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Other Information

Management is responsible for the other information. The other information comprises the financial and nonfinancial information included in the annual report but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.

March 2, 2023

Lifepoint Health, Inc.
Consolidated Statements of Operations
For the Years Ended December 31, 2022, 2021 and 2020
(In millions)

	2022	2021	2020
Revenues	$ 8,020	$ 8,937	$ 8,122
Salaries and benefits	4,016	4,176	3,877
Supplies	1,243	1,505	1,418
Other operating expenses, net	2,039	2,245	2,190
Government stimulus income	(14)	(17)	(646)
Depreciation and amortization	323	345	378
Interest expense, net	480	466	528
Transaction-related costs	46	86	132
Other non-operating (gains) losses, net	(8)	19	4
	8,125	8,825	7,881
(Loss) income before income taxes	(105)	112	241
Provision for (benefit from) income taxes	100	(27)	(64)
Net (loss) income	(205)	139	305
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(66)	(9)	(22)
Net (loss) income attributable to Lifepoint Health, Inc.	$ (271)	$ 130	$ 283

Lifepoint Health, Inc.

Consolidated Statements of Comprehensive (Loss) Income
For the Years Ended December 31, 2022, 2021 and 2020
(In millions)

	2022	2021	2020
Net (loss) income	$ (205)	$ 139	$ 305
Other comprehensive gain (loss):			
Unrealized gains (losses) on changes in funded status of pension benefit obligations	4	6	(1)
Other comprehensive gain (loss)	4	6	(1)
Comprehensive (loss) income	(201)	145	304
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(66)	(9)	(22)
Comprehensive (loss) income attributable to Lifepoint Health, Inc.	$ (267)	$ 136	$ 282

Lifepoint Health, Inc.
Consolidated Balance Sheets
As of December 31, 2022 and 2021
(In millions)

	2022	2021
ASSETS		
Current assets:		
Cash and cash equivalents	$ 395	$ 853
Accounts receivable	1,042	1,035
Inventories	195	195
Prepaid expenses	128	121
Other current assets	323	250
	2,083	2,454
Property and equipment, at cost	4,455	4,315
Accumulated depreciation	(1,339)	(1,051)
Property and equipment, net	3,116	3,264
Intangible assets, net	83	85
Investments	684	655
Other long-term assets	795	742
Goodwill	3,811	3,914
Total assets	$ 10,572	$ 11,114
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 405	$ 371
Accrued salaries	225	284
Other current liabilities	545	521
Current maturities of long-term debt	29	106
	1,204	1,282
Long-term debt, net	6,865	7,017
Other long-term liabilities	940	954
Total liabilities	9,009	9,253
Redeemable noncontrolling interests	143	139
Equity:		
Lifepoint Health, Inc. stockholders' equity	1,095	1,371
Noncontrolling interests	325	351
Total equity	1,420	1,722
Total liabilities and equity	$ 10,572	$ 11,114

Lifepoint Health, Inc.

Consolidated Statements of Cash Flows
For the Years Ended December 31, 2022, 2021 and 2020
(In millions)

	2022	2021	2020
Cash flows from operating activities:			
Net (loss) income	$ (205)	$ 139	$ 305
Adjustments to reconcile net (loss) income to net cash provided by (used in) operating activities:			
Depreciation and amortization	323	345	378
Other non-cash amortization	33	33	35
Non-cash interest (income) expense, net	(4)	(24)	15
Debt transaction costs	-	-	115
Stock-based compensation	5	117	2
Other non-operating (gains) losses, net	(8)	19	4
Reserve for self-insurance claims, net of payments	(6)	6	30
Changes in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:			
Accounts receivable	(7)	(112)	110
Inventories, prepaid expenses and other current assets	(105)	(83)	(20)
Accounts payable, accrued salaries and other current liabilities	(20)	131	(36)
Medicare advance payments and deferred payroll taxes	-	(1,075)	1,075
Income taxes payable/receivable and deferred income taxes	72	(71)	(102)
Other	4	(15)	9
Net cash provided by (used in) operating activities	82	(590)	1,920
Cash flows from investing activities:			
Purchases of property and equipment	(227)	(274)	(170)
Net cash impact related to common control transaction	-	(875)	-
Proceeds from sales of hospitals and equity method investment	135	119	24
Investment in ScionHealth term loan	(47)	-	-
Other	1	(4)	26
Net cash used in investing activities	(138)	(1,034)	(120)
Cash flows from financing activities:			
Proceeds from borrowings	-	-	2,382
Payments of borrowings	(144)	-	(2,141)
Payments of debt financing costs	-	-	(103)
Distributions to Parent	(10)	(93)	-
Distributions and other cash transactions associated with noncontrolling interests and redeemable noncontrolling interests	(84)	(26)	(13)
Termination of finance lease obligations	(130)	(28)	-
Payments of finance lease obligations	(34)	(29)	(20)
Net cash (used in) provided by financing activities	(402)	(176)	105
Change in cash and cash equivalents	(458)	(1,800)	1,905
Cash and cash equivalents at beginning of period	853	2,653	748
Cash and cash equivalents at end of period	$ 395	$ 853	$ 2,653
Supplemental disclosure of cash flow information:			
Interest payments	$ 373	$ 379	$ 424
Capitalized interest	$ 5	$ 3	$ 2
Property and equipment acquired under finance leases	$ 44	$ 50	$ 43
Income tax payments, net	$ 28	$ 44	$ 38

Lifepoint Health, Inc.

Consolidated Statements of Equity
For the Years Ended December 31, 2022, 2021 and 2020
(Dollars in millions)

	Common Stock		Capital in Excess of Par Value	Accumulated Other Comprehensive (Loss) Income	Accumulated (Deficit) Income	Noncontrolling Interests	Total
	Shares	Amount					
Balance at December 31, 2019	100	$ -	$ 1,296	$ (8)	$ (386)	$ 26	$ 928
Comprehensive (loss) income	-	-	-	(1)	283	8	290
Stock-based compensation	-	-	2	-	-	-	2
Reclassification of equity to redeemable noncontrolling interests related to joint venture transaction	-	-	(26)	-	-	-	(26)
Fair value adjustments related to redeemable noncontrolling interests	-	-	(5)	-	-	-	(5)
Cash distributions to joint venture partners	-	-	-	-	-	(2)	(2)
Balance at December 31, 2020	100	-	1,267	(9)	(103)	32	1,187
Comprehensive income	-	-	-	6	130	5	141
Stock-based compensation	-	-	117	-	-	-	117
Net equity adjustments related to common control transactions	-	-	48	-	-	-	48
Distributions to Parent	-	-	(85)	-	-	-	(85)
Noncontrolling interests recognized in common control transactions	-	-	-	-	-	317	317
Cash distributions to joint venture partners	-	-	-	-	-	(3)	(3)
Balance at December 31, 2021	100	-	1,347	(3)	27	351	1,722
Comprehensive income (loss)	-	-	-	4	(271)	65	(202)
Stock-based compensation	-	-	5	-	-	-	5
Distributions to Parent	-	-	(10)	-	-	-	(10)
Cash distributions to joint venture partners, net of contributions	-	-	-	-	-	(84)	(84)
Non-cash contributions from joint venture partners	-	-	-	-	-	17	17
Non-cash adjustments related to noncontrolling interests and redeemable noncontrolling interests and other	-	-	(4)	-	-	(24)	(28)
Balance at December 31, 2022	100	$ -	$ 1,338	$ 1	$ (244)	$ 325	$ 1,420

Note 1. Organization and Summary of Significant Accounting Policies

Organization

Lifepoint Health, Inc. ("Lifepoint" or the "Company"), a Delaware corporation, acting through its subsidiaries, is a leading provider of healthcare serving patients, clinicians, communities and partner organizations across the healthcare continuum. The Company generates revenues by providing a broad range of general and specialized healthcare services to patients through a growing diversified healthcare delivery network, which at December 31, 2022 was comprised of 62 community hospital campuses, 31 inpatient rehabilitation facilities ("IRFs"), three behavioral health facilities and additional sites of care that include acute rehabilitation units ("ARUs"), outpatient centers and post-acute care facilities. At December 31, 2022, on a consolidated basis, the Company operated 96 healthcare facilities in 28 states throughout the United States ("U.S.") with approximately 10,000 licensed beds and approximately 50,000 dedicated employees.

Unless otherwise indicated or the context otherwise requires, references throughout these notes to the consolidated financial statements to the "Company" or "Lifepoint" refer to Lifepoint Health, Inc., and each of its consolidated subsidiaries. References in this Report to the "Sponsor" refer to certain funds that are affiliates of the Company (the "Apollo Funds") that are ultimately controlled and/or managed by certain affiliates of Apollo Management Holdings, L.P. ("Apollo Management" and, when acting on behalf of the Apollo Funds, "Apollo"), which is an affiliate of Apollo Global Management, Inc.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through majority voting control and variable interest entities which the Company is the primary beneficiary. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation. Noncontrolling interests in non-wholly-owned consolidated subsidiaries of the Company are presented as noncontrolling interests and redeemable noncontrolling interests and distinguish between the interests of the Company and the interests of the noncontrolling owners. Net income attributable to noncontrolling interests and redeemable noncontrolling interests represents the amounts attributable to the noncontrolling interests for each of the applicable periods presented. Investments in entities the Company does not control but does have a substantial ownership interest and can exercise significant influence are accounted for using the equity method.

The Company's financial statements have been presented on the basis of push down accounting in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") No. 805-50-S99. Under the push down basis of accounting, certain transactions incurred by the parent company which would otherwise be accounted for in the accounts of the parent are "pushed down" and recorded on the financial statements of the subsidiary. Accordingly, certain items resulting from the acquisition by Apollo have been recorded on the financial statements of the Company.

Use of Estimates

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

Revenue Recognition and Accounts Receivable

Overview

The Company recognizes revenues in the period in which performance obligations are satisfied. Generally, the Company bills patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. Amounts the Company receives for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in the Company's financial statements are recorded at the net consideration to which the Company expects to be entitled to receive in exchange for providing patient care.

The majority of the Company's performance obligations are satisfied over time for the delivery of patient care in both outpatient and inpatient settings. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected charges for services anticipated to be provided. The Company believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the remaining services needed to satisfy the obligation. Generally, unsatisfied or partially unsatisfied performance obligations at the end of the reporting period are related to patients admitted to the Company's hospitals that have not yet been discharged. The performance obligations for these patients are typically satisfied when the patients are discharged, which generally occurs within a matter of days of admission. Patients are generally billed when discharged, though they may be billed on an interim basis for longer stays. Accordingly, because all of the Company's performance obligations are part of a contract that is expected to have a duration of one year or less, the Company has elected to apply the exemption provided by ASC 606, "Revenue from Contracts with Customers" ("ASC 606") to not disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied as of period end.

Subsequent adjustments that are determined to be the result of an adverse change in the patient's or the payer's ability to pay are recognized as bad debt expense. With the adoption of ASC 606, bad debt expense is included under the caption "Other operating expenses, net" in the accompanying consolidated statements of operations, instead of separately as a deduction to arrive at revenue. Bad debt expense for the years ended December 31, 2022, 2021 and 2020 was not material for the Company.

Contractual Discounts

The Company derives a significant portion of its revenues from Medicare, Medicaid and other payers that receive discounts from the Company's established billing rates. The Company must estimate the total amount of these discounts to prepare its financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Company estimates contractual discounts on a payer-specific basis given its interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Subsequent changes in estimates for contractual discounts are reflected as an adjustment to revenues in the period of the change. Medicare, Medicaid and other discounted payer accounts receivables are written off after they have been final settled with the payer.

Kentucky Hospital Rate Improvement Program

The Commonwealth of Kentucky has implemented a Medicaid Hospital Rate Improvement Program ("KY HRIP"), which provides supplemental Medicaid payments to all Kentucky hospitals, other than university hospitals and state mental hospitals, and is intended to reduce the gap between the Kentucky Medicaid program's regular inpatient Medicaid payments and each hospital's Medicare allowable costs. During the first quarter of 2021, CMS and the Commonwealth of Kentucky approved a modification to the KY HRIP, which increased the inpatient hospital reimbursement rate from a contracted managed care rate up to a percentage of the average commercial rate. This modification was applied retrospectively to the beginning of the KY HRIP fiscal year, which commenced on July 1, 2020. As a result of this modification, the Company recognized additional revenues of $113 million in its consolidated statement of operations for the year ended December 31, 2021, of which $33 million is related to the period from July 1, 2020 to December 31, 2020. Additionally, the Company recognized additional provider taxes of $15 million for the year ended December 31, 2021, included under the caption "Other operating expenses, net" in the accompanying consolidated statement of operations, of which $5 million is related to the period from July 1, 2020 to December 31, 2020.

Cost Report Settlements

Cost report settlements under reimbursement agreements with Medicare, Medicaid and certain other payers for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the payment terms of the reimbursement agreement with the payer, correspondence from the payer, and the Company's historical experience. Estimated settlements are adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. For the years ended December 31, 2022, 2021 and 2020, the net adjustments to estimated cost report settlements and other reimbursement adjustments resulted in an increase to revenues of $32 million, $62 million and $34 million, respectively.

The net cost report settlements due to the Company were $3 million and nominal at December 31, 2022 and 2021, respectively, and are included under the caption "Accounts receivable" on the accompanying consolidated balance sheets. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs consistent with the constraints that are required by ASC 606.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third-party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. The Company evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. The Company estimates the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that the Company utilizes include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that the Company expects to collect. Because the Company provides care to patients regardless of their ability to pay, the Company has determined that the differences between the amounts it bills based on gross or discounted charges and the amounts the Company expects to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and the Company accounts for this variable consideration in accordance with the provisions of ASC 606. Self-pay accounts receivable are written off after collection efforts have been followed in accordance with the Company's policies.

Charity Care

The Company provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the years ended December 31, 2022, 2021 and 2020, the Company estimates that its costs of care provided under its charity care programs approximated $18 million, $23 million and $27 million, respectively. The Company does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Company's policy not to pursue collection of amounts related to these patients, and therefore contracts with these patients do not exist.

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

Financing Component

The Company has elected to apply the practical expedient permitted under ASC 606 and does not adjust the estimated amount of consideration from patients and third-party payers for the effects of a significant financing component due to the Company's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payer pays for that service will be one year or less.

Rental Income

The Company leases certain real estate assets it owns to unrelated third parties, primarily medical office buildings to non-employed physicians. The Company recognizes rental income for these operating lease arrangements in which the Company is the lessor on a straight-line basis over the lease term in accordance with ASC 842, "Leases" ("ASC 842").

Concentration of Revenues

The Company's revenues by payer and approximate percentages of revenues were as follows for the years ended December 31, 2022, 2021 and 2020 (dollars in millions):

	2022		2021		2020	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 3,227	40.2 %	$ 3,368	37.7 %	$ 3,134	38.6 %
Medicaid	1,353	16.9	1,645	18.4	1,392	17.1
HMOs, PPOs and other private insurers	3,030	37.8	3,691	41.3	3,382	41.6
Self-pay	57	0.7	55	0.6	55	0.7
Other (a)	338	4.2	156	1.8	137	1.7
Revenue from contracts with customers	8,005	99.8	8,915	99.8	8,100	99.7
Rental income	15	0.2	22	0.2	22	0.3
Revenues	$ 8,020	100.0 %	$ 8,937	100.0 %	$ 8,122	100.0 %

(a) Includes revenues from managed ARUs and ancillary goods and services.

During the years ended December 31, 2022, 2021 and 2020, approximately 57.1%, 56.1% and 55.7%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs, collectively. The Company's management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies.

Any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs could have an adverse effect on the Company's revenues or results of operations. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payer or geographic area that would subject the Company to any significant credit risks in the collection of its accounts receivable.

The Company's revenues by primary service type and approximate percentages of revenues were as follows for the years ended December 31, 2022, 2021 and 2020 (dollars in millions):

	2022		2021		2020	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Inpatient services	$ 3,474	43.3 %	$ 3,525	39.4 %	$ 3,379	41.6 %
Outpatient services	4,193	52.3	5,234	58.6	4,584	56.4
Non-patient (a)	353	4.4	178	2.0	159	2.0
Revenues	$ 8,020	100.0 %	$ 8,937	100.0 %	$ 8,122	100.0 %

(a) Includes revenues from managed ARUs and ancillary goods and services.

General and Administrative Costs

The majority of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as "general and administrative" by the Company would include its corporate overhead costs, which were $236 million, $213 million and $181 million for the years ended December 31, 2022, 2021 and 2020, respectively, excluding depreciation and amortization, net income and losses associated with non-consolidated equity investments, debt transaction costs, certain transaction and advisory costs recognized in connection with the Company's business development activities, and accelerated stock-based compensation expense recognized during the year ended December 31, 2021 in connection with a transaction involving the Company's indirect parent, DSB Parent, L.P., a Delaware limited partnership (the "Parent"). Refer to Note 12 for further discussion of the Company's accounting for the stock-based compensation.

Impact of COVID-19 and the CARES Act

Impact of COVID-19

During March 2020, the global COVID-19 pandemic began to significantly affect the Company's facilities, employees, patients, communities, business operations and financial performance, as well as the U.S. economy and financial markets, as a whole. More than three years into the pandemic, the Company continues to be deeply committed to protecting the health of its communities and continues to respond to the evolving COVID-19 situation across the country. Importantly, the Company is taking every precaution to ensure it can continue providing quality care and safeguard the health and well-being of patients, employees, providers, volunteers and visitors in each community it serves. The national footprint of the Company's health system, along with its Health Support Center, has enabled the Company to support its communities during this challenging time.

CARES Act Overview

The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was signed into law on March 27, 2020. Among other things, the CARES Act contains a number of provisions that are intended to assist healthcare providers as they combat the effects of the COVID-19 pandemic. Those provisions include, among others:

- the temporary suspension of Medicare sequestration from March 1, 2020, to December 31, 2020;
- the delay of the planned reductions to the Medicaid disproportionate share hospital ("DSH") payments program until October 1, 2023;
- an appropriation of $180 million to Health Resources and Services Administration's Federal Office of Rural Health Policy that will be awarded to small rural hospitals by the states through the Small Rural Hospital Improvement Program;
- an appropriation of $250 million to the Hospital Preparedness Program; and
- an appropriation of $100 billion to the Public Health and Social Services Emergency Fund (the "Emergency Fund") for a new program to reimburse, through grants or other mechanisms, hospitals, healthcare providers and other approved entities for COVID-19-related expenses or lost revenues.

The Paycheck Protection Program and Health Care Enhancement Act was enacted on April 24, 2020, which, among other things, provides an additional allocation of $75 billion to the Emergency Fund and an allocation of $25 billion for COVID-19 testing.

On December 21, 2020, Congress adopted the Consolidated Appropriations Act, 2021 (the "CAA"), which provides an additional $900 billion in COVID-19 relief, including an additional allocation of $3 billion to the Emergency Fund. In addition, the CAA, among other things, delays the planned reductions to the Medicaid DSH payments program through federal fiscal year ("FFY") 2023, adds additional reductions to the Medicaid DSH payments program in FFYs 2026 and 2027, provided for a 3.75% increase in the Medicare Physician Fee Schedule ("PFS") rates in calendar year ("CY") 2021 and allocates $30 billion for the purchase and administration of COVID-19 vaccines and related therapeutics. In addition, the CAA extended the temporary suspension of Medicare sequestration through March 31, 2021. The temporary suspension was subsequently extended through December 31, 2022, by HR 1868, which, to offset the cost of the suspension, extended Medicare sequestration through 2030. The Protecting Medicare and American Farmers from Sequester Cuts Act (the "Sequester Cuts Act") further extended the temporary suspension of Medicare sequestration through March 31, 2022, and reduced the sequestration cuts for the period of April 1, 2022, through June 30, 2022, to 1%. The Sequester Cuts Act also delayed application of 4% cuts to Medicare and other federal programs resulting from the requirements of the Statutory Pay-As-You-Go-Act of 2010 (the "PAYGO Act") that were scheduled to go into effect in CY 2022 until CY 2023. On December 23, 2022, Congress adopted the Consolidated Appropriations Act, 2023 (the "CAA23"), which reduces the Medicare sequestration cuts through CY 2024, and extends Medicare sequestration through 2032. The CAA23 also delays application of 4% cuts to Medicare and other federal programs mandated by the PAYGO Act that were scheduled to go into effect in CY 2023 and CY 2024 until CY 2025.

Stimulus Payments

The Emergency Fund distributed $50 billion to hospitals based on their 2018 net patient revenue. Additionally, since that time, the Emergency Fund has distributed more than $80 billion to a number of different types of healthcare providers, including participants in state Medicaid/CHIP programs, providers in areas particularly impacted by the COVID-19 outbreak, rural providers (including hospitals and rural health clinics), skilled nursing facilities, dentists, providers of services with lower shares of Medicare reimbursement or who predominantly serve Medicaid beneficiaries, and providers requesting reimbursement for the treatment of uninsured patients.

Payments made by the Emergency Fund to healthcare providers are not loans, and, as a result, they do not need to be repaid. However, healthcare providers must agree to and meet the terms and conditions that are associated with the payments, which include, among other things, filing attestations acknowledging receipt of payments, accepting in-network amounts for presumptive or actual out-of-network COVID-19 patients, not using the payments received from the Emergency Fund to reimburse expenses or losses that other sources are obligated to reimburse, and submitting such reports as may be required by HHS regarding the provider's compliance with the terms and conditions of the Emergency Fund. Healthcare providers that received more than $10,000 from the Emergency Fund between April 10, 2020 through June 30, 2020 (the "First Payment Received Period") were required to submit a report on their use of those funds no later than September 30, 2021. The Company successfully submitted the required reports for all of its providers that received and retained payments from the Emergency Fund during First Payment Received Period prior to the deadline. However, the Company will be required to submit additional reports in the future for payments that were received and retained by the Company's providers from the Emergency Fund after the end of the First Payment Received Period. The reporting requirements and guidance from HHS related to the Emergency Fund have been subject to frequent clarifications and revision, and there can be no assurance that the Company will not be required to submit additional reports or provide additional information related to the payments it has received from the Emergency Fund in the future. In addition, HHS has indicated that it will be closely monitoring the payments that are made to providers through the Emergency Fund, and that HHS, along with the Office of Inspector General of HHS (the "OIG"), will be auditing providers to ensure that recipients comply with the terms and conditions that are associated with the Emergency Fund and other COVID-19 relief programs.

The Company has accounted for the stimulus payments received as a government grant related to income in a manner consistent with International Accounting Standards 20, "Accounting for Government Grants and Disclosure of Government Assistance" ("IAS 20"). In accordance with IAS 20, government grants are recognized either as other income or a reduction to a related expense when there is reasonable assurance that the grant will be received, and the entity will comply with any conditions attached to the grant.

For the years ended December 31, 2022, 2021 and 2020, the Company recognized $14 million, $17 million and $646 million, respectively, of stimulus payments as other income under the caption "Government stimulus income" in the accompanying consolidated statements of operations.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, HHS temporarily expanded the Centers for Medicare and Medicaid Services ("CMS") Accelerated and Advance Payment Program to a broad group of Medicare Part A and Part B providers. Under the expanded CMS Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period. The repayment of these accelerated/advance payments did not begin until one year after the date of the provider's or supplier's receipt of the payment, which means repayment of these amounts did not commence until the second quarter of 2021. Under the applicable repayment terms, the amounts previously advanced to the provider or supplier are automatically recouped from the provider's or supplier's new Medicare claims at a rate of 25% for a period of 11 months. After the end of that 11-month period, the amounts previously advanced to the provider or supplier will be automatically recouped from the provider's or supplier's new Medicare claims at a rate of 50% for a period of six months. At the end of the 17-month recoupment period, a letter requesting repayment of any remaining balance will be issued, and the provider or supplier will have 30 days from the date of the letter to repay the balance in full. If the remaining balance is not repaid after 30 days, the unpaid balance will accrue interest at a rate of 4% from the date of the demand letter until the balance has been repaid in full.

The Company received a total of $991 million of Medicare advance payments under the CMS Accelerated and Advance Payment Program during the year ended December 31, 2020. During the year ended December 31, 2021, the Company fully repaid all Medicare advance payments and the Company does not anticipate receiving any additional funds from the CMS Accelerated and Advance Payment Program.

CARES Act Tax Provisions

The CARES Act also provided for certain federal income tax changes, including an increase in the interest expense tax deduction limitation, the deferral of the employer portion of Social Security payroll taxes, refundable payroll tax credits, employee retention tax credits, net operating loss carryback periods, alternative minimum tax credit refunds and bonus depreciation of qualified improvement property. During the year ended December 31, 2020, the Company deferred cash payments of approximately $84 million related to Social Security payroll tax payments. During the year ended December 31, 2021, the Company fully repaid all previously deferred Social Security payroll taxes.

The federal income tax changes brought about by the CARES Act are complex and further guidance is expected. The Company may change its provision for income taxes and its deferred income taxes as its understanding of the CARES Act tax provisions evolves due to additional U.S. Department of Treasury guidance. Any such adjustments could materially impact the Company's provision for income taxes and, as a result, its financial results in the relevant periods.

Cash and Cash Equivalents

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

Inventories

Inventories of supplies are stated at the lower of cost (first-in, first-out) or market and consist of purchased items. Inventories acquired in connection with business combinations are recorded at fair value which approximates replacement cost. Inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

Investments

The Company accounts for its investments in entities in which the Company does not control under either the cost method or the equity method of accounting in accordance with ASC 321 "Investments – Equity Securities" ("ASC 321") or ASC 323, "Investments – Equity Method and Joint Ventures" ("ASC 323"), respectively. The Company does not consolidate its cost and equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses or evaluates them for impairment and observable price changes. Refer to Note 8 for further discussion of the Company's investments.

Property and Equipment

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

The following table provides information regarding the Company's property and equipment included in the accompanying consolidated balance sheets as of December 31, 2022 and 2021 (in millions):

	2022	2021
Land	$ 180	$ 179
Buildings and improvements	2,376	2,357
Equipment	1,751	1,617
Construction in progress	148	162
Property and equipment, at cost	4,455	4,315
Accumulated depreciation	(1,339)	(1,051)
Property and equipment, net of accumulated depreciation	$ 3,116	$ 3,264

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

	Years		
Buildings and improvements (including those under finance leases)	3	-	40
Equipment	2	-	15
Equipment under finance leases	3	-	6

Depreciation expense (including amortization of finance lease obligations) totaled $323 million, $344 million and $376 million for the years ended December 31, 2022, 2021 and 2020, respectively.

Whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances. There were no long-lived asset impairments recorded for the years ended December 31, 2022, 2021 and 2020.

Goodwill and Intangible Assets

The Company accounts for its acquisitions in accordance with ASC 805 using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350, Intangibles – Goodwill and Other ("ASC 350"), goodwill and intangible assets with indefinite lives are reviewed by the Company annually for impairment on October 1. Prior to the Kindred Transaction, the Company historically determined that its consolidated business comprised a single reporting unit for goodwill impairment testing purposes. Due to the significance of the Kindred Transaction and the impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280, "Segment Reporting" ("ASC 280") and ASC 350 during 2022 and determined that the Company is now comprised of two distinct reporting units (i) acute hospital operations and (ii) rehabilitation hospital operations.

For the annual impairment evaluation, the Company estimates fair values of its reporting units utilizing both a discounted cash flow ("DCF") analysis and a guideline public company ("GPC") analysis considering observable market data of the Company's industry peers. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates, profitability and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing the Company's assumptions. The cash flows employed in the DCF analysis are based on the Company's most recent financial budgets and business plans and, when applicable, various growth rates and profitability for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the reporting unit.

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

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the income tax provision in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is not likely, a valuation allowance is established. The establishment or increase in a valuation allowance is included as an expense within the provision for income taxes in the consolidated statements of operations. The Company classifies interest and penalties related to its tax positions as a component of income tax expense. Refer to Note 5 for further discussion of the Company's accounting for income taxes.

Reserves for Self-Insurance Claims

Given the nature of the Company's operating environment, the Company is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("SIR") and deductible levels**.** At December 31, 2022, the Company's SIR for professional liability claims is $15 million per claim at the majority of its acute care hospitals. Additionally, the Company participates in state-specific professional liability programs in Indiana, New Mexico and Pennsylvania. The Company has a $25,000 deductible for professional liability at each of its IRFs and behavioral health hospitals. At December 31, 2022, the Company's deductible for workers' compensation claims at each of its acute care and behavioral health hospitals was $1 million per claim in all states in which it operates except for Montana and Washington. The Company participates in state-specific programs for its workers' compensation claims arising in these states. There is no deductible for workers' compensation claims at IRFs. The Company's SIR and deductible levels are evaluated annually as a part of the Company's insurance program's renewal process.

The Company's reserves for self-insurance and deductible claims reflect the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The Company's expense for self-insurance and deductible claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's self-insured retention and deductible levels; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance and deductible claims was approximately $69 million, $86 million and $85 million for the years ended December 31, 2022, 2021 and 2020, respectively.

The Company's reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. These reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. The Company's reserves for self-insured claims have been discounted to their present value using a discount rate of 1.8% at December 31, 2022, 1.6% at December 31, 2021, and 1.7% at December 31, 2020. The Company's management selects a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

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

The following table provides information regarding the classification of the Company's reserves for self-insured claims at December 31, 2022 and 2021 (in millions):

	2022	2021
Current portion	$ 74	$ 79
Long-term portion	219	216
	$ 293	$ 295

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2022 and 2021 (in millions):

	2022	2021
Reserve at the beginning of the period	$ 295	$ 287
Increase for the provision of current year claims	65	72
Increase for the provision of prior year claims	5	13
Payments related to current year claims	(3)	(5)
Payments related to prior year claims	(72)	(72)
Provision for the change in discount rate	(1)	1
Non-cash change in reserve for claims in excess of SIR levels	2	(5)
Liabilities assumed in connection with the Kindred Transaction	2	4
Reserve at the end of the period	$ 293	$ 295

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of the Company's quarterly and semi-annual actuarial calculations resulted in changes to its reserves for self-insured claims for prior years. As a result, the Company's related self-insured claims expense increased by $5 million and $13 million for the years ended December 31, 2022 and 2021, respectively.

Point of Life Indemnity, Ltd.

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

Self-Insured Medical Benefits

The Company is self-insured for substantially all of the eligible medical plan claims of its employees. The reserve for medical benefits primarily reflects the current estimate of incurred but not reported losses based upon an annual actuarial calculation as of the balance sheet date. The undiscounted reserve for self-insured medical benefits was $50 million and $46 million at December 31, 2022 and 2021, respectively, and is included in the Company's accompanying consolidated balance sheets under the caption "Other current liabilities".

Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to the Company. The Company's accompanying consolidated financial statements include all assets, liabilities, revenues, and expenses at their consolidated amounts, which include the amounts attributable to the Company and the noncontrolling interest. The Company recognizes as a separate component of earnings that portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company. Refer to Note 9 for further discussion of the Company's noncontrolling interests and redeemable noncontrolling interests.

Variable Interest Entities

The Company follows the provisions of ASC 810, "Consolidation" for determining whether an entity is a variable interest entity ("VIE"). In order to determine if the Company is a primary beneficiary of a VIE for financial reporting purposes, it must consider whether it has the power to direct activities of the VIE that most significantly impact the performance of the VIE and whether the Company has the obligation to absorb losses or the right to receive returns that are significant to the VIE. The Company consolidates a VIE when it is the primary beneficiary.

As of December 31, 2022, the Company consolidated 22 acute care hospitals and 31 IRFs that are subject to joint venture agreements. Under GAAP, the Company determined that six of its acute care hospitals and 28 of its IRF joint ventures qualify as VIEs, and furthermore, the Company concluded that it is the primary beneficiary in all of the VIEs. The Company holds an ownership interest and acts as manager in each of the partnerships. Through the management services agreement, the Company is delegated necessary responsibilities to provide management services, administrative services and direction of the day-to-day operations. Based upon the Company's assessment of the most significant activities of its acute care hospitals and IRFs, the Company, as manager, has the ability to direct the majority of those activities in all such joint ventures which qualify as VIEs.

The analysis upon which the consolidation determination rests can be complex, can involve uncertainties, and requires judgment on various matters, some of which could be subject to different interpretations.

The Company's consolidated VIEs comprised approximately $1,361 million, or 12.9%, of the Company's total assets and $595 million, or 6.6%, of the Company's total liabilities as of December 31, 2022.

Stock-Based Compensation

The Company's Parent has issued profits units (the "Units") to certain employees, directors, consultants and other service providers under the terms and conditions of the Third Amended and Restated Limited Partnership Agreement of the Parent dated May 27, 2022 (as amended, the "Parent Partnership Agreement") and forms of award agreements. The Company accounted for these stock-based awards in accordance with the provisions of ASC 718, "Compensation – Stock Compensation" ("ASC 718"). In accordance with ASC 718, the Company recognized compensation expense based on the estimated grant date fair value of each stock-based award. The Company recognizes forfeitures of Units as they occur. Refer to Note 12 for further discussion of the Company's accounting for the Units.

Defined Benefit Pension Plans

The Company maintains certain assets and assumed certain liabilities associated with two separate defined benefit pension plans covering certain employees at two of its facilities. The Company accounts for its defined benefit pension plans in accordance with ASC 715, "Compensation – Defined Benefit Plans" ("ASC 715"). In accordance with ASC 715, the Company recognizes the unfunded liability of its defined benefit pension plans in the Company's consolidated balance sheets and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the defined benefit pension plans' assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligations are measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality. Refer to Note 11 for further discussion of the Company's defined benefit pension plans.

Defined Contribution Plans

During the year ended December 31, 2022, the Company maintained a defined contribution retirement plan covering a majority of its employees. This defined contribution retirement plan contains discretionary matching contribution formulas, as well as definite contribution formulas for employees at certain facilities. Refer to Note 11 for further discussion of the Company's defined contribution plan.

Reclassifications

Certain reclassifications have been made to the prior years to conform to current year presentation. These reclassifications had no effect on results of operations, financial position or cash flows as previously reported.

Note 2. Business Development Update

Springstone Transaction

On August 26, 2022, the Company entered into a definitive agreement with (i) entities affiliated with Medical Properties Trust, Inc. ("MPT") and (ii) BH EIK Management, LP, a management company owned by certain members of the executive leadership team ("Springstone Management") of Springstone Health Opco, LLC ("Springstone"), to acquire a majority ownership interest in Springstone from Springstone Management and to acquire a promissory note issued by Springstone to an affiliate of MPT (the "Springstone Transaction"). Springstone is a national behavioral health provider with 18 behavioral health hospitals and 35 outpatient locations across nine states. Pursuant to the Springstone Transaction, MPT will continue to own the majority of Springstone's real estate locations, subject to an amended and restated master lease between affiliates of MPT and Springstone (the "Springstone Master Lease"), and retain a noncontrolling interest in Springstone, subject to a put/call agreement.

The Springstone Transaction was consummated on February 7, 2023, upon which certain of the Company's subsidiaries entered into the Springstone Master Lease, and the Company funded $230 million in cash to complete the transaction. Refer to Note 7 for further discussion of the Springstone Master Lease.

Cornerstone Behavioral Health El Dorado

On January 20, 2023, a subsidiary of Knight Health Holdings LLC (d/b/a ScionHealth), a Delaware limited liability company ("ScionHealth"), acquired Cornerstone Healthcare Group Holding, Inc., a Delaware corporation ("Cornerstone"), which operates 15 specialty hospitals, eight senior living locations, and Cornerstone Behavioral Health El Dorado ("El Dorado") (the "Cornerstone Transaction"). Immediately following ScionHealth's acquisition of Cornerstone on January 20, 2023, the Company paid $35 million in cash to acquire El Dorado, a 54 bed behavioral health facility located in Tucson, Arizona, from ScionHealth (the "El Dorado Transaction"). The Company will account for the acquisition of El Dorado in accordance with ASC Subtopic 805-50 "Related Issues" ("ASC 805-50") as a transaction between entities under common control.

In connection with the Cornerstone Transaction and the El Dorado Transaction, the Company entered into a number of transition services agreements and other ancillary agreements with ScionHealth and its subsidiaries pursuant to which (i) the Company provides certain transition services to ScionHealth to support the businesses acquired by ScionHealth in connection with the Cornerstone Transaction and (ii) ScionHealth provides certain transition services to the Company to support El Dorado, including leasing certain employees to the Company through the first quarter of 2023.

Everest Rehabilitation

On January 24, 2023, a wholly-owned, indirect subsidiary of the Company, entered into a definitive agreement with entities affiliated with Everest Rehabilitation Hospitals, LLC, ("Everest"), to acquire four IRFs (the "Operational IRFs") located in Arkansas, Texas, and Ohio (the "Operational IRF Transaction") for an aggregate purchase price of approximately $38 million. The closing of the Operational IRF Transaction was consummated on March 1, 2023. Additionally, in connection with the closing of the Operational IRF Transaction, certain of the Company's affiliated entities entered into a definitive agreement with entities affiliated with Everest to acquire six IRFs that Everest is currently developing in Texas and Florida (the "Developing IRFs") for an aggregate purchase price of approximately $60 million. The Company anticipates closing the acquisition of the Developing IRFs on a rolling basis beginning in the third or fourth quarter of 2023.

De Novo IRF Openings

The Company commenced the operations of four de novo IRFs during 2022. Refer to the table below for additional details.

Facility Name	Location	Opening Date	Licensed Beds
Dignity Health East Valley Rehabilitation Hospital - Gilbert	Gilbert, Arizona	December 21, 2022	40
Mercy Rehabilitation Hospital South	St. Louis, Missouri	December 6, 2022	50
Saint Thomas Rehabilitation Hospital (a)	Nashville, Tennessee	June 14, 2022	40
Tampa Rehabilitation Hospital	Tampa, Florida	May 17, 2022	80

(a) The Company holds a noncontrolling ownership interest in Saint Thomas Rehabilitation Hospital and has accounted for it as an equity investment in accordance with ASC 323.

Kindred Transaction

On June 18, 2021, the Company entered into a securities purchase agreement (the "Kindred Purchase Agreement") for us and/or one or more affiliated assignees to acquire, directly or indirectly, Kindred Healthcare, LLC ("Kindred"), a leading specialty hospital company that operates facilities providing post-acute care, rehabilitation services and behavioral health services throughout the U.S. Upon the closing of the Kindred Transaction, as described below, the Company and Kindred established a new healthcare company operating under the name ScionHealth, which is separate from Lifepoint.

On December 23, 2021, the Company, Kentucky Hospital Holdings JV, LP ("Knight"), the indirect parent of Kindred, ScionHealth, and certain of their respective affiliates entered into reorganization agreements (the "Reorganization Agreements") that, among other things, provided for (i) the separation of the IRF, behavioral health, contract rehabilitation service and certain support center businesses (collectively, the "Knight Transferred Business") from the businesses of Knight and its subsidiaries, (ii) the separation of the equity and assets comprising 18 select acute care hospitals of the Company (the "Artemis Business") from the business of the Company and its subsidiaries, (iii) the transfer of the Knight Transferred Business to the Company, (iv) the transfer of the Artemis Business to Knight, (v) the acquisition by the Company of Class B Units of ScionHealth, with an aggregate value of $350 million, and (vi) reciprocal indemnification obligations with respect to the businesses transferred, in each case of clauses (i) through (vi), pursuant to the reorganization, separation and distribution steps described therein, including the assignment by Knight Health LLC, a Delaware limited liability company formed at the direction of certain affiliates of the Company, of certain rights and obligations under the Kindred Purchase Agreement, including any post-closing purchase price adjustments (the "Reorganization"). The Class B Units of ScionHealth acquired by the Company are perpetual non-convertible non-voting units that accrue cumulative dividends at the rate of 10.00% per annum and, upon liquidation, are entitled to a return of their nominal value issue price of $350 million plus accrued, unpaid dividends.

On December 23, 2021, concurrently with the consummation of the Reorganization, the Kindred Transaction was consummated. Pursuant to the consummation of the Kindred Transaction and the Reorganization, (i) ScionHealth indirectly holds all of the transferred interests in the Artemis Business, (ii) ScionHealth directly holds all of the issued and outstanding limited partnership interests in Knight, (iii) Kentucky Hospital Holdings JV GP LLC, a Delaware limited liability company and direct subsidiary of ScionHealth, holds all of the issued and outstanding general partnership interests in Knight, and (iv) the Company holds all of the transferred interests in the Knight Transferred Business and the Class B Units of ScionHealth described above. The Company refers to the foregoing transactions as the "Kindred Transaction".

Transition Services Agreements

In connection with the Kindred Transaction, the Company entered into a number of transition services agreements ("TSAs") and other ancillary agreements with ScionHealth and its subsidiaries For the year ended December 31, 2022, in connection with the TSAs, the Company was reimbursed by ScionHealth for certain costs incurred on their behalf of $61 million, and paid ScionHealth $3 million for certain costs incurred on the Company's behalf.

Additionally, the Company and ScionHealth are party to a number of commercial services agreements, pursuant to which the Company provides ScionHealth with therapy services, rehabilitation unit and behavioral health unit management, consulting and development services, among other commercial services. For the year ended December 31, 2022, the Company recorded revenues related to these commercial services agreements of $55 million.

Lastly, given the recency of the Kindred Transaction and the ongoing integration efforts between the Company and ScionHealth, the Company may, from time to time, have a net receivable/payable recorded from/to ScionHealth with respect to net working capital and TSAs. The Company had a net receivable of $84 million and $9 million, respectively, recorded under the caption "Other current assets" in its accompanying consolidated balance sheet at December 31, 2022 and 2021.

Accounting for the Kindred Transaction

The Company accounted for the Kindred Transaction in accordance with ASC 805-50 as a transaction between entities under common control. In accordance with ASC 805-50, the Company recognized the assets and liabilities transferred in connection with the Kindred Transaction at the common parent's historical cost basis as of December 23, 2021. In accordance with ASC 805-50, combinations of entities under common control requires retrospective adjustment of comparative period financial information for the periods in which the entities were under common control. The Company and the Knight Transferred Business were under common control beginning December 23, 2021, and therefore, the Company has not retrospectively adjusted its previously issued financial statements.

The following tables summarize the impact of the net asset transfers in connection with the Kindred Transaction and the finalized purchase price allocation (in millions):

Net assets transferred from ScionHealth to Lifepoint	$ 1,031
Net assets transferred from Lifepoint to ScionHealth	(404)
Cash transferred to ScionHealth from Lifepoint	(929)
Class B Units of ScionHealth transferred to Lifepoint	350
Net equity adjustments related to common control transactions	$ 48

	From ScionHealth To Lifepoint	From Lifepoint To ScionHealth
Current assets	$ 198	$ (271)
Property and equipment, net	153	(501)
Other long-term assets	475	(30)
Goodwill and intangible assets	1,095	(121)
Current liabilities	(123)	118
Long-term liabilities	(473)	378
Noncontrolling interests and redeemable noncontrolling interests	(294)	23
Net assets transferred to (from) Lifepoint	$ 1,031	$ (404)

Transaction-Related Costs

During the years ended December 31, 2022, 2021 and 2020, the Company recognized transaction-related costs of $46 million, $86 million and $132 million, respectively. The transaction-related costs recognized during the years ended December 31, 2022 and 2021 were primarily related to the Kindred Transaction, Springstone Transaction and other business development activities. The transaction-related costs recognized during the year ended December 31, 2020 were primarily related to debt refinancing activities which are discussed further in Note 3.

Additional Divestitures

Colorado Plains Medical Center and Western Plains Medical Complex

Effective May 1, 2022, the Company sold Colorado Plains Medical Center ("Colorado Plains"), a 50 bed acute care facility located in Fort Morgan, Colorado, and Western Plains Medical Complex ("Western Plains"), a 99 bed acute care facility located in Dodge City, Kansas, to an unrelated third party. The Company received cash proceeds from the Colorado Plains and Western Plains transaction of $135 million, including net working capital, of which $63 million was utilized to settle a finance lease obligation related to Western Plains.

In connection with the sale of Colorado Plains and Western Plains, the Company recognized a net gain of $12 million, which is included under the caption "Other non-operating (gains) losses, net" in the accompanying consolidated statements of operations for the year ended December 31, 2022. The net gain on sale is primarily attributable to transaction proceeds in excess of the book values of the net assets associated with Colorado Plains and Western Plains, partially offset by losses associated with the write-off of allocated goodwill and the termination of a finance lease obligation related to Western Plains.

Providence Health and KershawHealth

Effective August 1, 2021, the Company sold Providence Health, comprised of two hospital campuses located in Columbia, South Carolina, and KershawHealth, located in Camden, South Carolina, to an unrelated third party. The Company received cash proceeds from the transaction of $86 million, including net working capital, a portion of which was utilized to settle a $28 million finance lease obligation related to KershawHealth. Refer to Note 7 for additional information regarding the Company's accounting for leases.

In connection with the divestiture of Providence Health and KershawHealth, the Company recognized a net impairment loss of $42 million during the year ended December 31, 2021, which is included under the caption "Other non-operating (gains) losses, net" in the accompanying consolidated statement of operations for the year ended December 31, 2021. The net impairment loss is primarily attributable to the write-down of property and equipment and allocated goodwill to their estimated fair values, as well as the termination of a finance lease obligation related to KershawHealth.

Capital Medical Center

On December 23, 2020, the Company entered into a definitive agreement with an unrelated third party to sell its majority ownership interest in Capital Medical Center, located in Olympia, Washington. Effective April 1, 2021, the Company sold its ownership interest in Capital Medical Center for cash proceeds of $38 million, including net working capital, in addition to the purchaser's assumption of certain finance lease obligations.

In connection with the Company's divestiture of Capital Medical Center, the Company recognized a net gain on sale of $24 million during the year ended December 31, 2021, which is included under the caption "Other non-operating (gains) losses, net" in the accompanying consolidated statement of operations for the year ended December 31, 2021. The net gain on sale is primarily attributable to the purchaser's assumption of certain finance lease obligations and liabilities, partially offset by the write-off of property and equipment, allocated goodwill, and certain other assets.

Note 3. Long-Term Debt

The Company's long-term debt, including current portions and finance lease obligations, consisted of the following at December 31, 2022 and 2021 (in millions):

	2022	2021
ABL Facility	$ -	$ -
Term Loan Facility	3,215	3,215
6.75% Secured Notes	600	600
4.375% Secured Notes	600	600
9.75% Unsecured Notes	1,270	1,425
5.375% Unsecured Notes	500	500
Unamortized debt issuance costs and premium	(100)	(128)
Finance lease obligations	809	911
Total debt	$ 6,894	$ 7,123

Maturities of the Company's long-term debt outstanding at December 31, 2022, excluding finance lease obligations and unamortized debt issuance costs, are as follows for the years indicated (in millions):

2023	$ -
2024	-
2025	3,815
2026	1,270
2027	600
Thereafter	500
	$ 6,185

ABL Facility

General

Effective November 16, 2018, the Company entered into a senior secured asset-based revolving credit facility (as amended from time to time the "ABL Facility") in an aggregate principal amount of $800 million with a maturity of five years. The ABL Facility also includes both a letter of credit sub-facility and a swingline loan sub-facility. In addition, the Company may request one or more incremental revolving commitments in an aggregate principal amount up to the greater of (x) the greater of (i) $255 million and (ii) 0.23 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, and (y) the amount by which the borrowing base exceeds the aggregate commitments under the ABL Facility, subject to certain conditions and receipt of commitments by existing or additional lenders.

On April 13, 2020, the Company entered into an amendment to the ABL Facility that provided for an $80 million last-out term loan with a maturity of 364 days, which was incremental to the $800 revolving commitment under the ABL Facility. Such term loan was drawn at closing and then subsequently repaid in full on December 14, 2020, which effectively terminated such term loan.

As of December 31, 2022, the Company had no borrowings outstanding under the ABL Facility and approximately $53 million in letters of credit outstanding primarily related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements. Amounts available for borrowing under the ABL Facility were approximately $573 million as of December 31, 2022.

On January 27, 2023, the Company entered into an Incremental Assumption and Amendment Agreement No. 2 with certain of the Company's subsidiaries, DSB Acquisition LLC, a Delaware limited liability company ("Holdings"), the lenders party thereto and Citibank, N.A., as administrative agent, which amended and restated the ABL Facility. The amended and restated ABL Facility has a stated maturity of five years; provided, that if more than $200 million aggregate principal amount of the Notes (as defined below) or the Term Loan Facility remain outstanding 91 days before the stated maturity thereof, then the amended and restated ABL Facility will mature and the commitments under the facility will terminate on such date. The amended and restated ABL Facility continues to provide revolving availability of $800 million, with a $150 million letter of credit sub-facility and a $40 million swingline sub-facility, and the Company continues to have the right to request one or more incremental revolving commitments as provided in the ABL Facility. Availability under the amended and restated ABL Facility continues to be subject to a borrowing base that is based on a specified percentage of eligible accounts receivable. Borrowings under the amended and restated ABL Facility continue to be subject to the satisfaction of customary conditions, including the absence of a default and the accuracy of representations and warranties.

On February 6, 2023, the Company borrowed $250 million under the ABL Facility in order to fund the Springstone Transaction, El Dorado Transaction and Everest Operational IRF Transaction as discussed further in Note 2.

Collateral and Guarantors

The obligations under the ABL Facility are guaranteed by Holdings, on a limited recourse basis and each of the direct and indirect material, wholly-owned domestic subsidiaries of the Company that guaranteed the obligations under the ABL Facility. The obligations are secured by a pledge of the capital stock of the Company and substantially all of their assets and those of each subsidiary guarantor subject to certain exceptions. Such security interests consist of a first-priority lien with respect to "ABL Priority Collateral" (which generally includes most accounts receivable and certain related assets of the Company and the subsidiary guarantors) and a second-priority lien with respect to the "Non-ABL Priority Collateral" (which generally includes most inventory and fixed assets, equity interests and intellectual property of the Company and the subsidiary guarantors). Additionally, certain of the Company's restricted subsidiaries that are not guarantors will pledge certain of their assets (the "Credit Support Party Collateral") on a first-priority basis, as further security of the obligations under the ABL Facility. The Credit Support Party Collateral will secure only the obligations under the ABL Facility.

Interest Rates and Fees

Prior to the amendment and restatement effective January 27, 2023, borrowings under the ABL Facility bore interest at a rate equal to, at the Company's option, either (a) a London Interbank Offered Rate ("LIBOR") rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an initial applicable margin of 1.75% for LIBOR loans and 0.75% for base rate loans. The applicable margin for borrowings was subject to step-downs based on average availability thresholds.

Effective January 27, 2023, borrowings under the ABL Facility will bear interest at a rate equal to, at the Company's option, either (a) an adjusted term Secured Overnight Financing Rate ("SOFR") for the interest period in effect, subject to a floor of 0.00%, or (b) a base rate determined by the highest of (i) the prime rate in effect, (ii) the federal funds effective rate plus 0.50% and (iii) an adjusted term SOFR with an interest period of one month plus 1.00%, subject to a floor of 1.00%, in each case plus an applicable margin of 1.75% for adjusted term SOFR loans and 0.75% for base rate loans. The applicable margin for borrowings will be subject to step-downs based on average availability thresholds.

The Company is required to pay a commitment fee under the ABL Facility in respect of the unutilized commitments at an initial rate equal to 0.375% per annum. The commitment fee may be subject to one step-down based on the average daily utilization under the ABL Facility. The Company will also be required to pay customary agency fees as well as letter of credit participation fees.

Restrictive Covenants and Other Matters

The ABL Facility contains certain customary affirmative covenants and events of default. The negative covenants in the ABL Facility include, among other things, limitations (none of which are absolute) on the Company and its subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates, enter into sale-leaseback transactions, change their lines of business, restrict dividends from their subsidiaries or restrict liens, change their fiscal year, and modify the terms of certain debt.

The ABL Facility requires that the Company and its restricted subsidiaries maintain a minimum fixed charge coverage ratio of not less than 1.00 to 1.00 at any time when availability is less than an agreed amount.

The ABL Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the ABL Facility are entitled to take various actions, including the acceleration of amounts due under the ABL Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the ABL Facility.

Term Loan Facility

General

Effective November 16, 2018, the Company entered into the Term Loan Facility, which is a senior secured term loan credit facility in an aggregate principal amount of $3,550 million with a maturity of seven years. In addition, the Company may request one or more incremental commitments in an aggregate principal amount up to the sum of (x) the greater of (i) $800 million and (ii) 0.75 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, plus additional amounts subject to certain agreed leverage requirements, certain other conditions and receipt of commitments by existing or additional lenders.

On January 21, 2020, the Company amended its Term Loan Facility to, among other things, reduce the applicable interest rate margin for the term loans by 0.75% to 3.75% with respect to LIBOR-based loans and 2.75% with respect to base rate loans.

On January 23, 2020, the Company made a prepayment of $400 million of term loans outstanding under the Term Loan Facility with a portion of the net proceeds from the sale-leaseback transaction with MPT completed effective December 17, 2019 (the "2019 Sale Leaseback Transaction"), which is discussed further in Note 7. After giving effect to the prepayment, the Company had prepaid all remaining quarterly amortization payments in respect of the Term Loan Facility.

On February 24, 2020, the Company closed the issuance of $600 million of incremental term loans (the "Incremental Term Loan") under the Term Loan Facility. The Incremental Term Loan bears interest at a rate equal to, at its option, (a) a LIBOR rate plus an applicable margin of 3.75% or (b) a base rate plus an applicable margin of 2.75%. There are no scheduled amortization payments required on the Incremental Term Loan prior to maturity. The net proceeds from the Incremental Term Loan, together with the net proceeds from the 4.375% Secured Notes and cash on hand, was used to fund the settlement of the tender offer, the redemption of the Company's 8.25% Senior Secured Notes due 2023 (the "8.25% Secured Notes") and the redemption of the Company's 11.5% Senior Notes due 2024 (the "11.5% Unsecured Notes") and to pay certain fees in connection with the refinancing transactions described herein.

On December 4, 2020, the Company made an optional prepayment of $500 million of term loans outstanding under the Term Loan Facility with the net proceeds from the offering of $500 million in aggregate principal amount of 5.375% Senior Notes due 2029 (the "5.375% Unsecured Notes"), together with cash on hand.

Collateral and Guarantors

All obligations under the Term Loan Facility are unconditionally guaranteed by Holdings on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the Company, subject to certain exceptions. The obligations under the Term Loan Facility are secured by a pledge of the capital stock of the Company and substantially all of its assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company (including Legacy Lifepoint) and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the Non-ABL Priority Collateral and a second-priority lien with respect to the ABL Priority Collateral.

Interest Rates

Borrowings under the Term Loan Facility bear interest at a rate equal to, at the Company's option, either (a) a LIBOR rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an applicable margin of 3.75% for LIBOR loans and 2.75% for base rate loans.

Restrictive Covenants and Other Matters

The Term Loan Facility contains certain customary affirmative covenants and events of default. The negative covenants in the Term Loan Facility include, among other things, limitations (none of which are absolute) on the Company and its subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates enter into sale-leaseback transactions, change their lines of business, restrict dividends from subsidiaries or restrict liens, change their fiscal year and modify the terms of certain debt or organizational agreements.

The Term Loan Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the Term Loan Facility are entitled to take various actions, including the acceleration of amounts due under the Term Loan Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the Term Loan Facility.

6.75% Secured Notes

On April 13, 2020, the Company completed the offering of $600 million in aggregate principal amount of 6.750% Senior Secured Notes due 2025 (the "6.75% Secured Notes"). The 6.75% Secured Notes will mature on April 15, 2025. Interest on the 6.75% Secured Notes will accrue at 6.75% per annum and will be paid semi-annually, in arrears, on April 15 and October 15 of each year, beginning October 15, 2020. The net proceeds from the offering were used for general corporate purposes.

The Company's obligations under the 6.75% Secured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Term Loan Facility and the 4.375% Senior Secured Notes due 2027 (the "4.375% Secured Notes"). The 6.75% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 6.75% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority Collateral.

The Company may redeem the 6.75% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the 6.75% Secured Notes Indenture.

The 6.75% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions as described in the 6.75% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 6.75% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 6.75% Secured Notes Indenture also provides for customary events of default.

4.375% Secured Notes

On February 13, 2020, the Company completed the offering of $600 million in aggregate principal amount of its 4.375% Secured Notes. The 4.375% Secured Notes will mature on February 15, 2027. Interest on the 4.375% Secured Notes will accrue at 4.375% per annum and will be paid semi-annually, in arrears, on February 15 and August 15 of each year, beginning August 15, 2020. The net proceeds from the offering, together with the net proceeds from the Incremental Term Loan and cash on hand, were used to fund the settlement of the tender offer, the 8.25% Notes Redemption (as defined herein) and the 11.5% Notes Redemption (as defined herein) and to pay certain fees in connection with the refinancing transactions described herein.

The Company's obligations under the 4.375% Secured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Term Loan Facility. The 4.375% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 4.375% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority Collateral.

Prior to February 15, 2022, the Company may redeem the 4.375% Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 4.375% Secured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to February 15, 2022, the Company may also redeem up to 40% of the original aggregate principal amount of the 4.375% Secured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 104.375%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 4.375% Secured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after February 15, 2022, the Company may redeem the 4.375% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of February 13, 2020 (as amended or supplemented from time to time, the "4.375% Secured Notes Indenture").

The 4.375% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions as described in the 4.375% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 4.375% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 4.375% Secured Notes Indenture also provides for customary events of default.

9.75% Unsecured Notes

On November 16, 2018, the Company issued $1,425 million aggregate principal amount of 9.750% Senior Notes due 2026 (the "9.75% Unsecured Notes", and, together with the 5.375% Unsecured Notes, 6.75% Secured Notes and the 4.375% Secured Notes, the "Notes"). The 9.75% Unsecured Notes will mature on December 1, 2026. Interest on the 9.75% Unsecured Notes accrues at 9.750% per annum and will be paid semi-annually, in arrears, on June 1 and December 1 of each year, beginning June 1, 2019.

The Company's obligations under the 9.75% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 9.75% Unsecured Notes and the related guarantees are unsecured obligations of the Company and the subsidiary guarantors.

The Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the 9.75% Unsecured Notes Indenture.

The 9.75% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 9.75% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 9.75% Unsecured Notes Indenture also provides for customary events of default.

5.375% Unsecured Notes

On December 4, 2020, the Company completed the offering of the 5.375% Unsecured Notes. The 5.375% Unsecured Notes will mature on January 15, 2029. Interest on the 5.375% Unsecured Notes will accrue at 5.375% per annum and will be paid semi-annually, in arrears, on January 15 and July 15 of each year, beginning July 15, 2021. The net proceeds of the offering, together with cash on hand, were used to prepay $500 million of the total aggregate principal amount outstanding under the Term Loan Facility and to pay related fees and expenses in connection with the offering.

The Company's obligations under the 5.375% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 5.375% Unsecured Notes and the related guarantees are unsecured obligations of the Company and the subsidiary guarantors.

Prior to January 15, 2024, the Company may redeem the 5.375% Unsecured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 5.375% Unsecured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to December 4, 2023, the Company may also redeem up to 40% of the original aggregate principal amount of the 5.375% Unsecured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 105.375%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 5.375% Unsecured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after January 15, 2024, the Company may redeem the 5.375% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in the Indenture, dated as of December 4, 2020 (the "5.375% Unsecured Notes Indenture").

The 5.375% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 5.375% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 5.375% Unsecured Notes Indenture also provides for customary events of default.

Notes Repurchase Program

On June 3, 2022, the Executive Committee of the Board of Directors of the Company authorized the repurchase of up to $200 million aggregate principal amount of the Notes (the "Notes Repurchase Program"). During the year ended December 31, 2022, the Company repurchased $155 million aggregate principal amount of its 9.75% Unsecured Notes for an aggregate repurchase price of $144 million in connection with the Notes Repurchase Program. As of December 31, 2022, the Company had remaining authority to repurchase up to an additional $45 million aggregate principal amount of the Notes in accordance with the Notes Repurchase Program. Future repurchases, if any, under the Notes Repurchase Program will depend on a number of factors, including but not limited to market conditions.

Tender Offer, Redemption and Discharge of 8.25% Secured Notes and 11.5% Unsecured Notes

On February 7, 2020, the Company commenced a tender offer and consent solicitation (the "tender offer") to purchase any and all of its outstanding (i) 8.25% Secured Notes issued pursuant to the indenture, dated as of April 29, 2016, among the Company, the guarantors party thereto and Wilmington Trust, National Association, as trustee (as amended, supplemented or otherwise modified, the "8.25% Secured Notes Indenture") and (ii) 11.5% Unsecured Notes issued pursuant to the indenture, dated as of April 29, 2016, among the Company, the guarantors party thereto and Wilmington Trust, National Association, as trustee (as amended, supplemented or otherwise modified, the "11.5% Unsecured Notes Indenture"). The early tender deadline for the tender offer was February 21, 2020, and the expiration date for the tender offer was March 6, 2020.

Upon expiration of the early tender deadline, on February 24, 2020, the Company accepted and purchased (i) $623 million of the aggregate principal amount of the 8.25% Secured Notes that were validly tendered for total consideration of $1,052.50 per $1,000 principal amount, plus accrued and unpaid interest thereon, and (ii) $84 million of the aggregate principal amount of the 11.5% Unsecured Notes that were validly tendered for a total consideration of $1,072.50 per $1,000 principal amount, plus accrued and unpaid interest thereon. Following the expiration of the tender offer, on March 9, 2020, the Company accepted and purchased an additional $0.2 million of the aggregate principal amount of the 8.25% Secured Notes that were validly tendered after the early tender deadline for a tender consideration of $1,022.50 per $1,000 principal amount, plus accrued and unpaid interest thereon. No additional 11.5% Unsecured Notes were tendered after the early tender deadline.

On March 9, 2020, (i) pursuant to the 8.25% Secured Notes Indenture, the Company provided notice to the holders that it had elected to redeem any and all of the 8.25% Secured Notes that remain outstanding after giving effect to the tender offer at a redemption price of 104.125%, plus accrued and unpaid interest thereon, on May 1, 2020 (the "8.25% Notes Redemption") and (ii) pursuant to the 11.5% Unsecured Notes Indenture, the Company provided notice to the holders that it had elected to redeem any and all of the 11.5% Unsecured Notes that remain outstanding after giving effect to the tender offer at a redemption price of 105.750%, plus accrued and unpaid interest thereon, on May 1, 2020 (the "11.5% Notes Redemption"). Concurrently with the delivery of the notices of redemption, on March 9, 2020, the Company (i) irrevocably deposited with the trustee for the 8.25% Secured Notes approximately $192 million, which was the amount sufficient to fund the 8.25% Notes Redemption and to satisfy and discharge the Company's obligations under the 8.25% Secured Notes and the 8.25% Secured Notes Indenture, and (ii) irrevocably deposited with the trustee for the 11.5% Unsecured Notes approximately $297 million, which was the amount sufficient to fund the 11.5% Notes Redemption and to satisfy and discharge the Company's obligations under the 11.5% Unsecured Notes and the 11.5% Unsecured Notes Indenture.

Debt Transaction Costs

The Company recognized $115 million of debt transaction costs associated with the various debt financing activities completed during 2020, which are included under the caption "Transaction-related costs" in the Company's accompanying consolidated statement of operations for the year ended December 31, 2020. These debt transaction costs were comprised of $61 million of early termination premiums associated with the tender offer, 8.25% Notes Redemption and 11.5% Notes Redemption, the write-off of $47 million of previously capitalized debt issuance costs associated with the Term Loan Facility, the 8.25% Secured Notes and the 11.5% Unsecured Notes and $7 million of other miscellaneous legal and financing costs.

Finance Lease Obligations

Refer to Note 7 for discussion of the Company's finance lease obligations.

Interest Rate Swap Agreement

On December 21, 2018, the Company entered into an interest rate swap agreement with Citibank, N.A. as counterparty (the "Interest Rate Swap") whereby the Company paid a fixed rate of 2.63% on a notional amount of $1,100 million and received one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and terminated on February 19, 2022. Refer to Note 10 for additional information regarding the Company's accounting for its Interest Rate Swap.

Note 4. Goodwill and Intangible Assets

Goodwill

The following table presents the changes in the carrying amount of goodwill for the years ended December 31, 2022 and 2021 (in millions):

Balance at January 1, 2021	$	2,919
Net goodwill impact related to the Kindred Transaction		1,013
Write-off allocation related to 2021 divestitures		(18)
Balance at December 31, 2021		3,914
Additions related to acquisitions		16
Finalization of the purchase price allocation for the Kindred Transaction		(74)
Write-off allocation related to 2022 divestitures		(45)
Balance at December 31, 2022	$	3,811

Prior to the Kindred Transaction, the Company historically determined that its consolidated business comprised a single reporting unit for goodwill impairment testing purposes. Due to the significance of the Kindred Transaction and the impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280, "Segment Reporting" ("ASC 280") and ASC 350 during 2022 and determined that the Company is now comprised of two distinct reporting units (i) acute hospital operations and (ii) rehabilitation hospital operations. For the annual impairment evaluation, the Company estimates fair values of its reporting units utilizing both a DCF analysis and a GPC analysis. The Company did not recognize any goodwill impairment charges during the years ended December 31, 2022, 2021 and 2020.

Intangible Assets

The following table provides information regarding the Company's intangible assets included in the accompanying consolidated balance sheets as of December 31, 2022 and 2021 (in millions):

	2022	2021
Amortizable intangible assets:		
Physician minimum revenue guarantees and other		
Gross carrying amount	$ 21	$ 24
Accumulated amortization	(12)	(13)
Net total	9	11
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	26	28
Licenses, provider numbers, accreditations and other	48	46
Net total	74	74
Total intangible assets:		
Gross carrying amount	95	98
Accumulated amortization	(12)	(13)
Net total	$ 83	$ 85

Physician Minimum Revenue Guarantees

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or "physician minimum revenue guarantees," with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460, "Guarantees" ("ASC 460"). In accordance with ASC 460, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized as a component of other operating expenses, in the accompanying consolidated statements of operations, over the period of the physician contract, which typically ranges from four to five years.

Certificates of Need and Certificates of Need Exemptions

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and certain equipment at the Company's facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. The Company has acquired facilities in certain states that have adopted certificate of need laws. The Company has determined that these intangible assets have an indefinite useful life.

Licenses, Provider Numbers, Accreditations and Other

To operate hospitals, the Company must obtain certain licenses, provider numbers and accreditations from federal, state and other accrediting agencies. The Company has acquired facilities in certain jurisdictions that require licenses, provider numbers and accreditations.

Kindred Transaction

In connection with the Kindred Transaction, indefinite-lived intangible assets comprised of certificates of need and licenses totaling $42 million were transferred from ScionHealth to the Company, and indefinite-lived intangible assets comprised of certificates of need and provider numbers totaling $6 million were transferred from the Company to ScionHealth.

Amortization Expense

Amortization expense for the Company's intangible assets during the years ended December 31, 2022, 2021 and 2020 was $5 million, $8 million and $9 million, respectively.

Total estimated amortization expense for the Company's intangible assets during the next five years are as follows (in millions):

2023	$ 4
2024	2
2025	2
2026	1
	$ 9

Note 5. Income Taxes

The Company recognized a provision for income taxes of $100 million for the year ended December 31, 2022, and a benefit from income taxes of $27 million and $64 million for the years ended December 31, 2021 and 2020, respectively. The provision for income taxes recognized for the year ended December 31, 2022 is primarily a result of an increase in the valuation allowance for certain deferred tax assets due to the limitation on the deductibility of interest expense under Section 163(j) of the Code (and the regulations thereunder) and write-offs of goodwill associated with divestitures. The benefit from income taxes recognized for the year ended December 31, 2021 is primarily a result of a reduction in the valuation allowance for certain deferred tax assets, partially offset by limitations on the tax deductibility of interest expense (back to its previous limitation of 30% of adjusted taxable income), stock-based compensation expense, write-offs of goodwill associated with divestitures, and certain transaction and advisory costs recognized during the year ended December 31, 2021.

The provision for (benefit from) income taxes for the years ended December 31, 2022, 2021 and 2020 consisted of the following (in millions):

	2022	2021	2020
Current:			
Federal	$ 56	$ 46	$ (73)
State	5	5	8
	61	51	(65)
Deferred:			
Federal	(70)	23	99
State	1	(7)	38
	(69)	16	137
Change in valuation allowance	108	(94)	(136)
Total	$ 100	$ (27)	$ (64)

The following table reconciles the differences between the statutory federal income tax rate to the Company's effective tax rate on net (loss) income before income taxes and including net income attributable to noncontrolling interests and redeemable noncontrolling interests for the years ended December 31, 2022, 2021 and 2020:

	2022	2021	2020
Federal statutory rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal income tax benefits	5.6	(2.6)	3.8
Change in valuation allowance	(102.6)	(83.3)	(56.5)
Tax effect of goodwill write-offs and impairments	(8.7)	9.9	0.2
Noncontrolling interests and redeemable noncontrolling interests	12.8	-	(1.9)
State net operating loss carryforward expirations, refunds and rate and state apportionment changes	(11.2)	-	10.4
Taxes payable and deferred tax liability adjustments	(10.7)	-	-
Rate benefit from federal net operating loss carryback to 35% year	-	-	(3.8)
Nondeductible acquisition and merger-related costs	-	30.2	-
Other nondeductible expenses and other items	(1.3)	1.1	0.4
Effective income tax rate	(95.1) %	(23.7) %	(26.4) %

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects were as follows as of December 31, 2022 and 2021 (in millions):

	2022	2021
Deferred income tax liabilities:		
Depreciation and amortization	$ (98)	$ (130)
Right-of-use operating lease assets	(24)	(61)
Tax deductible goodwill	(28)	(26)
Investments in partnerships	(46)	(123)
Other	(6)	(6)
Total deferred income tax liabilities	(202)	(346)
Deferred income tax assets:		
Provision for doubtful accounts	43	34
Employee compensation	40	51
Net operating loss carryforwards	115	109
Insurance reserves	76	76
Section 163(j) interest expense carryforward	118	47
Investments in partnerships	1	36
Right-of-use operating lease obligations	24	62
Deferred loss on sale of facilities	21	37
Other	50	52
Total deferred income tax assets	488	504
Valuation allowance	(305)	(197)
Net deferred income tax assets	183	307
Deferred income taxes	$ (19)	$ (39)

Noncurrent deferred income tax liabilities totaled $19 million and $39 million at December 31, 2022 and 2021, respectively, and are included under the caption "Other long-term liabilities" on the accompanying consolidated balance sheets. During the year ended December 31, 2022, the Company finalized its accounting for the Kindred Transaction in accordance with ASC 805-50. The Company reduced its deferred income tax liabilities associated with investments in partnerships as of the December 23, 2021 transaction date, by $58 million, with a corresponding reduction to consolidated goodwill of $58 million.

As of December 31, 2022, the Company had federal net operating loss carryforwards ("NOLs") of approximately $106 million with an indefinite carryforward period and subject to annual usage limitations under Section 382 of the Code. In addition, the Company had state and local NOLs of approximately $2 billion that expire at various dates between 2023 and 2042 or have an indefinite carryforward period.

The Company has established a valuation allowance for deferred tax assets at December 31, 2022 and 2021, due to the uncertainty of realizing these assets in the future. During the year ended December 31, 2022, the Company increased its valuation allowance by $108 million primarily because of the limitation on the deductibility of interest expense under Section 163(j) of the Code. During the year ended December 31, 2021, the Company reduced its valuation allowance by $163 million as a result of the transfers and utilization of certain net deferred tax assets and liabilities between the Company and ScionHealth.

The Company made federal income tax payments of $20 million, $50 million, and $33 million for the years ended December 31, 2022, 2021 and 2020, respectively. A net refund of federal income taxes previously paid by Legacy Lifepoint for the tax year ended December 31, 2013, in the amount of $23 million was received during the year ended December 31, 2021 related to the carryback of the final Legacy Lifepoint federal NOL generated for the year ended November 16, 2018, to the tax year ended December 31, 2013. The 2017 tax year refund resulted from an automatic accounting method change, for tax purposes, related to income recognition made by Legacy Lifepoint. The Company made net state and local income tax payments in the amount of $8 million, $17 million, and $5 million for the years ended December 31, 2022, 2021 and 2020, respectively.

The Company's policy is to accrue interest and penalties related to potential underpayment of income taxes within the provision for income taxes. Interest is computed on the difference between the Company's uncertain tax benefit positions and the amount deducted or expected to be deducted in our income tax returns. During the year ended December 31, 2022, the Company increased taxes payable by $6 million for an uncertain tax benefit position associated with prior years.

The Company files a consolidated U.S. federal income tax return, as well as income tax returns in various state jurisdictions. All of the Company's tax years are subject to examination by the Internal Revenue Service and various state taxing authorities.

Note 6. Other Current Liabilities

The following table provides information regarding the Company's other current liabilities, which are included in the accompanying consolidated balance sheets at December 31, 2022 and 2021 (in millions):

	2022	2021
Accrued interest	$ 86	$ 44
Current portion of self-insurance reserves	74	79
Current portion of right-of-use operating lease obligations	71	61
Self-insured medical benefits liabilities	50	46
Medicaid supplemental payment program provider taxes	25	23
Accrued property taxes	24	23
Accrued expenses and other	215	245
	$ 545	$ 521

Note 7. Leases

Summary

The Company leases real property and equipment under finance and operating leases. The leases expire at various times and have various renewal options. For leases with terms greater than 12 months, the Company records the related assets and obligations at the present value of lease payments over the term. Interest rates used in computing the present value of the lease payments are based on the Company's incremental borrowing rate at the inception of the lease. The Company's lease agreements generally require the Company to pay maintenance, repairs, taxes and insurance costs.

The following table presents certain information related to the Company's lease assets and liabilities at December 31, 2022 and 2021 (dollars in millions):

	Balance Sheet Classification	2022	2021
Assets:			
Finance leases	Property and equipment, net	$ 514	$ 635
Operating leases	Other long-term assets	638	609
Total lease assets		$ 1,152	$ 1,244
Liabilities:			
Current:			
Finance leases	Current maturities of long-term debt	$ 29	$ 106
Operating leases	Other current liabilities	71	61
Long-term:			
Finance leases	Long-term debt, net	780	805
Operating leases	Other long-term liabilities	572	546
Total lease liabilities		$ 1,452	$ 1,518
Weighted-average remaining term (in years):			
Finance leases		17.0	13.2
Operating leases		9.7	10.1
Weighted-average discount rate:			
Finance leases		9.6 %	6.4 %
Operating leases		7.6 %	7.3 %

The following table presents certain information related to finance and operating lease expense for the years ended December 31, 2022, 2021 and 2020 (in millions):

	Statement of Operations Classification	2022	2021	2020
Finance lease expense:				
Amortization related to lease assets	Depreciation and amortization	$ 44	$ 44	$ 47
Interest related to lease liabilities	Interest expense, net	49	82	91
Operating lease expense	Other operating expenses, net	114	76	86
Short-term, variable and other lease expense	Other operating expenses, net	42	45	47
Total lease expense		$ 249	$ 247	$ 271

The following table presents supplemental cash flow information related to finance and operating leases for the years ended December 31, 2022, 2021 and 2020 (in millions):

	2022	2021	2020
Operating cash flows related to operating leases	$ 149	$ 118	$ 128
Operating cash flows related to finance leases	$ 53	$ 79	$ 82
Financing cash flows related to finance leases	$ 34	$ 29	$ 20

The following table reconciles the undiscounted cash flows to the finance and operating lease obligations included in the consolidated balance sheet at December 31, 2022 (in millions):

	Finance Leases	Operating Leases
2023	$ 87	$ 116
2024	87	104
2025	87	98
2026	82	90
2027	72	81
Thereafter	993	444
Total minimum lease payments	1,408	933
Less: Amounts attributable to interest	(1,068)	(290)
Present value of minimum lease payments	340	643
Non-cash portions of finance lease obligations	469	-
Less: Current portions of lease obligations	(29)	(71)
Long-term portion of lease obligations	$ 780	$ 572

Kindred Transaction

In connection with the Kindred Transaction, effective December 23, 2021, right-of-use operating lease assets and liabilities of $439 million and $435 million, respectively, were transferred from ScionHealth to the Company, and right-of-use operating lease assets and liabilities of $21 million and $22 million, respectively, were transferred from the Company to ScionHealth. Additionally, the Company transferred finance lease obligations with a carrying value of $332 million to ScionHealth.

MPT Lease Modifications

On August 1, 2021, the Company sold KershawHealth, which was subject to the Amended and Restated Master Lease Agreement with certain affiliates of MPT, dated March 21, 2016 (the "Capella Master Lease") and paid $28 million to MPT to terminate its lease obligation associated with KershawHealth. The removal of KershawHealth from the Capella Master Lease triggered a lease modification for accounting purposes in accordance with ASC 842, which resulted in the reclassification of right-of-use operating lease assets and obligations of $98 million and $106 million, respectively, related to certain other properties subject to the Capella Master Lease, to property and equipment and finance lease obligations of $129 million and $137 million, respectively.

Effective December 23, 2021, the Company terminated the Capella Master Lease, the Amended and Restated Hot Springs Master Lease Agreement with certain affiliates of MPT dated March 21, 2016 (the "Hot Springs Lease") and the Master Lease Agreement with certain affiliates of MPT dated December 17, 2019 (the "2019 Master Lease"), and certain subsidiaries of the Company entered into a new master lease agreement with certain affiliates of MPT, dated December 23, 2021, with respect to ten of the Company's facilities (the "2021 Master Lease"). The entry into the 2021 Master Lease triggered a lease modification for accounting purposes in accordance with ASC 842, which resulted in the reclassification of right-of-use operating lease assets and obligations of $61 million and $66 million, respectively, to property and equipment and finance lease obligations of $41 million and $46 million, respectively. All of the facilities subject to the 2021 Master Lease are accounted for as finance leases as of December 31, 2022.

Effective May 1, 2022, the Company sold Western Plains, which was subject to the 2021 Master Lease. In connection therewith, the 2021 Master Lease was amended. The purchase of Western Plains from MPT triggered a lease modification for accounting purposes in accordance with ASC 842, which resulted in the derecognition of a $33 million finance lease obligation related to Western Plains, and the recognition of additional property assets and finance lease obligations of $6 million related to certain other properties subject to the 2021 Master Lease.

Effective December 13, 2022, the 2021 Master Lease was amended to, among other things, provide for a five-year extension and amendment of certain financial covenants. Additionally, as a result of increases in the discount rates associated with the 2021 Master Lease, the Company's finance lease obligations include a non-cash end-of-term deferred gain of $462 million.

Lease Covenants

Certain of the Company's lease agreements, including the 2021 Master Lease and the Springstone Master Lease, contain financial covenants, including required minimum lease coverage and fixed charge coverage ratios. The Company's lease agreements generally include non-financial covenants, which may include those requiring the Company to maintain licenses necessary for operation of a facility or required for certification under Medicare or Medicaid. The failure to comply with or obtain a waiver of such covenants or otherwise cure such non-compliance could result in an event of default under the applicable lease. Certain of the Company's lease agreements, including the 2021 Master Lease and the Springstone Master Lease, are structured as master leases under which certain defaults related to one facility may result in a default on the entire portfolio subject to the applicable master lease agreement.

Note 8. Investments and Notes Receivable

Investments

The Company accounts for its investments in entities in which the Company does not control under either the cost method or the equity method of accounting in accordance with ASC 321 or ASC 323, respectively. The Company does not consolidate its cost and equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period or evaluates them for impairment and observable price changes. Investment income is included under the caption "Other operating expenses, net" in the accompanying consolidated statements of operations.

The following table presents the changes in the Company's investments during the years ended December 31, 2022 and 2021 (in millions):

Balance at January 1, 2021	$	256
Income		83
Contributions		7
Distributions and other		(61)
ScionHealth Class B Units		350
Other investments recognized in connection with the Kindred Transaction		20
Balance at December 31, 2021		655
Income [(a)]		102
Contributions		26
Distributions and other [(a)]		(99)
Balance at December 31, 2022	$	684

(a) Includes a gain of approximately $60 million recognized in connection with the receipt of a dividend associated with a cost method investment.

ScionHealth Class B Units

In connection with the Kindred Transaction, Lifepoint acquired Class B Units in ScionHealth (the "Class B Units") with an aggregate initial value of $350 million. The Class B Units in ScionHealth, a privately held company, do not have a readily determinable fair value, and therefore, the Company has accounted for the Class B Units using the measurement alternative in accordance with ASC 321. The Company's investment in the Class B Units was recorded at $350 million and is included under the caption "Investments" in the accompanying consolidated balance sheets at December 31, 2022 and 2021. The Company noted no observable price changes or transactions between the date of acquisition and December 31, 2022. The Class B Units are perpetual non-convertible, non-voting units that accrue cumulative dividends at the rate of 10.00% per annum and, upon liquidation, are entitled to a return of their nominal value issue price of $350 million plus accrued, unpaid dividends.

Investments Related to Lifepoint Forward Innovation Strategy

In connection with the Lifepoint Forward innovation strategy, the Company made investments of cash and contributions of existing investments and securities into certain unconsolidated but affiliated entities owned by the Company, Parent, ScionHealth and other affiliated entities (collectively, "Forward Health Ventures"). Forward Health Ventures, in turn, makes targeted and strategic investments in new and existing early-stage enterprises primarily focused on developing meaningful solutions to enhance quality, increase access to care, and improve value across our enterprise, including a significant focus on digital health capabilities that span the healthcare continuum. In exchange for the Company's investments of cash and contributions of existing investments and securities, Forward Health Ventures has issued to Lifepoint noncontrolling equity interests and perpetual cumulative preferred instruments. At December 31, 2022 and 2021, in the aggregate, the Company's cost method investment in Forward Health Ventures totaled $53 million and $31 million, respectively. In addition to the cost method investment in Forward Health Ventures, the Company also entered into management and administrative services arrangements with Forward Health Ventures and commercial arrangements with certain underlying early-stage enterprises, including pilot and services agreements and a revolving credit facility that the Company provides to one of these enterprises. The revolving credit facility provides for loans up to approximately $8 million, has a 5-year maturity (or earlier upon our demand) and bears interest at 9.00%. At December 31, 2022, $6 million was drawn and outstanding.

Notes Receivable

On March 10, 2022, certain of the Company's subsidiaries invested approximately $47 million for an aggregate $50 million principal amount of ScionHealth's senior secured term loan (the "Term Loan Note Receivable"). The Term Loan Note Receivable matures on December 23, 2028 and bears interest at a rate equal to, at ScionHealth's option, (a) a eurocurrency rate plus an applicable margin of 5.25% or (b) a base rate plus an applicable margin of 4.25%. The Company has accounted for the Term Loan Note Receivable in accordance with ASC 310, "Receivables". At December 31, 2022, the Term Loan Note Receivable had a carrying value of approximately $46 million and is included under the caption "Other long-term assets" on the Company's accompanying consolidated balance sheet.

Note 9. Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling Interests

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

The following table presents the changes in the Company's noncontrolling interests during the years ended December 31, 2022 and 2021 (in millions):

Balance at January 1, 2021	$	32
Net income attributable to noncontrolling interests		5
Cash distributions		(3)
Noncontrolling interests recognized in connection with the Kindred Transaction		317
Balance at December 31, 2021		351
Net income attributable to noncontrolling interests		65
Cash distributions, net of contributions		(84)
Finalization of the purchase price allocations for the Kindred Transaction		(24)
Non-cash contributions from joint venture partners		17
Balance at December 31, 2022	$	325

Redeemable Noncontrolling Interests

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

The following table presents the changes in the Company's redeemable noncontrolling interests during the years ended December 31, 2022 and 2021 (in millions):

Balance at January 1, 2021	$	181
Net income attributable to redeemable noncontrolling interests		4
Distributions and repurchases		(23)
Redeemable noncontrolling interests transferred in connection with the Kindred Transaction		(23)
Balance at December 31, 2021		139
Net income attributable to redeemable noncontrolling interests		1
Sale of redeemable noncontrolling interest units		5
Distributions and repurchases		(5)
Fair value adjustments		3
Balance at December 31, 2022	$	143

Note 10. Fair Value of Financial Instruments

Fair Value Hierarchy

Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the fair value hierarchy pursuant to ASC 820, "Fair Value Measurements and Disclosures" ("ASC 820") that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

Level 1: Quoted market prices in active markets for identical assets or liabilities.
Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.
Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability.

Cash and Cash Equivalents, Accounts Receivable, Accounts Payable and Other Current Liabilities

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

Long-Term Debt

The carrying amounts and fair values of the Company's ABL Facility, Term Loan Facility, 6.75% Secured Notes, 4.375% Secured Notes, 9.75% Unsecured Notes and 5.375% Unsecured Notes, excluding unamortized debt issuance costs, as of December 31, 2022 and December 31, 2021 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2022	December 31, 2021	December 31, 2022	December 31, 2021
ABL Facility	$ -	$ -	$ -	$ -
Term Loan Facility	$ 3,215	$ 3,215	$ 3,014	$ 3,211
6.75% Secured Notes	$ 600	$ 600	$ 563	$ 626
4.375% Secured Notes	$ 600	$ 600	$ 506	$ 603
9.75% Unsecured Notes	$ 1,270	$ 1,425	$ 1,024	$ 1,500
5.375% Unsecured Notes	$ 500	$ 500	$ 281	$ 493

The fair values of the Company's long-term debt instruments were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820.

Interest Rate Swap

The Company measured its Interest Rate Swap at fair value on a recurring basis. The fair value of the Company's Interest Rate Swap is based on quotes from its counterparty. The Company considers those inputs to be Level 2 in the fair value hierarchy. At December 31, 2021 the fair value of the Company's Interest Rate Swap was a total liability of $4 million. At December 31, 2021, the total liability is included under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheet.

The Company has not designated its Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging." Accordingly, all changes in the fair value of the Company's Interest Rate Swap were recognized through interest expense in its statements of operations. The Company recognized non-cash interest income of $4 million and $27 million during the years ended December 31, 2022 and 2021, respectively, compared to non-cash interest expense of $7 million during the year ended December 31, 2020 related to changes in the fair value of its Interest Rate Swap. The Interest Rate Swap terminated on February 19, 2022.

Financial Liabilities

The Company has a contingent consideration liability payable to the former owners of Canyon Vista Medical Center ("Canyon Vista") that represents the Level 3 estimated fair value of the contingent consideration using unobservable inputs and assumptions available to the Company. The key assumptions used in estimating the fair value of the Canyon Vista contingent consideration liability are the range of probabilities that the payments will be earned by the seller and a discount rate adjusted for the Company's credit risk.

At December 31, 2022 and 2021, the Canyon Vista contingent consideration liability was recorded at an estimated fair value of $12 million and $19 million, respectively, of which $1 million and $2 million is included under the caption "Other current liabilities" at December 31, 2022 and 2021, respectively, and $11 million and $17 million, respectively, is included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheets. For the years ended December 31, 2022 and 2020, the Company recognized a non-cash gain and non-cash charge of $4 million and $5 million, respectively, related to the change in the estimated fair value of the Canyon Vista contingent consideration liability, which is included under the caption "Other non-operating losses, net" on the accompanying consolidated statement of operations.

Note 11. Employee Benefit Plans

Defined Benefit Pension Plans

The Company maintains certain assets and assumed certain liabilities associated with two separate defined benefit pension plans (i) associated with certain employees of Marquette General Hospital covered by a collective bargaining agreement (the "Marquette Pension Plan") and (ii) associated with certain non-union employees of Bell Hospital (the "Bell Pension Plan" and, collectively with the Marquette Pension Plan, the "Pension Plans"). Both Pension Plans are closed to new participants. Participants in the Marquette Pension Plan are required to make annual contributions totaling 6% of annual compensation to the Marquette Pension Plan to continue accruing benefits. Participants in the Bell Pension Plan no longer accrue benefits. The Company makes contributions to the Pension Plans sufficient to meet its minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended.

Status and Expense

The following table presents the changes in the benefit obligations and plan assets of the Pension Plans during the years ended December 31, 2022 and 2021 and the unfunded liability of the Pension Plans at December 31, 2022 and 2021 (in millions):

	2022	2021
Change in benefit obligations:		
Benefit obligations at beginning of year	$ 73	$ 77
Service costs	1	1
Interest costs	2	2
Actuarial gains	(19)	(4)
Benefits paid	(2)	(3)
Benefit obligations at end of year	55	73
Change in plan assets:		
Fair value of plan assets at beginning of year	59	54
Actual (loss) return on plan assets	(11)	5
Employer contributions	1	2
Benefits and expenses paid	(2)	(2)
Fair value of plan assets at end of year	47	59
Unfunded pension benefit obligations	$ 8	$ 14

The Company recognizes changes in the funded status of the Pension Plans as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). For the years ended December 31, 2022 and 2021, the Company recognized comprehensive gains of $4 million and $6 million, respectively, as an increase in equity. These adjustments were primarily related to changes in the Company's unfunded pension liability due to changes in the discount rates and mortality assumptions used to measure the projected benefit obligation.

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligations as of December 31, 2022 and 2021 (in millions):

	2022	2021
Discount rate	5.1 %	2.8 %
Rate of compensation increases, when applicable	3.0 %	3.0 %

Plan Assets

At December 31, 2022, the Pension Plans' investments include a balance of mutual funds and money market funds in order to achieve an overall rate of return that minimizes the need for additional employer contributions. The Company measures the fair value of its Pension Plans' assets in accordance with ASC 820. The Pension Plans' investments in mutual funds are valued at the net asset value ("NAV") of shares reported in the active market in which the funds are traded. Because quoted prices are available for mutual funds and the markets in which they are traded are generally considered active, the Company has classified each of them as a Level 1 investment. The Pension Plans' investments in money market funds are valued at quoted prices in markets that are not active by a combination of inputs, including but not limited to dealer quotes who are market makers in the underlying funds and other directly and indirectly observable inputs. Because the inputs used to value money market funds are either directly or indirectly observable, but are not quoted prices in active markets, the Company has classified these assets as Level 2 investments. The Pension Plans' investments in pooled, common and collective funds are valued at the NAV of shares owned based on the readily determinable quoted market price that each fund publishes at the end of each day. While the underlying assets are actively traded on an exchange, the pooled, common and collective funds are not and, therefore, the Company has classified these assets as Level 2 investments.

The following table summarizes the assets of the Pension Plans, measured at fair value as of December 31, 2022 and 2021, by major asset category and aggregated by level within the fair value hierarchy (in millions):

	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
December 31, 2022:				
Mutual funds	$ 32	32	-	-
Money market funds	1	-	1	-
Pooled, Common and Collective Funds	14	-	14	-
Total	$ 47	$ 32	$ 15	$ -
December 31, 2021:				
Mutual funds	$ 39	$ 39	-	-
Money market funds	2	-	2	-
Pooled, Common and Collective Funds	18	-	18	-
Total	$ 59	$ 39	$ 20	$ -

The Company does not expect to contribute to the Pension Plans during the year ended December 31, 2023. Additionally, the Company expects to make future benefit payments from the Pension Plans as follows for the years indicated (in millions):

2023	$ 3
2024	3
2025	3
2026	3
2027	4
Five years thereafter	19
	$ 35

Multiemployer Pension Plan

The Company has the obligation to contribute to a multiemployer pension plan on behalf of certain employees covered by collective bargaining agreements, in accordance with the terms of such collective bargaining agreements. The Company's contributions to the multiemployer pension plan are determined based on the terms of the applicable collective bargaining agreements. Multiemployer plans are different from single-employer plans because assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers. Also, if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers. If the Company stops participating in the multiemployer plan, the Company may be required to pay a withdrawal liability based on its portion of the unfunded status of the plan. Currently, the Company does not anticipate ending its participation in this plan.

Defined Contribution Plans

During the year ended December 31, 2022, the Company maintained a defined contribution retirement plan covering a majority of its employees. This defined contribution plans contains discretionary matching contribution formulas and definite non-elective contribution formulas for employees at certain facilities. The Company's expense related to its defined contribution plans was $28 million, $30 million and $31 million for the years ended December 31, 2022, 2021 and 2020, respectively.

Deferred Compensation Plans

The Company maintains supplemental deferred compensation plans with respect to certain of its employees and affiliated physicians. As of December 31, 2022 and 2021, the assets associated with these deferred compensation plans were $45 million and $64 million, respectively, and the liabilities were $56 million and $68 million, respectively. These amounts are included under the captions "Other long-term assets" and "Other long-term liabilities", respectively, on the accompanying consolidated balance sheets at December 31, 2022 and 2021.

Note 12. Stock-Based Compensation

The Parent is authorized to issue profits units (the "Units") to employees, executives, directors, and other service providers of the Company, under the terms and conditions of the Parent Partnership Agreement. The Company has determined that the Units are a substantive class of members' equity for accounting purposes because the Units are legal equity of the Parent, they have participation features, including distribution and liquidation rights, which allow them to participate in the residual returns of the Parent and vested interests are retained upon termination, subject to certain repurchase rights. As a result, these awards are accounted for under ASC 718, "Compensation – Stock Compensation" ("ASC 718").

In June 2021, certain affiliates of the Parent completed the sale of the Parent, including the Company and its subsidiaries, to other affiliates of the Parent (the "Parent Transaction"). Following the Parent Transaction, the Company continues to be owned by affiliates of the Parent and the transaction had no business or operational impact on the Company. However, in connection with the Parent Transaction, all unvested and outstanding Units held by certain current employees, executives, and directors of the Company became vested. The Company has accounted for this event as a modification in accordance with ASC 718 and recognized additional stock-based compensation expense of $112 million during the nine months ended September 30, 2021 related to the modification and accelerated vesting of such Units. Additionally, for the nine months ended September 30, 2021, the Company made cash distributions to the Parent of $93 million to partially fund the Parent's repurchase of certain previously issued Units and capital units, primarily held by certain former employees, as well as certain current employees, executives, and directors of the Company.

Following the Parent Transaction, on June 25, 2021, an aggregate of 20,775,000 Units were granted to certain executives and employees of the Company under the Parent Partnership Agreement and a newly adopted equity incentive plan and an additional 1,000,000 Units were granted on September 28, 2021. Approximately 2,800,000 units were granted in 2022 to certain executives, directors, and certain of our employees and our affiliates' employees.

Service Units

Service Units have been granted to certain members of the board of directors and Tranche A Units have been granted to certain of our employees and executives and certain of our affiliates' employees. Units that have been granted to members of the board of directors vest on a time-basis only, on the date that is the earliest of (i) six months and one day following grant date or (ii) the date of the applicable director's termination of service due to death, disability or as a result of the director's removal from the board of directors other than for cause. Tranche A Units granted to certain employees and executives vest in equal installments on the last day of each of the first twenty calendar quarters that commence on or after the grant date. Service Units and Tranche A Units will automatically vest upon the sale of the Company. In the event of an initial public offering, all unvested Service Units and Tranche A Units will remain outstanding and continue to vest based on the stated vesting pattern. Unvested Service Units and Tranche A Units are forfeited upon a holder's termination of service.

Service Units and Tranche A Units are accounted for as equity awards and related compensation expense is recognized ratably over the vesting period. As of December 31, 2022, Service Units had unrecognized compensation expense of $17 million. The expense is expected to be recognized over a weighted-average period of 1.9 years from December 31, 2022.

Performance Units

Performance Units, which have been granted as Tranche B Units and Tranche C Units, will vest based upon equity holders of the Parent realizing certain targeted multiples of invested capital ("MOIC thresholds"). Performance Units are accounted for as equity awards with expense recognition occurring upon the realization of the stated MOIC thresholds due to a liquidity event. Unvested Units that do not vest on termination are forfeited upon such termination, subject to certain conditions.

The following table summarizes the Company's total stock-based compensation expense for the years ended December 31, 2022, 2021 and 2020 (in millions):

	2022	2021	2020
Service Units	$ 5	$ 30	$ 2
Performance Units	-	87	-
	5	117	2
Modification expense for awards classified as a liability	-	-	3
Total stock-based compensation expense	$ 5	$ 117	$ 5

Valuation Assumptions

The fair value of all Units was determined using a Monte Carlo simulation framework. The following table shows the weighted average assumptions used by the Company to develop the fair value estimates and the resulting estimates of weighted-average fair value per Unit granted during the years ended December 31, 2022, 2021 and 2020:

	2022	2021	2020
Common equity value of the Company (in millions)	$ 3,600	$ 3,600	$ 1,999
Expected volatility	63.1 %	63.1 %	48.0 %
Risk-free interest rate	0.92 %	0.92 %	0.60 %
Expected dividends	-	-	-
Average expected term (years)	5.0	5.0	3.7

Units Activity

The following represents the activity of the Units for the years ended December 31, 2022, 2021 and 2020:

	Service Units		Performance Units			
	Tranche A and Units to the Board	Weighted Average Grant Date Fair Value per Unit	Tranche B	Weighted Average Grant Date Fair Value per Unit	Tranche C	Weighted Average Grant Date Fair Value per Unit
Unvested at January 1, 2020	6,727,380	$ 1.19	10,315,890	$ 0.68	5,607,945	$ 0.53
Granted	2,197,487	1.08	2,103,320	1.08	1,051,660	1.08
Vested	(2,217,947)	1.10	-	-	-	-
Forfeited	(75,100)	1.19	(110,000)	0.74	(55,000)	0.60
Unvested at December 31, 2020	6,631,820	1.19	12,309,210	0.75	6,604,605	0.61
Granted	7,329,723	3.51	7,258,331	2.39	7,258,316	2.04
Vested	(7,381,809)	1.41	(12,221,590)	0.75	(6,560,795)	0.61
Forfeited	(30,529)	1.18	(87,620)	0.58	(43,810)	0.38
Unvested at December 31, 2021	6,549,205	3.53	7,258,331	2.39	7,258,316	2.04
Granted	971,400	3.53	916,667	2.39	916,672	2.04
Vested	(1,504,327)	3.53	-	2.39	-	2.04
Forfeited	(953,753)	3.53	(1,118,333)	2.39	(1,118,330)	2.04
Unvested at December 31, 2022	5,062,525	$ 3.53	7,056,665	$ 2.39	7,056,658	$ 2.04

Note 13. Commitments and Contingencies

Capital Expenditure Commitments

The Company is reconfiguring some of its facilities to more effectively accommodate patient services and to provide for a greater variety of services. The Company has incurred approximately $148 million in costs related to uncompleted projects as of December 31, 2022, which is included under the caption “Property and equipment, at cost” in the Company’s accompanying consolidated balance sheet. At December 31, 2022, these uncompleted projects had an estimated cost to complete of approximately $163 million. The estimated timeframe for completion of these projects generally ranges from less than one year up to two years. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities. At December 31, 2022, the Company estimated its total remaining capital expenditure commitments to be approximately $573 million. The majority of this amount represents long-term commitments that are computed as a percentage of revenues at the applicable facility.

Legal Proceedings and General Liability Claims

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

In addition, the Company is subject to the regulation and oversight of various state and federal governmental agencies. Further, under the False Claims Act, private parties have the right to bring qui tam, or “whistleblower,” suits against healthcare facilities that submit false claims for payments to, or improperly retain identified overpayments from, governmental payers. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or “whistleblower” actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act’s requirements for filing such suits. As a result, they could be proceeding without the Company’s knowledge. If a provider is found to be liable under the False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus substantial civil monetary penalties that are subject to annual adjustment for inflation for each separate false claim.

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

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

The Company accrues an estimate for a contingent liability when losses are both probable and reasonably estimable. The Company reviews its accruals each quarter and adjusts them to reflect the impact of developments, advice of legal counsel and other information pertaining to a particular matter.

Note 14. Subsequent Events

In accordance with the provisions of ASC 855, "Subsequent Events," the Company evaluated all material events subsequent to the balance sheet date through March 2, 2023, the date of issuance, for events requiring disclosure or recognition in the Company's consolidated financial statements. There were no subsequent events requiring disclosure or recognition in the Company's consolidated financial statements other than those included elsewhere in the notes to these consolidated financial statements.

Item 16. ***Form 10-K Summary*****.**

None.

SIGNATURES

Lifepoint Health, Inc. has caused this Report to be signed on its behalf by the undersigned thereunto duly authorized.

LIFEPOINT HEALTH, INC.

Date: March 2, 2023

By: /s/ Michael S. Coggin
Michael S. Coggin
Executive Vice President and Chief Financial Officer

ANNUAL REPORT

OF

LIFEPOINT HEALTH, INC.

FOR THE

FISCAL YEAR ENDED DECEMBER 31, 2023

PREPARED IN ACCORDANCE WITH

ANNUAL REPORT ON FORM 10-K
(AS MODIFIED UNDER DEBT AGREEMENTS)

Lifepoint Health, Inc.
(Exact Name of Company as Specified in Its Charter)

Delaware	**27-0500485**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**

330 Seven Springs Way **Brentwood, Tennessee**	**37027**
(Address of Principal Executive Offices)	**(Zip Code)**

(615) 920-7000
(Company's Telephone Number, Including Area Code)

Lifepoint Health, Inc.

Annual Report

For the Fiscal Year Ended December 31, 2023

TABLE OF CONTENTS

DISCLOSURE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report for the fiscal year ended December 31, 2023 (this "***Report***") contains forward-looking statements that involve risks and uncertainties. Forward-looking statements include any statements that address future results or occurrences. In some cases, you can identify forward-looking statements by terminology such as: "may," "might," "will," "would," "should," "could" or the negatives thereof. Generally, the words "anticipate," "believe," "continue," "expect," "intend," "estimate," "project," "plan" and similar expressions identify forward-looking statements. In particular, statements about our expectations, beliefs, plans, objectives, assumptions or future events or performance contained elsewhere in this Report are forward-looking statements. These forward-looking statements include statements that are not historical facts, including statements concerning our possible or assumed future actions and business strategies. We have based these forward-looking statements on our current expectations, assumptions, estimates and projections. While we believe these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks, uncertainties and other factors, many of which are outside of our control, which could cause our actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. Such factors include, among others, the following:

- changes in industry and general economic trends nationally and regionally in our facilities' markets, including negative macroeconomic conditions, high interest rates, general inflationary pressures, disruptions to global supply networks, geopolitical conflict and an ongoing challenging labor market;
- the potential impact on us of financial and capital market instability and/or disruptions to the banking system due to bank failures and other factors, including any potential impact on our ability to access and or obtain the return of cash and cash equivalents, and/or our ability to access credit, liquidity and capital market sources on acceptable terms or at all;
- uncertainty about the effect that recent acquisitions or joint ventures may have on our business, financial condition, results of operations, employees, patients, local communities, business relationships and other parties, and the possibility that the anticipated benefits from recent acquisitions or joint ventures will not be realized within the timeframe expected or at all;
- uncertainty about the effect that integrating acquired facilities, including the effect that our expansion and diversification into new services and segments may continue to have on our employees, patients, local communities, business relationships and other parties;
- our ability to execute our acquisition strategy, including acquisitions of facilities on favorable terms, capital improvements to acquired facilities, and healthcare delivery network diversification;
- our ability to successfully complete asset sales and divestitures on favorable terms;
- the potential for material obligations if we acquire facilities with unknown or contingent liabilities;
- the decline of future patient volumes and related revenues, including shifts from in-person patient services to telehealth services;
- supply shortages, workforce disruptions or shortages and increased costs of providing care to our patients, including increased equipment, staffing and supply expenses;
- the emergence of, and effects related to, pandemics, epidemics and highly contagious infectious diseases, including the impact of any developments related to novel coronavirus ("***COVID-19***") on our business, financial condition, results of operations or cash flow;
- payment changes, including policy considerations and changes resulting from federal and state budgetary restrictions as a result of reductions in government spending, government shutdowns or otherwise;
- impact from or likelihood of the repeal of, or material modification to, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "***Affordable Care Act***"), as a result of court or legislative action;
- impact from changes to or limitations on Medicaid supplemental payment programs;
- our compliance with new and existing laws and regulations, as well as costs and benefits associated with compliance;
- any potential action brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the "qui tam" or "whistleblower" provisions of the federal False Claims Act (the "***False Claims Act***");
- impact from the changes in payer mix marked by a shift of patients from private insurance to Medicare and Medicaid programs;
- claims and legal actions relating to professional liabilities and other litigation risks;
- delayed payments and repayments resulting from reviews of claims to Medicare and Medicaid for our services;
- impact of controls imposed by payers designed to reduce inpatient services;
- risks associated with outsourcing functions to third parties;
- our relationships with our joint venture partners;
- changes in physician employment regulations;
- increases in the amount and risk of collectability of patient accounts receivable, particularly in connection with the increasing number of underinsured and uninsured patients;
- our need to make investments continually in our processes and information systems to protect the privacy of patients, employees and other persons and reduce the risk of successful cybersecurity attacks;
- damage to our reputation, regulatory penalties, legal claims and liability under state and federal laws that we could suffer upon any cybersecurity or privacy breaches;
- our ability to adapt to changes in medical and other technology;

- potential increased expenses and uncertainties related to anticipated capital expenditures, including routine projects, investments in information systems and capital projects related to acquisitions, construction of new facilities and construction projects and the expectation that capital commitments could be a component of future acquisitions;
- effects of competition in a facility's market and in the healthcare industry generally;
- recruitment and retention of senior executives, qualified management, experienced physicians and nurses, and other healthcare professionals;
- effects of union organizing activities;
- potential recoupment of previously recognized income from electronic health record ("***EHR***") incentive programs;
- changes or delays in timeframes for completion of capital projects;
- changes in depreciation and amortization expenses;
- accounting estimates and the impact of accounting methodologies and new accounting pronouncements;
- consolidation of commercial insurance companies and patient shifts to lower cost healthcare plans, including association health plans and short-term limited duration health insurance plans, which generally provide lower payment for services rendered;
- participation in the healthcare insurance exchanges (the "***Exchanges***") and the impact of increasing enrollment by patients in insurance plans with narrow networks, tiered networks, high deductibles or high co-payments;
- governmental or third-party investigations, legal actions and voluntary self-disclosures relating to overpayments or other regulatory compliance matters;
- the ability of our local management teams to identify and meet the needs of our patients, medical staffs and their communities;
- the efforts of insurers, healthcare providers and others to contain healthcare costs;
- our ability to obtain adequate levels of general and professional liability insurance;
- the impact of climate change, extreme weather conditions, natural disasters such as hurricanes and earthquakes, hostilities or acts of terrorism and other criminal activities;
- our ability to implement initiatives promoting cost reductions and operational efficiencies;
- the impact of our existing indebtedness and possible refinancing or future indebtedness that may be incurred; and
- other factors referenced under the caption "Risk Factors" in this Report.

Given these uncertainties, readers are cautioned not to place undue reliance on such forward-looking statements. We disclaim any obligation to update any such factors or to announce the result of any revisions to any of the forward-looking statements contained herein to reflect future results, events or developments.

Statements in this Report are made as of the date hereof unless stated otherwise. New factors emerge from time to time, and it is not possible to predict all such factors.

EXPLANATORY INFORMATION REGARDING THIS REPORT

This Report has been prepared in accordance with the obligations of the Company (as defined in this Report) under (i) Section 4.02 of each of the Indentures (collectively, the "***Indentures***") among the Company, as issuer, each of the subsidiary guarantors party thereto and Wilmington Trust, National Association, as trustee ("***Wilmington Trust***"): (A) dated as of February 13, 2020 relating to the Company's 4.375% Senior Secured Notes due 2027 (the "***4.375% Secured Notes***," and such Indenture, as amended or supplemented from time to time, the "***4.375% Secured Notes Indenture***"); (B) dated as of August 14, 2023 relating to the Company's 9.875% Senior Secured Notes due 2030 (the "***9.875% Secured Notes***," and such Indenture, as amended or supplemented from time to time, the "***9.875% Secured Notes Indenture***"); (C) dated as of October 10, 2023 relating to the Company's 11.00% Senior Secured Notes due 2030 (the "***11.0% Secured Notes***," and such Indenture, as amended or supplemented from time to time, the "***11.0% Secured Notes Indenture"***); (D) dated as of November 16, 2018 relating to the Company's 9.750% Senior Notes due 2026 (the "***9.75% Unsecured Notes***," and such Indenture, as amended or supplemented from time to time, the "***9.75% Unsecured Notes Indenture***"); and (E) dated as of December 4, 2020 relating to the Company's 5.375% Senior Notes due 2029 (the "***5.375% Unsecured Notes***," and together with the 4.375% Secured Notes, the 9.875% Secured Notes, the 11.0% Secured Notes, and the 9.75% Unsecured Notes, the "***Notes***" and such Indenture, as amended or supplemented from time to time, the "***5.375% Unsecured Notes Indenture***,"); (ii) Section 5.04 of the Asset-Based Revolving Credit Agreement, dated as of November 16, 2018 (as amended or supplemented from time to time, the "***ABL Agreement***" and the revolving facility provided thereunder, as amended, amended and restated, supplemented or otherwise modified from time to time, the "***ABL Facility***"), among the Company, as lead borrower, DSB Acquisition LLC, a Delaware limited liability company ("***Holdings***"), the lenders party thereto from time to time and Citibank, N.A., as administrative agent and collateral agent; and (iii) Section 5.04 of the Amended and Restated First Lien Credit Agreement, dated as of November 16, 2018 (as amended, or supplemented from time to time, the "***Term Loan Agreement***", the term loan facility provided thereunder, the "***Term Loan Facility***," and the Term Loan Agreement together with the ABL Agreement, the "***Credit Agreements***"), among the Company, as lead borrower, Holdings, the lenders party thereto and Citibank, N.A., as administrative agent and collateral agent. This Report has been prepared in all material respects in accordance with the rules and regulations of the Securities and Exchange Commission (the "***SEC***") applicable to an Annual Report on Form 10-K for the fiscal year ended December 31, 2023, except to the extent exceptions, exclusions and other differences in presentation are permitted to be excluded by the Indentures and the Credit Agreements.

USE OF NON-GAAP FINANCIAL INFORMATION

In this Report, we have provided same-facility information for the three months and years ended December 31, 2023 and 2022, and EBITDA and Adjusted EBITDA (each as defined in this Report) for the three months ended December 31, 2023 and 2022 and the twelve months ended December 31, 2023 and September 30, 2023 (collectively, the "***Non-GAAP Measures***") because we believe they provide the holders of our Notes (the "***Holders***") and the lenders under our Credit Agreements ("***Lenders***") with additional information to measure our performance and evaluate our ability to service our indebtedness. We believe that the presentation of Non-GAAP Measures is appropriate to provide additional information to the Holders and Lenders about certain material non-cash items and about unusual items that we do not expect to continue or to continue at the same level in the future as well as other items. Further, we believe the Non-GAAP Measures provide a meaningful measure of operating profitability because we use them for evaluating our business performance and understanding certain significant items.

The Non-GAAP Measures are not presentations made in accordance with United States ("***U.S.***") generally accepted accounting principles ("***GAAP***"), and our Non-GAAP Measures may not be comparable to similarly titled measures of other companies because such measures may include or exclude other specified items. The Non-GAAP Measures should not be considered as alternatives to operating income or any other performance measures derived in accordance with GAAP as measures of operating performance or cash flows as measures of liquidity. The Non-GAAP Measures have important limitations as analytical tools, and you should not consider them in isolation or as substitutes for analysis of our results as reported under GAAP. Because of these limitations, we rely primarily on our GAAP results and use the Non-GAAP Measures only as a supplement. Refer to Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations" for a description of the calculation and limitations of these measures.

DOCUMENT SUMMARIES AND REQUESTS

This Report contains summaries believed to be accurate with respect to certain documents, but reference is made to the actual documents for complete information. All such summaries, which do not purport to be complete, are qualified in their entirety by such reference. Copies of the documents referred to herein will be made available without cost to Holders and Lenders by making a written or oral request to us. Any such request may be made to us at the following address and telephone number:

Lifepoint Health, Inc.
330 Seven Springs Way
Brentwood, Tennessee 37027
Attn: Chief Legal Officer
Tel. (615) 920-7000

FISCAL YEAR

All references to "fiscal year" are to the twelve months ended December 31 of the year referenced.

OTHER ITEMS

Lifepoint Health, Inc., a Delaware corporation, along with each of its consolidated subsidiaries, is referred to herein as the "***Company***," "***Lifepoint***," "***we***," "***our***," and "***us***," in each case, unless the context otherwise requires.

References in this Report to the "***Sponsor***" refer to certain funds that are affiliates of the Company (the "***Apollo Funds***") that are ultimately controlled and/or managed by certain affiliates of Apollo Management Holdings, L.P. ("***Apollo Management***" and, when acting on behalf of the Apollo Funds, "***Apollo***"), which is an affiliate of Apollo Global Management, Inc.

PART I

Item 1. *Business*.

Our Company

We are a leading provider of healthcare serving patients, clinicians, communities and partner organizations across the healthcare continuum. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a growing diversified healthcare delivery network, which at December 31, 2023 was comprised of 60 community hospital campuses, 39 inpatient rehabilitation facilities ("***IRFs***"), 23 behavioral health facilities ("***BHFs***") and additional sites of care that include acute rehabilitation units ("***ARUs***"), outpatient centers and post-acute care facilities. As of December 31, 2023, we operated 122 healthcare facilities in 31 states throughout the U.S. with approximately 12,000 licensed beds and approximately 50,000 dedicated employees.

We seek to fulfill our mission of *Making Communities Healthier*® and strive to create places where people choose to come for healthcare, physicians and providers want to practice and employees want to work. Additionally, we are committed to upholding our core values, which are champion patient care; do the right thing; embrace individuality; act with kindness; and make a difference together. Together, our shared mission, vision and values guide our work and unite our employees across our organization.

Our Business Strategy

The key elements of our business strategy include:

- *Commitment to the Delivery of Exceptional Quality Patient Care*. Providing high quality patient care is essential to our mission and will always be our top priority across all business units. We believe our quality efforts are central to creating places where people choose to come for healthcare, physicians and providers want to practice and employees want to work. Our National Quality Program provides a structured, evidence-based approach to enhancing quality and patient safety and is nationally renowned. Several factors contribute to providing high quality patient care, including leadership and accountability at all levels of our organization, aligning ourselves with talented physicians and medical staff who share our commitment to quality, and providing a clinical environment that is satisfactory to our patients, physicians and employees. We continually strive to improve physician and employee satisfaction, which we believe is critical to delivering quality patient care. We also partner with academic medical centers, regional health systems and specialty providers to better serve the needs of our communities. In addition, demonstrating our results in delivering high quality patient care is increasingly vital to achieving our operating and financial success, including with governmental and commercial payers.

- *Continue to Grow in Existing Markets by Expanding Services and Access Points to Care*. We regularly conduct in-depth strategic reviews of the major service lines offered at each of our facilities and evaluate additional services through which we could better serve our communities and grow in our markets. We leverage our market-specific knowledge together with input and guidance from our local physician and community leaders to prioritize the healthcare services our communities are seeking. Focus areas include: expansion of specialty service lines to meet unserved or underserved patient needs; expansion of access points to care, including outpatient, ancillary, retail and virtual health services; and investment in technology and equipment. We invest strategically in our markets in order to increase the quality and scope of services we provide, meet the needs of our communities and maintain our strong reputation as the healthcare provider of choice. This, in turn, helps us to continue recruiting physicians and growing the revenue of our facilities. We are also focused on leveraging our rehabilitation and behavioral health capabilities to bring much-needed services to our existing acute facilities.

- *Continue to Expand Our Rehabilitation and Behavioral Health Joint Venture De Novo Pipeline*. We have a deep pipeline of de novo rehabilitation and behavioral health opportunities in development and under construction through which we expect to drive meaningful growth in new and existing markets across the country over the coming years. With respect to inpatient rehabilitation, as of December 31, 2023, we have 10 facilities under construction, 12 facilities under definitive agreement and 11 facilities with signed letters of intent ("***LOIs***"), or 33 total de novo facilities. With respect to behavioral health, as of December 31, 2023, we have two facilities under construction, four facilities under definitive agreement and 13 facilities with signed LOIs, or 19 total de novo facilities. We can make no assurance that we and/or our joint venture partners will acquire any of the facilities that are currently subject to a LOI or definitive agreement or what the timing of any such acquisition will be. We continue to expand this pipeline, including through opportunistic acquisitions, such as the Everest Operational IRF Transaction (as defined in this Report). We believe growth through this de novo pipeline model is highly attractive, given the limited capital requirements and the alignment of our and our joint venture partners' interests.

- *Continue to Recruit and Retain Leading Physicians and Nurses.* Our physician and nurse engagement strategies drive our ability to enhance and expand our services to meet the healthcare needs of our communities. We have a comprehensive recruiting program that is directed by experienced departments at our Health Support Center ("***HSC***") and is supported at the local level by our hospital system chief executive officers and Boards of Trustees. We supplement our local teams with experienced specialists at our HSC and several third-party recruiting firms to assist us in identifying candidates that match the profile of our needs. We believe our physicians and nurses are attracted to our facilities because of several factors, including our commitment to quality care, our focus on employing and developing high quality support staff, and our integration into, and support of, the communities we serve. In addition, we maintain a flexible approach to aligning our goals with our physician partners, including our willingness to recruit physicians through multi-year employment and/or income guarantee arrangements. During 2023, we recruited 194 net new physicians and advance practice providers to our same-facility acute care hospital communities in primary care and specialty areas, compared to 22 net new physicians in the prior year. Additionally, we increased the number of employed nurses available at the bedside in our same-facility acute care hospital portfolio by 536 nurses during 2023.

- *Continue to Focus on Operational Efficiency*. We strive to improve our operating performance by making our administrative support functions as effective and efficient as possible in order to enable our healthcare providers to focus on patient care. We are currently focused on the implementation of a comprehensive shared services program within our Enterprise Business Services team, further centralizing key nonclinical administrative processes, such as finance, human resources, supply chain and marketing, in order to most effectively and efficiently deploy these services to support healthcare providers in our markets. As part of our comprehensive shared services program, we have invested in an enterprise resource planning ("***ERP***") technology solution. We believe this model is the most cost-effective and efficient approach to managing our non-clinical business functions across multi-facility enterprises. We have begun development and testing of our ERP, which will continue throughout 2024, with deployment expected to begin in waves in 2025.

- *Attracting and Retaining Experienced Executive Management and Leadership Teams.* Our executive management team has an average of more than 20 years of healthcare industry experience with a proven record of achieving strong operating and quality results. The executive management team is highly respected in the healthcare industry and has significant experience in managing and acquiring hospitals. Our executive management team is led by David Dill, who serves as our Chairman and Chief Executive Officer. Mr. Dill has more than 20 years of operational and financial leadership experience in the healthcare industry.

Our Competitive Strengths

We believe the following factors allow us to deliver on our mission and business strategies successfully:

- *Scaled, Diversified Healthcare Platform.* Lifepoint is a scaled, national platform, with more than 300 sites of care spread across 31 states as of December 31, 2023. Our scale enables us to develop and deploy shared national capabilities – across workforce development, physician recruiting, and technology, to name a few – into our markets to improve our local teams' ability to care for their communities. We also see benefits of our scale in our national sourcing and procurement platform. Lifepoint's diversification limits business concentration with any particular state, payer or service line. Lifepoint's five largest states constitute less than 50% of revenue for the year ended December 31, 2023, with the largest state constituting approximately 13% of revenue for the year ended December 31, 2023. Lifepoint's payer mix is diversified, with limited self-pay and minimal reliance on a single state Medicaid program or a single commercial payer. Lifepoint's service line mix is highly complementary, with a focus on high-acuity and complexity, with the largest service line comprising only approximately 30% of revenue for the year ended December 31, 2023. This diversification helps insulate Lifepoint from changes in reimbursement rates or policies related to a particular state, payer or service line.

- *Leading Acute Care Business.* We believe that Lifepoint's acute care business has a strong foundation of high quality and stable markets. Lifepoint has #1 market share in the majority of our acute care markets as of December 31, 2023, and is one of the largest employers and taxpayers in each of our communities. This high community relevance results in strong payer relations and helps facilitate physician and staff recruiting. Beyond our hospital campuses, Lifepoint operates comprehensive healthcare networks in our communities that span the entire continuum of care, including primary care and specialist physician practices, imaging centers, urgent care centers, cancer centers, freestanding emergency departments and ambulatory surgery centers. A critical component of these networks is our physician / employed provider enterprise, which includes approximately 3,000 providers across primary and specialty care. These employed providers and healthcare networks are highly complementary with our core inpatient facilities, supporting volume growth and ultimately, we believe, improving patient outcomes.

- *Established Rehab Business with Differentiated Growth Outlook.* Following the acquisition of Kindred Healthcare, LLC's ("***Kindred***") IRF and ARU portfolio, we are one of the largest providers of inpatient rehabilitation services in the nation as of December 31, 2023, delivering care to those who have experienced a loss of function from an injury or illness. The Health Resources and Services Administration of the U.S. Department of Health and Human Services ("***HHS***") ranked 10 of our IRFs in the top 10% in the nation and Newsweek ranked five of our IRFs as first in their state with regard to quality and outcomes in 2023. We largely operate these facilities as joint ventures with some of the country's largest health systems, including Ascension, Tampa General Hospital and Penn Medicine, among others. Lifepoint has longstanding and strong relationships with these partners, who value our industry-leading clinical performance and rehabilitation expertise. We maintain a deep pipeline of de novo joint venture partnership opportunities intended to bolster our growth, including, as of December 31, 2023, 10 facilities under construction, 12 facilities under definitive agreement and 11 facilities with signed LOIs. We believe our strong track record in de novo joint venture partnerships and the strong value proposition that we bring our partners position us well to continue to expand our rehabilitation services business over the coming years.

- *Growing Behavioral Business.* In our behavioral health business, following the Kindred Transaction and the Springstone Transaction (each as defined in this Report), Lifepoint is now a leading national provider of inpatient behavioral health services as well as various outpatient programs and services. We recognize that there is a widespread and critical need for expanding access to behavioral health services and believe that our platform is well-positioned to bring more of such services to both new communities as well as Lifepoint's existing communities. We believe we are well positioned to grow our behavioral health business given the expertise we have inherited from Springstone (as defined in this Report), as well as our strong track record in our rehabilitation joint venture partnerships with leading health systems that provides a "playbook" for growth in behavioral health as well. As of December 31, 2023, our behavioral health de novo joint venture partnership pipeline includes two facilities under construction, four facilities under definitive agreement and 13 facilities with signed LOIs.

- *Lifepoint Forward Innovation Strategy and AdvantagePoint Clinically Integrated Network.* Through our innovation strategy, Lifepoint Forward, we are developing meaningful solutions leveraging technology to enhance patient care quality, increase access to care, and improve efficiency across the Lifepoint footprint and communities across the country. This includes a significant focus on digital health capabilities that span the healthcare continuum. For example, we have implemented new technologies for on-demand telehealth services, artificial intelligence functionality, online scheduling for in-person and telehealth visits, virtual check-in and waiting room options, remote patient monitoring, data interoperability and advanced analytics of medical records, and computational linguistics designed to identify at-risk patients. We have also augmented our innovation strategy through our venture incubation studio, 25m Health, a partnership with venture capital firm 25madison focused on investing in and incubating growth companies with innovative solutions to help improve care in Lifepoint's markets. Additionally, through our clinically integrated network, AdvantagePoint Health, we provided quality-driven, value-based care to approximately 230,000 patients as of December 31, 2023. AdvantagePoint improves quality by aligning providers across the continuum of care and enhances coordination to ensure delivery of the right care for patients, in the right setting, and with the right resources.

Recent Updates to Our Business

Kindred Transaction

On June 18, 2021, we entered into a securities purchase agreement (the "***Kindred Purchase Agreement***") for us and/or one or more affiliated assignees to acquire, directly or indirectly, Kindred, a leading specialty hospital company that operated facilities providing post-acute care, rehabilitation services and behavioral health services throughout the U.S. Upon the closing of the Kindred Transaction, as described below, the Company and Kindred established a new healthcare company operating under the name ScionHealth, which is separate from Lifepoint.

On December 23, 2021, the Company, Kentucky Hospital Holdings JV, LP ("***Knight***"), the indirect parent of Kindred, Knight Health Holdings LLC (d/b/a ScionHealth), a Delaware limited liability company and direct parent of Knight ("***ScionHealth***"), and certain of their respective affiliates entered into reorganization agreements that, among other things, provided for (i) the separation of the IRF, behavioral health, contract rehabilitation service and certain support center businesses (collectively, the "***Knight Transferred Business***") from the businesses of Knight and its subsidiaries, (ii) the separation of the equity and assets comprising 18 select acute care hospitals of the Company (the "***Artemis Business***") from the business of the Company and its subsidiaries, (iii) the transfer of the Knight Transferred Business to the Company, (iv) the transfer of the Artemis Business to Knight, (v) the acquisition by the Company of Class B Units of ScionHealth (the "***Class B Units***"), with an aggregate value of $350 million, and (vi) reciprocal indemnification obligations with respect to the businesses transferred, in each case of clauses (i) through (vi), pursuant to the reorganization, separation and distribution steps described therein, including the assignment by Knight Health, LLC, a Delaware limited liability company formed at the direction of certain affiliates of the Company, of certain rights and obligations under the Kindred Purchase Agreement, including any post-closing purchase price adjustments (the "***Reorganization***"). The Class B Units acquired by the Company are perpetual non-convertible non-voting units that accrue cumulative dividends at the rate of 10.00% per annum and, upon liquidation, are entitled to a return of their nominal value issue price of $350 million plus accrued, unpaid dividends.

On December 23, 2021, concurrently with the consummation of the Reorganization, the Kindred Transaction was consummated. Pursuant to the consummation of the Kindred Transaction and the Reorganization, (i) ScionHealth indirectly holds all of the transferred interests in the Artemis Business, (ii) ScionHealth directly holds all of the issued and outstanding limited partnership interests in Knight, (iii) Kentucky Hospital Holdings JV GP LLC, a Delaware limited liability company and direct subsidiary of ScionHealth, holds all of the issued and outstanding general partnership interests in Knight, and (iv) the Company holds all of the transferred interests in the Knight Transferred Business and the Class B Units. We refer to the foregoing transactions as the "***Kindred Transaction***."

Our acquisition of Kindred's inpatient rehabilitation and contract rehabilitation service business (including 28 IRFs with 1,447 beds), behavioral health business (including two BHFs with 96 beds), and certain support center businesses transformed us into a more diversified healthcare platform, well-positioned to advance healthcare delivery in communities across the country.

Rehabilitation Expansion

We have continued to expand our rehabilitation business since closing the Kindred Transaction. During 2023, we acquired five operational IRFs with 180 total beds in Arkansas, Texas, and Ohio from Everest Rehabilitation Hospitals, LLC ("***Everest***") and entered into a definitive agreement to acquire five additional IRFs under development by Everest, which are anticipated to close on a rolling basis beginning in the second quarter of 2024. Further, during the two years ended December 31, 2023, our consolidated joint ventures have opened six de novo IRFs with approximately 300 beds. As of December 31, 2023, our consolidated inpatient rehabilitation operations include 39 IRFs with approximately 1,900 beds across 19 states. For additional information regarding the foregoing transactions, refer to Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Behavioral Health Expansion

On August 26, 2022, we entered into a definitive agreement with (i) entities affiliated with Medical Properties Trust, Inc. ("***MPT***") and (ii) BH EIK Management, LP, a management company owned by certain members of the executive leadership team ("***Springstone Management***") of Springstone Health Opco, LLC ("***Springstone***"), for an affiliate of the Company (the "***Lifepoint Member***") to acquire a majority ownership interest in Springstone from Springstone Management and to acquire a promissory note issued by Springstone to an affiliate of MPT (the "***Springstone Transaction***"). Springstone was a national behavioral health provider with 18 BHFs and 37 outpatient locations across nine states. Pursuant to the Springstone Transaction, MPT will continue to own the majority of Springstone's real estate locations, subject to an amended and restated master lease between affiliates of MPT and Springstone (the "***Springstone Master Lease***"), and an affiliate of MPT ("***MPT DS***") retained a noncontrolling interest in Springstone, subject to a put/call agreement (the "***Put/Call Agreement***"). The Springstone Transaction was consummated on February 7, 2023, upon which certain of our subsidiaries entered into the Springstone Master Lease, and we funded $229 million in cash to complete the transaction. On January 25, 2024, MPT DS delivered to the Lifepoint Member a put option notice pursuant to the Put/Call Agreement, notifying the Lifepoint Member of its exercise of the put right under the Put/Call Agreement. In accordance with the Put/Call Agreement, the Lifepoint Member is obligated to acquire all of the equity interests of Springstone owned by MPT DS. We expect to close on the purchase of MPT DS's equity interest in Springstone during the three months ended March 31, 2024 for a purchase price of approximately $12 million, following which we will own all of the outstanding equity interests of Springstone.

During fiscal 2023, we also acquired from ScionHealth Cornerstone Behavioral Health El Dorado ("***El Dorado***"), a 54-bed BHF located in Tucson, Arizona (the "***El Dorado Transaction***"), and one of our consolidated joint ventures opened Valley Springs Behavioral Health Hospital, a 150-bed BHF located in Holyoke, Massachusetts. Following these acquisitions, as of December 31, 2023, our consolidated behavioral health operations include 23 BHFs with approximately 1,700 beds across ten states. For additional information regarding the foregoing transactions, refer to Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Our Operations

Services

Our acute care business provides a broad range of medical and surgical services across inpatient and outpatient settings, including general surgery, internal medicine, diagnostic care, cardiology, radiology, oncology, orthopedics, women's services, neurology, rehabilitation services, pediatric services and emergency services. In some of our health systems, we offer specialized services such as open-heart surgery, skilled nursing, psychiatric care and neurosurgery. In many markets, we also provide outpatient services such as same day surgery, laboratory, x-ray, respiratory therapy, imaging, sports medicine and lithotripsy. Lifepoint's acute health systems provide care through a number of different touchpoints in our local markets, including hospitals, ambulatory surgery centers, urgent care centers, freestanding emergency rooms, and physician practices. Our acute health systems play a critical role in our communities, oftentimes serving as the main provider of healthcare and the largest employer in our communities.

Our rehabilitation business is a leading provider of inpatient rehabilitation services to those who have experienced a loss of function from an injury or illness. These services include physical and occupational therapy, rehabilitation nursing, speech-language pathology, internal medicine and medical subspeciality consultation, and nutritional services. This care is provided in our IRFs and ARUs in partnership with some of the nation's largest health systems.

Our behavioral health business provides inpatient behavioral health care in freestanding specialty hospitals as well as specialized units within community hospitals. We also administer other intensive outpatient programs throughout our footprint.

Management and Oversight

Our executive management team has extensive experience in operating a broad range of general as well as specialized healthcare services across a diversified healthcare delivery network and plays a vital role in the strategic planning for our facilities. Our local acute care hospital management teams are typically comprised of a CEO, chief operating officer, chief financial officer and a chief nursing officer, and our local IRF and BHF management teams are typically comprised of a CEO, controller, and chief nursing officer. Local management teams work with each hospital's Board of Trustees or governing board, and our HSC management teams, to develop annual operating plans setting forth growth strategies through the expansion of current services, implementation of new services and the recruitment and retention of physicians in each community, as well as plans to improve operating efficiencies and reduce costs. We believe that the ability of each of these local management teams to identify and meet the needs of patients, medical staffs and the community as a whole is critical to the success of these facilities. We base the compensation for each local management team in part on its ability to achieve the goals set forth in the annual operating plan, including quality of care, patient satisfaction and financial measures.

The Board of Trustees at each acute care hospital, consisting of local community leaders, members of the medical staff and the facility CEO, advises the local management teams and helps develop the strategic operating plan for their facility. In addition, it plays a key role in providing the patient care excellence that we demand. Members of each Board of Trustees are identified and recommended by our local management teams. The Boards of Trustees oversee policies concerning medical, professional and ethical practices, monitor these practices and ensure that they conform to our high standards. We maintain company-wide compliance and quality assurance programs and use patient care evaluations and other assessment methods to support and monitor quality of care standards and to meet accreditation and regulatory requirements.

The majority of our acute care hospitals have a physician engagement group or a physician leadership group comprised of key physicians and members of the facility's administrative team, and the majority of our IRFs have a similar medical executive committee. The mission of such groups is to provide ongoing dialogue between facility administration and members of the medical staff and community physicians primarily in the areas of operations, quality patient care, employee satisfaction and/or community relations.

We also provide support to the local management teams through our HSC resources in areas such as revenue cycle, business office, legal, managed care, clinical efficiency, physician services and other administrative functions. These resources allow for sharing best practices and standardization of policies and processes among all of our facilities.

Cost Management

We strive to improve our operating performance by making our revenue cycle processes more efficient, making an even higher level of purchases through our group purchasing organization, operating more efficiently and effectively, and working to appropriately standardize our policies, procedures and practices across all of our affiliated facilities. Additionally, we are currently focused on the implementation of a comprehensive shared services program within our Enterprise Business Services team, further centralizing key nonclinical administrative processes, such as finance, human resources, supply chain and marketing, in order to deploy these services to support our healthcare providers across our markets. We have begun development and testing of an ERP technology solution, which will continue throughout 2024, with deployment beginning in waves in 2025. We believe this model is the most cost-effective and efficient approach to managing these nonclinical business functions across multi-facility enterprises.

Attracting Patients

We believe that the most important factors influencing a patient's choice in where to receive healthcare services are the quality of care delivered by the facility, the overall reputation of the facility, the availability and expertise of physicians and nurses, and the location and convenience of the facility. Other factors that affect utilization include local demographics and population growth, local economic conditions and the facility's success in contracting with a wide range of local payers.

Outpatient Services

The healthcare industry continues to experience a shift from inpatient services to outpatient services as Medicare, Medicaid and managed care payers have sought to reduce costs by shifting lower-acuity cases to an outpatient setting. Advances in medical equipment technology and pharmacology also have supported the shift to outpatient utilization. However, we expect the decline in inpatient admission use rates to moderate over the long term as the baby boomer population reaches ages where inpatient admissions become more prevalent. We have responded to the shift to outpatient services through expanding service offerings and increasing the throughput and convenience of our emergency departments, outpatient surgery facilities and other ancillary units in our facilities.

Sources of Revenues

General

Our facilities generate revenues by providing healthcare services to our patients. Depending upon the patient's medical insurance coverage, we are paid for these services by governmental Medicare and Medicaid programs, commercial insurance, including health maintenance organizations ("***HMOs***"), preferred provider organizations ("***PPOs***") and plans offered through the Exchanges, private insurers, and directly by the patient. The amounts we are paid for providing healthcare services to our patients vary depending upon the payer. Governmental payers generally pay significantly less than the hospital's customary charges for the services provided. Insured patients are generally not responsible for any difference between customary hospital charges and the amounts received from commercial insurance payers. However, insured patients are responsible for payments not covered by insurance, such as exclusions, deductibles and co-payments.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2023, 2022 and 2021:

	2023	2022	2021
	% of Revenues	% of Revenues	% of Revenues
Medicare	37.4 %	40.1 %	37.7 %
Medicaid	19.1	16.8	18.4
HMOs, PPOs and other private insurers	37.9	37.1	41.3
Self-pay	0.7	0.7	0.6
Other (a)	4.7	5.1	1.8
Revenue from contracts with customers	99.8	99.8	99.8
Rental income	0.2	0.2	0.2
Revenues	100.0 %	100.0 %	100.0 %

(a) Includes revenues from managed ARUs and ancillary goods and services.

Medicare

For the year ended December 31, 2023, approximately 37.4% of our revenues related to patients participating in the Medicare program. Medicare provides hospital and medical insurance benefits, regardless of income, to persons aged 65 and over, some disabled persons and persons with end-stage renal or Lou Gehrig's disease. All of our hospitals are currently certified as providers of Medicare services.

Over the years, the U.S. Congress ("***Congress***") and the Centers for Medicare and Medicaid Services ("***CMS***") have made several sweeping changes to the Medicare program and its reimbursement methodologies, including the numerous changes contained in the Affordable Care Act. Many of these changes have resulted in decreased reimbursement to healthcare providers. In addition, the Budget Control Act of 2011, which is intended to reduce the federal deficit, included, among other things, aggregate reduction of Medicare payments to providers that will remain in effect through 2032, with the exception of a temporary suspension from May 1, 2020 through March 31, 2022, unless additional action is taken by Congress. In addition, the American Rescue Plan Act of 2021 ("***ARP***") increased the federal budget deficit in a manner that triggers an additional sequestration mandated under the Pay As You Go Act of 2010; however, Congress has delayed implementation of this payment reduction until 2025. Additional reductions in Medicare reimbursement could result from changes to the Affordable Care Act, or as a result of the enactment of Medicare reform, deficit reduction or other legislation.

Medicare Inpatient Prospective Payment System

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

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor each federal fiscal year ("***FFY***"), which begins on October 1 (for example, FFY 2024 began on October 1, 2023). The index used to adjust the base MS-DRG payment rate, which is known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. For FFYs 2024, 2023, and 2022, the hospital market basket index increased 3.3%, 4.1%, and 2.7%, respectively. Generally, however, the percentage increase in the MS-DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the Bureau of Labor Statistics' 10-year moving average of changes in annual economy-wide productivity. For FFYs 2024, 2023, and 2022, the productivity adjustment equated to a 0.2%, 0.3%, and 0.7% reduction in the market basket increase, respectively. As a result of these reductions and other changes implemented by CMS, the MS-DRG-rate increased by 3.1% for FFY 2024. Overall, CMS estimates that total Medicare spending on inpatient hospital services, including operating, capital, and new technology changes, would increase by $2.2 billion in FFY 2024.

CMS has implemented a number of programs and requirements that are intended to promote value-based purchasing and to link payments to quality and efficiency. For example, all acute care hospitals are required to participate in CMS' Hospital Inpatient Quality Reporting Program (the "***IQR Program***") in order to receive the full hospital market basket update. Acute care hospitals that do not participate in the IQR Program receive a 25% reduction in their IPPS annual payment update for the applicable FFY. Our acute care hospitals reported all quality measures required by CMS related to the IQR Program and nearly all will receive the full market basket update through FFY 2024. In addition, hospitals that are not meaningful EHR users are also subject to an additional 75% reduction of the hospital market basket increase.

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

Medicare also does not allow an inpatient hospital discharge to be assigned to a higher paying MS-DRG if certain designated hospital acquired conditions ("***HACs***") were not present on admission and the identified HAC is the only condition resulting in the assignment of the higher paying MS-DRG. In those situations, the case is paid as though the secondary diagnosis was not present. In addition, acute care hospitals that fall into the top 25.0% of national risk-adjusted HAC rates for all hospitals in the previous year receive a 1.0% reduction in their total Medicare payments.

Furthermore, inpatient payments are reduced pursuant to the Affordable Care Act if an acute care hospital experiences "excessive readmissions" within a 30-day period of discharge for certain conditions designated by CMS including heart attack, chronic obstructive pulmonary disease, heart failure, pneumonia, coronary artery bypass, and total hip arthroplasty. Hospitals with what HHS defines as "excessive readmissions" for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Each hospital's performance is publicly reported by HHS. HHS has the discretion to determine what "excessive readmissions" means, the amount of the payment reduction and other terms and conditions of this program. The basic maximum payment reduction amount is 3.0%. The 21st Century Cures Act (the "***Cures Act***") does, however, allow for an adjustment factor that would reduce the penalties imposed on hospitals, based on the portion of beneficiaries the hospitals serve that are eligible for both Medicare and Medicaid.

In response to the COVID-19 public health emergency, CMS announced that it would temporarily suppress, or not use, certain acute care hospital performance data that has been affected by COVID-19 in any of its hospital quality measurement and payment programs. In addition, for FFY 2023, all acute care hospitals received a neutral adjustment under the Medicare value-based purchasing program that is equal to the 2.0% that is withheld under the program.

Medicare Hospital Outpatient Prospective Payment System and Other Outpatient Services

CMS reimburses hospital outpatient services under the Medicare hospital outpatient prospective payment system ("***OPPS***"), and generally uses fee schedules to pay for durable medical equipment and physical, occupational and speech therapy, clinical diagnostic laboratory and independent diagnostic testing facility services. Under the OPPS, hospital outpatient services are classified into groups called ambulatory payment classifications ("***APCs***"). Services in each APC are clinically similar and are similar in terms of the resources they require. Depending on the services provided, a hospital may be paid for more than one APC for an encounter. CMS establishes a payment rate for each APC by multiplying the scaled relative weight for the APC by a conversion factor. The payment rate is further adjusted to reflect geographic wage differences. The APC conversion factor for calendar year ("***CY***") 2024 is $87.382 and the APC conversion factors for CYs 2023 and 2022 were $85.585 and $84.177, respectively, after the inclusion of the productivity adjustments and other reductions that were required by the Affordable Care Act. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, acute care hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Reporting Program (the "***OQR Program***"). Hospitals that do not satisfy the reporting requirements of the OQR Program are subject to a reduction of 2.0% in their annual payment update under the OPPS. Our acute care hospitals reported all quality measures required by CMS related to the OQR Program and will receive the full market basket update through CY 2024.

Section 603 of the Bipartisan Budget Act of 2015 limits reimbursement for items and services that are furnished by certain off-campus outpatient provider-based departments ("***off-campus PBDs***") of hospitals. CMS included several provisions implementing Section 603 in the OPPS final rule for CY 2017. Under the final rule, CMS continues to make OPPS payments to off-campus PBDs that were billing Medicare as hospital departments under the OPPS prior to November 2, 2015 ("***grandfathered PBDs***"). However, grandfathered PBDs generally are not able to relocate, and CMS has indicated that it may adopt limitations on the expansion of the service lines provided at grandfathered PBDs in the future. In addition to grandfathered PBDs, CMS continues to reimburse all items and services that are furnished in a "dedicated emergency department" of a hospital, as such term is defined for the purposes of the Emergency Medical Treatment and Active Labor Act ("***EMTALA***"), regardless of whether the items and services are emergency items and services, and all items and services that are furnished in off-campus PBDs that are located within 250 yards of a remote location of a hospital, which is a facility that is either created or acquired by a hospital for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the hospital, under the OPPS. All items and services not provided at a grandfathered or otherwise excepted off-campus PBD are generally paid by CMS under Medicare physician fee schedule ("***PFS***") rates that are approximately 40% of the applicable OPPS rate. In addition, in 2018, CMS issued a final rule that generally reimburses clinic visit services provided at all off-campus PBDs, including grandfathered PBDs, at a reduced Medicare PFS-equivalent payment rate. The payment reduction for clinic visit services provided at off-campus PBDs was to be phased in over a two year period beginning in FFY 2019.

In December 2018, a lawsuit was filed challenging the portion of CMS' final rule that reduced reimbursement for clinic visit services provided at grandfathered PBDs to the lower Medicare PFS-equivalent payment rate. On September 17, 2019, the U.S. District Court for the District of Columbia ruled that the reduction in reimbursement for clinic services provided at grandfathered PBDs exceeded CMS' statutory authority. As a result of the ruling, CMS paid claims for clinic visit services provided at grandfathered PBDs in CY 2019 at the full OPPS payment rate. However, in the OPPS final rule for CY 2020, CMS noted that the court's ruling only applied to clinic visit services provided in CY 2019, and, as a result, CMS moved forward with the planned phase-in of the second year of the clinic visit service payment reduction in CY 2020 while it appealed the court's decision. A new lawsuit was filed on January 13, 2020, challenging the continued phase-in of the reduction for CY 2020. On July 17, 2020, the U.S. Court of Appeals for the District of Columbia reversed the lower court's ruling regarding the CY 2019 reductions and upheld CMS' reimbursement reductions for clinic visit services provided at grandfathered PBDs. The ruling of the U.S. Court of Appeals for the District of Columbia was appealed to the U.S. Supreme Court, but the Supreme Court declined to hear the appeal. CMS has since reprocessed claims for clinic services provided at grandfathered PBDs in CY 2019 at the reduced payment rate. However, in an effort to maintain access to care in rural areas, CMS finalized a policy in its CY 2023 PFS final rule that exempts rural Sole Community Hospitals from its site-neutral payment policy for clinic visit services provided in excepted off-campus PBDs of these hospitals and pays for such clinic visits at the full OPPS payment rate.

In addition to those reimbursement reductions and in furtherance of its efforts to increase site neutrality in Medicare payments, CMS announced in the OPPS final rule for CY 2021 that it would eliminate the Medicare program's inpatient only procedure list over a three-year period, beginning with the removal of approximately 300 primarily musculoskeletal-related procedures, with the list being completely phased out by CY 2024. The elimination of the inpatient only procedure list would have made those procedures eligible to be paid by Medicare in the hospital outpatient setting when outpatient care was appropriate. However, in the OPPS final rule for CY 2022, CMS reversed course and reinstated the Medicare program's inpatient only procedure list. As a result, almost all of the procedures that had been removed from the Medicare inpatient only procedure list for CY 2021 have been added back to the list for CY 2022.

As part of the OPPS final rule for CY 2018, CMS also finalized a change to the payment rate for certain Medicare Part B drugs purchased by qualifying hospitals through the 340B Drug Pricing Program (the "***340B Program***"). The 340B Program allows certain non-profit and governmental hospitals and other healthcare providers to obtain substantial discounts on covered outpatient drugs (prescription drugs and biologics other than vaccines) from drug manufacturers. Under the final rule, CMS pays for separately reimbursable, non-pass through drugs and biologicals (other than vaccines) purchased through the 340B Program at the average sales price ("***ASP***") minus 22.5% rather than ASP plus 6%. CMS estimated that this change reduced Medicare payments for drugs and biologicals by $1.6 billion in CY 2018. To maintain budget neutrality, CMS implemented an offsetting increase in the conversion factor. As a result, OPPS reimbursement rates for non-drug items and services provided by all hospitals, including those not eligible to participate in the 340B Program, were increased in connection with the reduction to 340B Program payments. In the OPPS final rule for CY 2019, CMS expanded the 340B Program payment reductions to drugs that are obtained through the 340B Program and furnished by non-excepted, off-campus PBDs.

In September 2018, a lawsuit was filed challenging the authority of CMS to make the 340B Program payment reductions set forth in the OPPS final rule for CY 2018. On December 27, 2018, the U.S. District Court for the District of Columbia held that the payment reductions exceeded CMS' statutory authority and entered a permanent injunction against the reductions. However, because the 340B Program payment reductions were made in a budget-neutral manner and the savings derived from the reductions were used to increase reimbursement for all of the other items and services provided under the OPPS, the court ordered the parties to submit briefs as to how the issue should be remedied. The lawsuit was subsequently expanded to include the 340B Program payment reductions that were made in CY 2019, and an additional lawsuit has been filed against the 340B Program payment reductions being made by CMS in CY 2020. CMS appealed the District Court's rulings, and, on July 31, 2020, the U.S. Court of Appeals for the District of Columbia reversed the lower court's ruling and upheld CMS' 340B Program payment reductions. The ruling of the U.S. Court of Appeals for the District of Columbia was appealed to the U.S. Supreme Court, and on June 15, 2022, the U.S. Supreme Court unanimously rejected the decision of the U.S. Court of Appeals and held that CMS' 340B Program payment reductions exceeded HHS's statutory authority.

In light of the U.S. Supreme Court's decision, in its CY 2023 OPPS final rule, CMS agreed to increase the payment rate for 340B Program-acquired drugs and biologicals from the ASP minus 22.5% to ASP plus 6%, beginning after September 28, 2022, consistent with its policy for drugs not acquired through the 340B Program. CMS stated that it would implement a -3.09% reduction to the payment rates for non-drug services to achieve budget neutrality for the 340B drug payment rate change for CY 2023. CMS further noted in the CY 2023 OPPS final rule that it would address the remedy for 340B drug payments from 2018 through 2022 in future rulemaking prior to the CY 2024 OPPS proposed rule.

On November 2, 2023, CMS issued a final rule outlining its remedy for the 340B-acquired drug payment policy for CYs 2018-2022. In the final rule, CMS finalizes a policy to make an additional payment to affected providers for 340B-acquried drugs as a one-time lump sum payment. CMS estimates that OPPS 340B providers received $10.6 billion less in 340B drug payments than they would have without the 340B policy, $1.6 billion of which has already been recovered by 340B providers. CMS further estimates that hospitals were paid $7.8 billion more for non-drug items and services during this time period than they would have been paid in the absence of the 340B payment policy. Accordingly, in order to maintain budget neutrality, CMS is also finalizing a corresponding offset to future payments for non-drug items and services to all OPPS providers, except new providers, by reducing the OPPS conversion factor by 0.5% each year until the total offset is reached (approximately 16 years), starting in CY 2026. Our revenues will be adversely affected by the reduction in future OPPS payments.

Medicare Disproportionate Share Hospital Payments

Acute care hospitals may also qualify for Medicare disproportionate share hospital ("***DSH***") payments, if they treat a high percentage of low-income patients (as determined by a ratio involving Medicare and Medicaid patients eligible to receive Supplemental Security Income). DSH payments are determined annually based on certain statistical information specified by HHS and are paid as an addition to MS-DRG payments. The Affordable Care Act requires Medicare DSH payments to providers to be reduced by 75% beginning in FFY 2014, subject to adjustment if the Affordable Care Act does not decrease uncompensated care to the extent anticipated. The amount that is withheld is reduced by the percentage change in uninsured individuals under the age of 65, and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. The IPPS final rule for FFY 2024 established the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2024 at approximately $6.7 billion, a decrease of approximately $957 million from FFY 2023.

Medicare Dependent and Low Volume Hospital Programs

On April 16, 2015, the Medicare Access and CHIP Reauthorization Act of 2015 ("***MACRA***") was enacted. Among other things, MACRA extended the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by Medicare, and the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located a certain distance from another general acute care hospital and have less than a certain number of Medicare discharges each fiscal year, through September 30, 2017. The Bipartisan Budget Act of 2018 extended both of these programs through FFY 2022. The Consolidated Appropriations Act, 2023 (the "***CAA23***"), which was adopted December 23, 2022, further extended both of these programs through FFY 2024.

Rural Emergency Hospitals

Pursuant to the Consolidated Appropriations Act 2021 (the "***CAA***"), Congress established Rural Emergency Hospitals ("***REHs***") as a new provider type to address the growing concern over closures of rural hospitals. REHs provide emergency department services and observation care and, at the election of the REH, other services furnished on an outpatient basis, but do not provide acute care inpatient services (other than post-hospital extended care services furnished in a distinct part unit licensed as a skilled nursing facility). To qualify as an REH, a facility must, as of December 27, 2020 (the enactment date of the CAA), have been a critical access hospital or a rural hospital with not more than 50 beds. Effective January 1, 2023, REHs that participate in Medicare will be paid for all "covered outpatient services" at a rate that is equal to the OPPS payment rate for the equivalent covered outpatient department service, increased by 5% to reflect the higher costs incurred by such hospitals. REHs will also receive a monthly facility payment, equal to $276,233 for CY 2024 (with the sequestration amount deducted), which amount will increase in subsequent years by the hospital market basket percentage increase. In the CY 2023 OPPS final rule, CMS finalized its policies relating to payment, provider enrollment and quality reporting for REHs, in addition to the conditions of participation that REHs must meet in order to participate in the Medicare and Medicaid programs.

Medicare Inpatient Rehabilitation Facility Prospective Payment System

Under the Medicare program, IRFs and ARUs in acute care hospitals meeting certain criteria established by CMS are reimbursed under the Medicare inpatient rehabilitation facility prospective payment system ("***IRF-PPS***"). Payments under the IRF-PPS are made on a per-discharge basis and cover the inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) and, for teaching institutions, are adjusted to include reimbursement for graduate medical education costs. Under the IRF-PPS, patients are classified into case mix groups that reflect the relative resource intensity typically associated with the patient's clinical condition. IRFs and ARUs reimbursed under the IRF-PPS are paid a predetermined amount per discharge that reflects the patient's case mix group that is adjusted for facility-specific factors, such as area wage levels, proportion of low-income patients, and location in a rural area. Each FFY, payment rates under the IRF-PPS are updated using a market basket index, which is reduced by a productivity adjustment. For FFY 2024, CMS increased IRF-PPS payment rates by 3.4% based on a IRF market basket update of 3.6% minus a productivity adjustment of 0.2%. To receive the full increase, IRFs and ARUs must satisfy the reporting requirements of the Inpatient Rehabilitation Facility Quality Reporting Program (the "***IRF QRP***"). IRFs and ARUs that do not satisfy the reporting requirements of the IRF QRP are subject to a reduction of 2.0% in their annual payment update under the IRF-PPS. All but five of our IRFs and ARUs reported all quality measures required by CMS related to the IRF QRP and will receive the full market basket update for FFY 2024. In addition to the base payment rate increase, CMS increased outlier payments for IRFs by 0.6% in FFY 2024. CMS estimates that overall IRF payments for FFY 2024 will increase by $355 million compared to FFY 2023 IRF-PPS payments.

In order to qualify for reimbursement under the IRF-PPS, at least 60% of an IRF's or ARU's inpatients during the most recent 12-month CMS-defined review period must have required intensive rehabilitation services for one or more of 13 specified conditions. IRFs and ARUs must also meet additional coverage criteria, including patient selection and care requirements relating to pre-admission screenings, ongoing coordination of care and involvement of rehabilitation physicians. An IRF or ARU that fails to meet the 60% threshold, or other criteria to be reimbursed under the IRF-PPS, will be paid under either the Medicare IPPS or OPPS, which generally provide for lower payment amounts.

Medicare Inpatient Psychiatric Facility Prospective Payment System

Under the Medicare program, inpatient psychiatric facilities ("***IPFs***"), which include freestanding psychiatric hospitals and inpatient psychiatric units in acute care hospitals that meet certain criteria established by CMS are reimbursed under the Medicare inpatient psychiatric facility prospective payment system ("***IPF-PPS***"). Under the IPF-PPS, IPFs receive predetermined per diem rates based primarily on the patient's condition (age, diagnosis, comorbidities), length of stay, and the location of the IPF. Payment rates are intended to cover all routine, ancillary, and capital costs of furnishing covered inpatient psychiatric services, including adjustments for teaching hospitals and IPFs with qualifying emergency departments. The IPF-PPS has additional payment policies for outlier cases, interrupted stays, and a per treatment payment for patients who undergo electroconvulsive therapy. Each FFY, payment rates under the IPF-PPS are updated using a market basket index, which is reduced by a productivity adjustment. For FFY 2024, CMS increased the IPF-PPS base payment rate by 3.3% (to $895.63 per day) based on a IPF market basket update of 3.5% minus a productivity adjustment of 0.2%. In addition to the base payment rate increase, CMS decreased outlier payments to IPFs by 0.9% in FFY 2024. Due to rounding, the 3.3% increase to payment rates and the 0.9% decrease due to outlier payment changes result in a 2.3% overall increase in IPF payments. To receive the full increase, IPFs must satisfy the reporting requirements of the Inpatient Psychiatric Facility Quality Reporting Program (the "***IPF QRP***"). IPFs that do not satisfy the reporting requirements of the IPF QRP are subject to a reduction of 2.0% in their annual payment update under the IPF-PPS. All but seven of our IPFs reported all quality measures required by CMS related to the IPF QRP and will receive the full market basket update for FFY 2024. CMS estimates that overall IPF payments for FFY 2024 will increase by $70 million compared to FFY 2023 IPF-PPS payments.

In order to qualify for reimbursement under the IPF-PPS, IPFs must meet certain classification and coverage criteria, including being primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons by, or under the supervision of, a physician, in addition to special staffing and medical record retention requirements. An IPF that fails to meet the criteria to be reimbursed under the IPF-PPS will be paid under either the Medicare IPPS or OPPS, which generally provide for lower payment amounts.

Cost Reports

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

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

Medicare Bad Debt Reimbursement

Under Medicare, the costs attributable to the deductible and coinsurance amounts that remain unpaid by Medicare beneficiaries after reasonable collection efforts can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the Medicare administrative contractor (*"**MAC**"*) from prior cost report filings.

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

Medicare Physician Fee Schedule and other Medicare Part B Services

Professional medical services provided to Medicare beneficiaries by physicians, physician assistants, nurse practitioners, and certain other healthcare practitioners, outpatient physical, occupational, and speech therapy services, and telehealth services are reimbursed under the PFS. Under the PFS, CMS has assigned a national relative value unit ("***RVU***") to most medical procedures and services that reflects the various resources required by a physician or practitioner to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service and the practice overhead and malpractice insurance expenses that are attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs and are then aggregated. The aggregated amount is multiplied by a conversion factor to determine the payment rate for the service. The conversion factor is updated by CMS on an annual basis.

MACRA, which was adopted in 2015, significantly changed how CMS determines the annual updates to the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased annually by an additional 0.5% for CYs 2016, 2017 and 2018 and, after the adoption of the Bipartisan Budget Act of 2018, were increased by 0.25% for CY 2019. PFS payment rates are scheduled to remain at their CY 2019 levels through CY 2025**.** The PFS conversion factor for CY 2024 is set at $32.74, which is a decrease of $1.15 (or 3.4%) from the CY 2023 PFS conversion factor of $33.89.

In addition to revising the methodology that is used to update payments that are made under the PFS, MACRA also established a Quality Payment Program ("***QPP***") for incentivizing physician and practitioner care that meets certain value, quality, cost, and performance criteria. Beginning in CY 2019, amounts paid to physicians and practitioners under the PFS are subject to adjustment through the QPP and participation in either the Merit-Based Incentive Payment System ("***MIPS***") or an Advanced Alternative Payment Model ("***APM***") program. Beginning with the 2023 performance year, physicians and practitioners will have the opportunity to participate in a new reporting option known as MIPS Value Pathways ("***MVPs***"). Physicians participate in "traditional" MIPS unless they are participants of specific forms of APM, report MVPs (beginning with performance year 2023), are newly enrolled in Medicare, or see a low volume of Medicare patients. Groups or eligible clinicians who choose not to participate and fall within specified circumstances may request an exception through a hardship application and incur no MIPS impact on Medicare payments. CMS also permits hardship applications, including, in 2020, 2021, and 2022 hardships based on circumstances arising from COVID related operational issues, through which clinicians can request reweighing of any or all performance categories if they encounter an extreme and uncontrollable circumstance or a public health emergency.

Physicians and practitioners who participate in the MIPS program, which essentially consolidated the prior Physician Quality Reporting System, the Value-Based Modifier, and the Meaningful Use of EHR incentive programs, are subject to positive, zero, or negative performance adjustments depending on how the physician's or practitioner's performance compared to a performance threshold. The payment adjustments are based on the physician's or practitioner's performance in the year that is two years prior to the current payment period. As a result, PFS payments in CY 2024 will be based on CY 2022 performance scores, and so on for the following years. HHS and CMS revise the MIPS reporting measures on an annual basis and have indicated that they intend to routinely increase the performance thresholds in connection with those revisions. In addition, from CY 2019 through CY 2024, MACRA provides $500 million per year for an additional performance adjustment for physicians and practitioners who participate in MIPS and achieve exceptional performance. Physicians and practitioners who participate in a specified APM program, which, among other things, requires the physician or practitioner to receive a substantial amount of their revenue from an APM, will receive, from CYs 2019 through 2024, a lump-sum incentive payment equal to 5% of their Medicare payments in the prior year for services paid under the PFS. Pursuant to the CAA23, for CY 2025, physicians and practitioners who participate in a specified APM program will receive a lump-sum incentive payment equal to 3.5 % of their Medicare payments in the prior year for services paid under the PFS. Beginning in CY 2026, PFS payment rates for physicians and practitioners participating in an APM program would be increased by 0.75% a year. Payments for other physicians and practitioners would be increased by 0.25% per year.

Medicaid

For the year ended December 31, 2023, approximately 19.1% of our revenues related to patients participating in the various state Medicaid programs. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. Medicaid programs are funded by both the federal government and states to provide healthcare benefits to limited categories of low-income individuals under 65 years of age. These programs and the reimbursement methodologies are administered by the states under approved plans and vary from state to state and from year to year. Amounts received under the Medicaid programs are often significantly less than the hospital's customary charges for the services provided. Most state Medicaid payments are made under a prospective payment system, fee schedule, cost reimbursement program, or some combination of these three methods. All of our hospitals are currently certified to participate in their respective state Medicaid programs.

As enacted, the Affordable Care Act essentially required states to expand Medicaid coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level ("***FPL***"). However, that portion of the Affordable Care Act was held to be unconstitutional by the U.S. Supreme Court, and, as a result, states may opt out of the expansion without losing their existing Medicaid funding. Therefore, the income level required for individuals to qualify for Medicaid varies widely from state to state. To offset the cost of the Medicaid program's expansion, the Affordable Care Act authorized the federal government to provide states with "matching funds," in the form of increases to the Federal Medical Assistance Percentage (the "***FMAP***" and, as increased, referred to as "***Enhanced FMAP***"), to cover the costs of covering the newly eligible individuals. The Enhanced FMAP was 100% for CYs 2014 through 2016; 95% in CY 2017; 94% in CY 2018; 93% in CY 2019; and will be 90% in CYs 2020 and thereafter. The ARP, which was signed into law on March 11, 2021, provides a new incentive, in the form of a temporary 5% increase to the FMAP, to states that have not yet expanded their Medicaid programs in an effort to encourage them to do so. In addition, to assist state Medicaid programs with the additional expenses attributable to the COVID-19 pandemic, the Families First Coronavirus Act provided a 6.2% increase in the FMAP retroactive to January 1, 2020. The temporary FMAP increase was phased out on January 1, 2024.

In recent years, we have benefited from the expansion of Medicaid under the Affordable Care Act, and since January 1, 2020, Missouri, Oklahoma, and Utah, three additional states in which we operate, expanded their Medicaid programs. However, a number of states in which we operate have not expanded their Medicaid programs or are seeking waivers that could reduce their Medicaid-eligible populations. Several states have adopted or are considering legislation designed to reduce or control their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs, and imposing additional taxes on hospitals to help finance such states' Medicaid systems. Given the reductions in the Enhanced FMAP, the temporary nature of the assistance provided by the ARP and the Coronavirus Aid, Relief, and Economic Security Act (the "***CARES Act***"), and the potential for further modifications to the Affordable Care Act, we are unable to predict how many, if any, additional states in which we operate will expand their Medicaid programs or how many, if any, of the states in which we operate that have expanded their Medicaid programs will keep their expansions in place in the future.

The Affordable Care Act also included a number of provisions that are intended to improve the quality of care that is provided to Medicaid beneficiaries. Among other things, the Affordable Care Act prohibits federal funds from being used to reimburse providers for services related to provider preventable conditions, such as HACs, wrong site surgeries and other provider preventable conditions that may be designated by each state Medicaid program.

Medicaid Supplemental Payments

Medicaid supplemental payments ("***MSPs***") are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and Upper Payment Limit ("***UPL***") payments.

Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating those patients. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. Although federal Medicaid law defines some level of hospitals that must receive Medicaid DSH funding, states have broad discretion to define additional hospitals that also may qualify for Medicaid DSH payments and the amount of such payments. However, the total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law.

Pursuant to the Affordable Care Act, as amended by subsequent legislation, funding for Medicaid DSH programs was to be reduced by $4 billion in FFY 2020 and $8 billion per year from FFY 2021 through FFY 2025. Congress has delayed the reduction in funding for Medicaid DSH programs on a number of occasions, most recently through the CAA, which eliminates the scheduled Medicaid DSH reductions for FFYs 2021 through 2023 but adds additional Medicaid DSH reductions for FFYs 2026 and 2027. We cannot predict whether Congress will further delay or otherwise modify the reductions in the future. Because many of the states in which we operate have not expanded Medicaid programs as intended under the Affordable Care Act, the reduction in Medicaid DSH payments may take place without a coupled increase in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars. UPL programs have expanded in recent years, and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs.

On November 18, 2019, CMS released a proposed rule, the Medicaid Fiscal Accountability Rule, that was intended to increase federal oversight of MSPs and state Medicaid financing policies. Among other things, the proposed rule would have added new reporting requirements on UPL payment arrangements, imposed limitations on UPL payments that are made to physicians and certain other practitioners, and imposed limits on the use of healthcare provider taxes, intergovernmental transfers and certified public expenditures. CMS withdrew the proposed rule in 2020. However, some of the reporting requirements contained in the Medicaid Fiscal Accountability Rule were included in the CAA, and, beginning in FFY 2022, each state will be required to provide CMS with, among other things, (i) a description of the stated purpose and intended effects of the state's MSPs, (ii) an explanation of how the state's MSPs will result in payments that are consistent with the requirements of the Medicaid program, including the program's standards with respect to efficiency, economy, quality of care, and access, (iii) the criteria used to determine provider eligibility for the state's MSPs, (iv) a comprehensive description of the methodology used to calculate the amount of, and distribute, MSPs to each eligible provider, and (v) an assurance that the total Medicaid payments made by the state to inpatient hospital providers, including any MSPs, will not exceed the UPL. The CAA also further clarifies how third-party payments are to be considered when determining Medicaid DSH hospital-specific limits. We cannot predict the impact, if any, that the reporting requirements and other Medicaid provisions in the CAA will have on MSPs and UPL payments that are made by state Medicaid programs or whether Congress or CMS will adopt any additional legislation or regulations that will eliminate or otherwise limit MSPs and/or UPL payments. In addition, we cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease.

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

North Carolina Healthcare Access and Stabilization Program (HASP) and Medicaid Expansion

On March 27, 2023, the governor of North Carolina signed into law a bill to expand Medicaid coverage in North Carolina, which expanded health coverage to an estimated 600,000 people across North Carolina on December 1, 2023. The legislation also enacted the Healthcare Access and Stabilization Program ("***HASP***") aimed at increasing Medicaid reimbursement rates to hospitals providing safety-net services for low-income patients. CMS approved initial HASP payments for the North Carolina fiscal year July 1, 2022 to June 30, 2023. HASP payments for future fiscal years will require annual approval by CMS. Increased reimbursement rates under the initial HASP preprint were applied retrospectively to the beginning of the North Carolina fiscal year, which commenced on July 1, 2022. We cannot predict whether, or the extent to which, future HASP payments will be approved by CMS or the impact any such decision will have on our business.

Medicaid Block Grants and Capped Federal Funding

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

On November 11, 2019, Tennessee, one of the states in which we operate, submitted an amendment to CMS for its Medicaid demonstration waiver that would convert federal funding for the Tennessee Medicaid program to a modified block grant program. CMS approved the amendment on January 8, 2021, and as required by state law, the Tennessee General Assembly approved the implementation of the amendment on January 15, 2021. Under the amendment, the Tennessee Medicaid program would receive federal matching funds for expenditures up to an aggregate annual cap. The aggregate cap would be based on the Tennessee Medicaid program's historical expenditures and would be increased to reflect a reasonable growth rate over time and for unexpected increases in enrollment. In exchange, the Tennessee Medicaid program would be given increased flexibility in how it operates and would be entitled to 55% of any savings that are achieved if spending is below the aggregate cap and the state meets certain quality targets. Any savings would generally be required to be re-invested in the Tennessee Medicaid or other health related programs. Despite being granted increased administrative flexibility, the Tennessee Medicaid program would be required to maintain the coverage and benefit levels that were in place as of December 31, 2020. A lawsuit was filed in the U.S. District Court for the District of Columbia on April 22, 2021, seeking to stop the conversion of the Tennessee Medicaid program to a modified block grant program. On June 30, 2022, following a public comment period, CMS sent a letter to Tennessee requesting that the state make certain modifications to the Tennessee Medicaid demonstration waiver, which included, among other things, a request that the state submit a new financing and budget neutrality model based on a traditional per member per month cap, instead of an aggregate cap. In response, on August 30, 2022, following a public comment period, Tennessee sent CMS a proposed amendment to its demonstration waiver intended to address CMS's concerns, including changes to the financing of the demonstration, moving from an aggregate cap to a per member per month cap, and revising the framework for reinvestment of demonstration savings. We cannot predict whether CMS will accept Tennessee's proposed amendments to its demonstration waiver or whether CMS will request further modifications or rescind altogether its approval of the amendment to the Tennessee Medicaid program or the impact that the amendment and related changes to the Tennessee Medicaid program would have on our operations and revenues.

Recovery Audit and Other Review Contractors

Recovery audit contractors ("***RACs***") are used by CMS and state agencies to detect Medicare and Medicaid overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare and Medicaid claims filed by healthcare providers. RACs perform post-discharge audits of medical records to identify overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services and are paid on a contingency basis. Any claims identified as overpayments are subject to a RAC program appeals process. In 2016, in connection with the procurement of the new recovery audit contracts, CMS made a number of enhancements to the RAC program, including the establishment of a RAC program Provider Relations Coordinator, requiring RACs to maintain an overturn rate of less than 10% at the first level of appeal, requiring RACs to maintain an accuracy rate of at least 95%, and establishing additional documentation request limits based on a provider's compliance with Medicare rules, that are intended to address provider and other stakeholder concerns. CMS has also limited the number of claims that RACs may audit by limiting the number of records that RACs may request from hospitals based on each hospital's claim denial rate for the previous year.

In addition to RACs, CMS employs Unified Program Integrity Contractors ("***UPICs***"), which integrate the functions of the former Zone Program Integrity Contractors, Program Safeguard Contractors, and Medicaid Integrity Contractors, to perform post-payment audits of Medicare and Medicaid claims and identify overpayments. A number of state Medicaid agencies and other contractors have also increased their review activities.

Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our facilities have had Medicare claims audited by the RAC program. While our facilities have successfully appealed many of the adverse determinations raised by Medicare RAC audits, we cannot predict if this trend will continue or the results of any future audits. We cannot predict the volume or outcome of any future audits conducted by the various RACs and other review programs to which our facilities will be subject.

Utilization and Claim Review

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

In addition to utilization reviews, CMS has also adopted a nationwide claim review and provider education program known as the Targeted Probe and Educate ("***TPE***") program, which is intended to reduce errors in the claims submission process and focuses on items and services that pose the greatest risk to the Medicare program or that have a high national error rate, such as short inpatient stays. Under the TPE program, MACs use data analysis to identify providers who, for a particular item or service, have high claim denial rates or billing practices that vary significantly from their peers. Once a provider has been identified, the MAC reviews between 20 and 40 of the provider's claims for the item or service and, if issues are noted, offers the provider an individualized education session that is based on the results of the review. The provider is then generally given 45 days to improve its systems and processes, and, after that period has ended, the MAC conducts another review of the provider's claims. If additional issues are identified, the provider is given the opportunity for another education session. Providers are typically given three rounds of review and education before being referred to CMS for further action, potentially including pre-payment review, referral for RAC review, or in some cases revocation of billing privileges.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payers including HMOs, PPOs and other private insurers. Also included in this category are the patient responsibility portions for co-payment and deductible obligations under these programs. Our revenues from HMOs, PPOs and other private insurers were approximately 37.9% of our revenues for the year ended December 31, 2023. Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services or accept fixed, pre-determined fees for our services. These contractual discounted arrangements often limit our ability to increase charges or revenues in response to increasing costs. We actively negotiate with these payers in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payer with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower-cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. Additionally, plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when we are not a participating provider in the network, it can result in higher patient responsibility amounts that a patient may not have the ability to pay or may choose not to pay. We expect these trends to continue in the coming years.

Self-Pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Our revenues from self-pay patients were approximately 0.7% of our revenues for the year ended December 31, 2023. Beginning in 2014, our self-pay revenues began to decrease as a percentage of overall revenues due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily has been a result of the Affordable Care Act and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities experienced in prior years, which included increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. We cannot predict how administrative or judicial interpretations, legislative actions or any other modifications to the Affordable Care Act that may be implemented or adopted, such as the cessation of cost sharing reduction payments or the repeal of the individual mandate, may impact our self-pay revenues. We also cannot predict whether the layoffs that may occur as a result of a decline in economic conditions, such as recession, economic downturn, and/or inflationary conditions in the U.S., will increase the number of underinsured and uninsured patients that seek treatment at our facilities.

In addition, effective January 1, 2022, the No Surprises Act requires healthcare providers, including hospitals and other healthcare facilities, to provide uninsured patients with a good faith estimate of the provider's total expected charges for scheduled items or services, including any expected ancillary services, before providing the items or services to the patient. Uninsured patients will be able to utilize a patient-provider dispute resolution process to challenge the provider's charges if they receive a bill that is substantially higher than the good faith estimate that was provided by the healthcare provider. We estimate that the uninsured patient good faith estimate and dispute resolution provisions of the No Surprises Act have not materially impacted the Company's revenues or cash flow.

Surprise Medical Billing

On December 21, 2020, Congress adopted legislation that is intended to limit the "surprise" medical bills that are often received by individuals receiving emergency and certain other services (such as anesthesia services) from out-of-network providers. Effective as of January 1, 2022, the No Surprises Act prohibits, among other things, out-of-network providers from balance billing patients for emergency care services that are provided by out-of-network facilities or at in-network facilities by out-of-network providers. The No Surprises Act also generally prohibits out-of-network providers from billing patients for non-emergency medical treatment unless the provider first notifies the patient of the provider's network status and estimated charges and the patient agrees to be financially liable for the additional amounts. Violations of the No Surprises Act are punishable by civil monetary penalties of up to $10,000, and the No Surprises Act may be enforced by both the state and federal governments.

When the prohibitions of the No Surprises Act apply, a patient's financial liability will generally be limited to his or her in-network amount. In addition, the patient's third-party payer must either pay the out-of-network provider an initial payment amount or issue a notice of denial to the provider for the services that were rendered within 30 days of the payer's receipt of the provider's claim. If the provider is not satisfied with the payer's initial payment amount, the provider and the payer will begin a 30-day negotiation period. If the provider and the payer cannot agree on a payment amount during the negotiation period, the parties may elect to initiate an independent dispute resolution ("***IDR***") process. The IDR process will be conducted by a neutral arbitrator that has been approved by the federal government. Under regulations that have been issued by HHS, the Department of Labor, and the Department of Treasury (collectively, the "***Departments***"), in making a payment determination, the arbitrator must begin with the "qualifying payment amount" (the "***QPA***"), which generally will be the plan or the insurer's median contracted rate, and then consider additional permissible information submitted by a party. A number of lawsuits have been filed against the Departments challenging various aspects of the final rules implementing the No Surprises Act, including the weight an arbitrator should give to the QPA in the IDR process. Multiple federal court decisions struck down provisions in the regulations that created a presumption or weighting in favor of the QPA as inconsistent with the language of the No Surprises Act. The regulations that have been issued by the Departments in connection with the No Surprises Act also require certain healthcare providers and facilities to make publicly available, post on a public website and provide a one-page notice to individuals about the requirements and prohibitions applicable to the facility or provider under the No Surprises Act, any applicable state balance billing limitations or prohibitions, and how the individual can contact the appropriate state and federal agencies if he or she believes the provider or facility has violated the requirements set forth in the notice.

We cannot predict how the No Surprises Act will be implemented by the Departments, or how it will ultimately be enforced by the federal and various state governments. We also cannot predict the amounts that will be received by our facilities and our employed providers for out-of-network services, whether the No Surprises Act will impact the in-network payment rates that are offered by third-party payers and the willingness of those payers to enter into participation agreements with us and our facilities in the future, or the costs we will incur in complying with the requirements of the No Surprises Act. In addition, a number of states are considering or have already adopted legislation to eliminate surprise medical billing. We cannot predict how state legislative actions to modify or pass these proposals may be implemented or adopted, or what impact, if any, those actions may have on our operations and revenues.

Price Transparency

Transparency in healthcare pricing has become a focal point for CMS, Congress, and many state legislatures. For example, effective as of January 1, 2021, hospitals generally are required to post their standard charges prominently on a publicly available website. Under CMS regulations, each hospital's standard charges must be posted in two ways: (1) a single machine-readable digital file containing the gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for all items and services provided by the hospital and (2) a public display in a consumer-friendly manner of cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for at least 300 "shoppable" services (70 CMS-specified and 230 hospital-selected). CMS is actively auditing and monitoring hospital compliance with its reporting requirements and has taken a number of steps to address hospital noncompliance, including issuing warning notices to and requesting corrective action plans from hospitals that are determined to be out of compliance with the price transparency requirements, implementing measures that are intended to increase the availability of the required machine-readable file, and increasing the civil monetary penalties that are applicable to violations of the price transparency requirements. CMS issued its first civil monetary penalties under the CMS hospital price transparency regulations in June of 2022. On April 26, 2023, CMS published an enforcement update, in which it outlined steps that CMS intends to take in order to increase compliance with the price transparency requirements, including, but not limited to, shortening the average time by which hospitals must come into compliance after a deficiency is identified and automatically imposing civil monetary penalties on hospitals that fail to submit a corrective action plan at the end of the 45-day corrective action plan submission deadline. On November 2, 2023, as part of the Medicare hospital outpatient prospective payment system final rule for CY 2024, CMS finalized a number of modifications to hospital price transparency requirements, including, among other things, requiring hospitals to display their standard charges data using a CMS template and to encode additional data elements specified in the rule. While all of the changes with respect to hospital price transparency regulations are effective as of January 1, 2024, the final rule also sets specific implementation dates for specific provisions, with most having an implementation date of July 1, 2024. The final rule also increases CMS' enforcement authority with respect to the hospital price transparency rules by, among other things, permitting CMS to require hospital officials to certify the accuracy and completeness of data in the hospital's machine-readable file, allowing CMS to work with health system leadership to address deficiencies across the health system, and allowing CMS to publicize on its website information related to its assessment of a hospital's compliance, any compliance action taken against a hospital, and notifications sent to health system leadership.

In addition to addressing surprise billing, the No Surprises Act contains a number of provisions that are intended to promote provider and health plan price transparency. Among other things, under the No Surprises Act, healthcare providers will be required to provide "good faith estimates" of their total expected charges for scheduled items and services to the patient's health plan if the patient is insured prior to the item and/or service being provided. Health plans will be required to provide patients with an "advanced explanation of benefits" that includes: (1) information regarding the network status of the provider, (2) a copy of the provider's "good faith estimate," (3) an estimate of the amount that the patient will be expected to pay for the item or service, and (4) information on any applicable pre-authorization requirements.

Although we continue to evaluate, and are taking proactive steps in response to, the legislative and regulatory developments regarding price transparency, we cannot predict how existing regulations will be implemented or interpreted or whether any other requirements will be imposed on providers and health plans. We also cannot predict what affect the public disclosure of hospitals' or insurance providers' negotiated rates will have on our future negotiations with payers or the effect that the disclosure of pricing information by healthcare providers and health plans will have on our patient volumes and revenues.

Executive Order - Competition in the American Economy

On July 9, 2021, President Biden issued an executive order that is intended to promote competition in the American economy. Among other things, the executive order encourages the Federal Trade Commission (the "***FTC***") to ban or limit non-compete agreements, directs the Food and Drug Administration to work with states and tribes to import prescription drugs from Canada, directs HHS to increase its support for generic and biosimilar drugs, issue a comprehensive plan to combat high drug prices, and support existing price transparency rules, and encourages the Department of Justice ("***DOJ***") and the FTC to review and revise their merger guidelines to ensure that patients are not harmed by hospital mergers. In response, on January 6, 2023, the FTC issued a proposed rule that would ban employers from imposing post-termination non-competes on its workers (whether employees or independent contractors), subject to certain exceptions, and require employers to rescind existing non-competes and actively inform workers that they are no longer in effect. The proposed rule may not apply to non-profit hospitals, which could create a competitive disadvantage for us in our hiring and retention efforts. Although we cannot predict whether the FTC's proposed rule will be adopted in its current form, any limitation or ban on our ability to enter into non-compete agreements with employed or contracted staff may impact our ability to hire and retain qualified physicians, nurses and other medical support personnel and may adversely affect our costs of doing business or our ability to deliver services in our communities. The FTC is not expected to vote on the proposed rule until April 2024, and the rule is widely expected to be challenged in court if adopted substantially in its current form. Also in response to the executive order, on February 3, 2023, the DOJ announced its withdrawal of three long-standing antitrust policy statements related to enforcement in the health care industry, and on July 14, 2023, the FTC followed suit, announcing its withdrawal of two long-standing antitrust policy statements related to enforcement in the health care industry. These statements had provided guidance in the form of "safety zones," which described conduct that the antitrust agencies would not challenge under the antitrust laws, absent extraordinary circumstances. The safety zones covered a wide variety of collaborations between health care providers, including mergers, joint ventures, joint purchasing arrangements, information exchanges, and the formation and operation of financially and clinically integrated networks and accountable care organizations. The withdrawal of these antitrust policy statements signals increased antitrust scrutiny for collaborations within the health care industry. We cannot predict the impact that the withdrawal of DOJ's antitrust policy statements will have on our operations or future transactions or how, if at all, the various other initiatives set forth in the executive order will be implemented by the regulatory agencies involved.

U.S. Supreme Court Decision – Dobbs v. Jackson Women's Health Organization

On June 24, 2022, the U.S. Supreme Court issued a decision in *Dobbs v. Jackson Women's Health Organization* (the "***Dobbs Decision***") that overturned *Roe v. Wade* (the "***Roe Decision***") and held that the U.S. Constitution does not confer a right to an abortion. This decision sparked a litany of changes in state laws across the country, including a number of state "trigger" laws that have or are set to take effect and which ban or severely restrict the performance of abortion services and in some cases impose civil and criminal penalties on service providers and patients. In turn, many state legislatures have introduced bills or proposed state constitutional amendments to protect access to abortions, and lawsuits have been filed in numerous states challenging trigger bans and other abortion restrictions that went into effect after the Dobbs Decision. We cannot predict the full implications of the Dobbs Decision or changes in state or federal laws resulting therefrom, including potential conflicting interpretations of requirements under existing or new laws relating to the provision of reproductive health services in the various jurisdictions in which we operate.

Executive Order - Protecting Access to Reproductive Health Care Services

Following the Dobbs Decision that overturned the Roe Decision, President Biden issued an executive order on July 8, 2022, that is intended, among other things, to coordinate the implementation of federal efforts to safeguard access to reproductive health care services (including abortion and contraception) and to protect patient privacy and access to accurate information. As directed by the executive order, on July 11, 2022, HHS announced new guidance that is intended to clarify provider responsibilities and protections under EMTALA with respect to providing stabilizing medical treatment for pregnant women and those experiencing pregnancy loss. Notably, HHS affirms that EMTALA obligations preempt directly conflicting state abortion laws or bans when needed for emergency care. Consequently, according to HHS, under federal law, providers in emergency situations are required to provide stabilizing care to someone with an emergency medical condition, including the performance of abortion services if necessary, regardless of the state where they live. A violation of EMTALA could result in termination of a provider's Medicare provider agreement and/or the imposition of civil monetary penalties. On August 23, 2022, at the request of the Attorney General of the State of Texas, the U.S. District Court for the Northern District of Texas issued a preliminary injunction against enforcement of HHS's new EMTALA guidance as it pertains to Texas's abortion law. The next day, the U.S. District Court for the District of Idaho issued a preliminary injunction in favor of the DOJ blocking enforcement of Idaho's abortion ban to the extent the law conflicts with EMTALA-mandated care. As expected, the federal government appealed the decision in Texas, and the State of Idaho appealed the decision in Idaho. On January 2, 2024, the U.S. Court of Appeals for the Fifth Circuit sided with the State of Texas, upholding the injunction issued by the U.S. District Court for the Northern District of Texas. On January 5, 2024, the U.S. Supreme Court agreed to hear the Idaho abortion case and stayed the district court's preliminary injunction pending resolution of the appeal. We cannot predict the outcome of the U.S. Supreme Court's decision and other lawsuits, or how federal and state government agencies will ultimately enforce EMTALA or related state laws in light of HHS's new guidance or the impact that the new guidance will have on our operations. We also cannot predict how, if at all, the various initiatives set forth in President Biden's executive order relating to reproductive health care services will be implemented by the regulatory agencies involved or the impact that the executive order will have on us, our employees, or our patients.

Healthcare Reform

In recent years, Congress has passed a number of laws, including the Affordable Care Act, that are intended to effect major changes in the U.S. healthcare system. The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The net effect of the Affordable Care Act, as currently adopted, on our business continues to be subject to a number of variables, including the law's complexity, its changing and often incomplete implementation of regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. While the U.S. Supreme Court rejected the most recent challenge to constitutionality of the Affordable Care Act, we cannot predict the outcome of other lawsuits that are still pending in lower courts regarding the implementation of various aspects of the Affordable Care Act or whether the U.S. Supreme Court will decide to hear future cases. Additionally, we cannot predict the impact that the current or future Presidential administrations and Congresses will have on the implementation and enforcement of the provisions of the Affordable Care Act or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

Expanded Coverage

Based on original Congressional Budget Office ("***CBO***") and CMS estimates, by 2020, the Affordable Care Act was originally expected to expand coverage for 32 to 34 million people, resulting in coverage of an estimated 95% of the legal U.S. population and an uninsured population of approximately 27 million individuals. This increased coverage was expected to occur through a combination of public program expansion and private sector health insurance and other reforms. In July 2021, the CBO estimated that, due to a number of factors, approximately 28 million people were uninsured in 2020 and that the number of uninsured individuals would remain relatively consistent through 2031.

Public program expansion has been driven primarily by expanding the categories of individuals who are eligible for Medicaid coverage and allowing individuals with relatively higher incomes to qualify for Medicaid coverage. When the Affordable Care Act was adopted, it essentially made the expansion of the Medicaid program mandatory. However, in 2012, the U.S. Supreme Court held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that chose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. Based on the U.S. Supreme Court's ruling, a number of states, including several in which the Company has facilities, have opted not to expand their Medicaid programs. Additional public program expansion has occurred through provisions of the Affordable Care Act that authorize the federal government to subsidize states that create non-Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL and allow Medicaid participating hospitals to make presumptive determinations of Medicaid eligibility for certain categories of individuals, such as pregnant women, infants, children, and parents and other caretaker relatives and their spouses. If an individual is found to be presumptively eligible for Medicaid benefits, the hospital will get paid for the services it provides during the temporary presumptive eligibility period, just as though the patient were already enrolled in the Medicaid program.

The expansion of health coverage through the private sector as a result of the Affordable Care Act has occurred through new requirements on health insurers, employers and individuals. For example, commencing January 1, 2014, health insurance companies were prohibited from imposing annual coverage limits, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. In addition, since January 1, 2011, each health plan has been required to keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. Also, since September 23, 2010, health insurers have not been permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old. Larger employers are subject to new requirements and incentives to provide health insurance benefits to their full-time employees, and, effective January 1, 2016, all employers subject to the requirement were required to offer health insurance coverage to 95% of their full-time employees and their dependents in order to avoid penalties.

To facilitate the purchase of health insurance by individuals and small employers, each state was required to establish an Exchange by January 1, 2014. For individuals and families below 400% of the FPL, the cost of obtaining health insurance through the Exchanges is subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. The ARP temporarily extends the availability of those subsidies to individuals and families with incomes over 400% of the FPL and increases the amount of the subsidies that are available for individuals and families who were already eligible for financial assistance under the Affordable Care Act. Health insurers participating in the Exchanges must offer a set of minimum benefits to be defined by HHS and may offer more benefits. Any benefits to us from the expansion of private sector coverage depend in large part on our success in contracting with payers whose policies are listed on the Exchanges. We currently have contracts with Exchange payers in every state in which we operate, and the reimbursement rates paid under those contracts generally are comparable to that paid to us by other private payers.

Public Program Spending

The Affordable Care Act provides for a number of Medicare, Medicaid and other federal healthcare program spending reductions. The CBO previously estimated that between 2013 and 2023, these program spending reductions would include $415 billion in Medicare fee-for-service market basket and productivity reimbursement reductions for all providers, the majority of which ($260 billion) would come from hospitals. The CBO's estimate also included an additional $56 billion in reductions of Medicare and Medicaid DSH funding. CMS had originally estimated that the Affordable Care Act would result in $64 billion in reductions of Medicare and Medicaid DSH funding, with $50 billion of the reductions coming from Medicare. Some of those reductions, most notably the Medicaid DSH funding reductions, have been delayed by subsequent legislation, and we cannot predict whether the public program spending reductions required by the Affordable Care Act will be further delayed or modified in the future.

Accountable Care Organizations

The Affordable Care Act required HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("***ACOs***"). ACOs are groups of hospitals and/or physicians and other designated professionals and suppliers who come together voluntarily to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS are eligible to share in a portion of the amounts saved by the Medicare program. There are several types of ACO programs, and as of January 17, 2023, 456 ACOs participate in the Medicare Shared Savings Program, and additional ACOs are being established by private payers. The number of ACOs participating in the Medicare Shared Savings Program decreased in 2023, but the policies finalized in the final PFS rule for CY 2023 are expected to grow participation next year. On November 1, 2022, CMS issued the CY 2023 PFS final rule which included "significant reforms" to the Medicare Shared Savings Program intended to incentivize participation and promote equity and alignment across quality programs. Among other things, such measures included providing advance shared savings payments to certain new ACOs that serve underserved populations, allowing smaller ACOs more time to transition to downside risk, a health equity adjustment that would upwardly adjust ACOs' quality performance scores to reward excellent care delivered to underserved populations, and certain changes to benchmarking methodologies that are designed to encourage more ACOs to participate and succeed. A few of our facilities currently participate in ACOs.

Bundled Payment Pilot Programs

The Affordable Care Act created the Center for Medicare & Medicaid Innovation ("***CMMI***") and made it responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs while improving quality of care. Under these projects and initiatives, participating providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care and accept accountability for costs and the quality of care that is provided. By financially rewarding providers for quality, cost-effective care and penalizing providers when costs exceed a certain amount, these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. In connection with these programs, CMMI has developed a voluntary Bundled Payment for Care Improvement Advanced Model to test innovative payment and service delivery models that have the potential to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care for beneficiaries. Participation in bundled payments programs is generally voluntary, but CMS does currently require hospitals in certain geographic areas to participate in the Comprehensive Care for Joint Replacement model, which covers certain extremity joint replacement procedures and is scheduled to end in 2024. CMS has developed a radiation oncology bundled payment program that was expected to begin on January 1, 2022, but has been delayed indefinitely until CMS determines a date through future rulemaking. CMS has indicated that it expects to develop additional voluntary and mandatory bundled payment models in the future. Several of our facilities currently participate in bundled payment programs.

Specialty Hospital Limitations

Over the last decade, we have faced competition from hospitals that have physician ownership. The Affordable Care Act prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand. As of December 31, 2023, we operated two acute care hospitals through joint ventures with physicians in which we own a controlling interest.

Competition for Patients

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

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

In addition, tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, exemptions from sales, property and income taxes, and participation in the 340B Program. In certain states, some not-for-profit hospitals are permitted by law to directly employ physicians while for-profit hospitals are prohibited from doing so.

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

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

In addition to competitive concerns, many of our communities are experiencing slow growth, and in some cases, population declines. We believe this trend has occurred mainly as a result of challenging economic conditions in the non-urban communities where our facilities primarily operate, which are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves. In addition, other economic factors, including, the recent negative macroeconomic conditions, rising inflation and, potentially, self-rationing of healthcare services, have made it more difficult to increase the number of patients who seek care at many of our facilities.

Human Capital Resources

Overview

Our facilities must compete with other healthcare providers for professional talent. A significant factor in our future success will be the ability of our facilities to attract and retain physicians, as it is physicians who decide whether a patient is admitted to the hospital and the procedures to be performed.

We also compete with other healthcare providers in recruiting and retaining qualified management and other healthcare providers such as nurses, pharmacists, and lab technicians and other non-physician personnel responsible for day-to-day operations of each of our facilities. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue, which was heightened by the COVID-19 pandemic and has since continued due to a variety of factors, including increased competition for a limited number of qualified candidates. This shortage has required, and may continue to require us, to enhance wages and benefits to recruit and retain nurses and other medical support personnel, recruit personnel from foreign countries, and utilize more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate.

At December 31, 2023, our subsidiaries collectively had approximately 50,000 employees, including approximately 14,000 part-time employees. The majority of these employees are hospital-based, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our facilities. We understand that, to fulfill our mission of Making Communities Healthier®, we must create places where people choose to come for healthcare, physicians want to practice, and employees want to work. To support this mission, talent development has been a longstanding strategic pillar for the organization.

Diversity, Equity and Inclusion

We are committed to creating an inclusive, community-based healthcare delivery system that provides equitable opportunities for all people, starting with our employees. As we have continued on our diversity, equity and inclusion ("***DEI***") journey, it has become clear that in a large and complex organization like ours – with people located across the nation – DEI requires the engagement and perspectives of many – many voices across many departments, disciplines and locations. Given this, we created an interdisciplinary team to continue to refine our overall DEI strategy and grow what we do in this critical area. This team is jointly led by three Lifepoint leaders who bring valuable expertise from their respective areas – representing Quality, People Services, and Communications – that are helping enrich our DEI strategy. Lifepoint's commitment to DEI has never been stronger, and we are excited about the opportunities to continue to expand our work and leadership in this area.

Serving the Community

We have a culture of giving and service that impacts the community of care beyond the bedside. We do this by: (i) educating our employees on the importance of positively impacting the communities they call home, (ii) serving our communities by advancing our mission both inside and outside our facilities' walls, (iii) investing in organizations that align with our mission and are making a difference and (iv) leading by example through our collective impact nationwide.

Our Lifepoint Community Foundation guides our charitable giving and economic development efforts, reviews requests for local financial or in-kind support and continuously evaluates the effectiveness of our social responsibility efforts in supporting our mission. Our local community support includes, among other charitable causes, strategic community impact partnerships with Second Harvest Food Bank of Middle Tennessee and Special Olympics Tennessee.

We are committed to taking care of our Lifepoint family so we can better care for others. The Lifecare Fund was established in 2010 as a safety net for employees experiencing serious financial hardship from unforeseen or unpreventable circumstances. Managed by the Community Foundation of Middle Tennessee, the Lifecare Fund has provided financial assistance for thousands of our employees during their times of greatest need.

Recruitment and Retention

We believe that healthcare is best delivered close to home, and our facilities strive to recruit and retain qualified management and staff personnel. Our frontline caregivers, including nurses, are the heartbeat of our organization, and we have a robust strategy to enhance the recruitment and retention of clinical staff into the future. This strategy includes meaningful education and career advancement opportunities, and competitive compensation. The scarce availability of nurses and other medical support personnel in some markets, which was heightened by the COVID-19 pandemic and has since continued due to a variety of factors, including increased competition for a limited number of qualified candidates, has required us to enhance wages and benefits and/or utilize more expensive temporary personnel in certain situations.

Our facilities also employ and have affiliations with physicians. Many physicians today prefer to be employed, rather than operating their own practices or joining existing medical groups. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians and incur additional expenses as a result. We expect this trend to continue.

We seek to attract both employed and affiliated physicians by maintaining a sharp focus on quality, driven by our National Quality Program; employing high performing talent; equipping our facilities with technologically advanced equipment and an attractive, up-to-date physical plant; and otherwise creating an environment within which physicians choose to practice. While physicians may terminate their association with our facilities at any time, we believe that, by striving to maintain and improve the quality of care at our facilities and by maintaining ethical and professional standards, our facilities will be better positioned to attract and retain qualified physicians with a variety of specialties.

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

Labor Costs and Union Activity

As of December 31, 2023, approximately 2,900 of our employees across certain of our facilities are unionized. While some of our non-unionized facilities experience union organizing activity from time to time, currently we do not expect these efforts to affect our future operations materially. Our facilities, like most facilities, have experienced rising labor costs and increases in the rate and utilization of contract labor. Our labor costs also may increase at higher rates among unionized employees. Unionized employees also may have rights under their collective bargaining agreements that restrict the ability of a facility to take certain actions with respect to these employees.

Government Regulation

Overview

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

Fraud and Abuse Laws

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

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

Anti-kickback Statute

The federal Anti-kickback Statute is a criminal statute that generally prohibits the payment, receipt, offer or solicitation of anything of value, whether in cash or in kind, with the intent of generating referrals or orders, or recommending or arranging for services or items covered by a federal or state healthcare program. Violations of the Anti-kickback Statute are punishable by, among other things, imprisonment, criminal fines, substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation, damages equal to three times the total remuneration associated with the unlawful referrals or services, and/or possible exclusion from participating in Medicare, Medicaid or other governmental healthcare programs. Violations of the Anti-kickback Statute can also result in liability under the False Claims Act.

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

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

In 1998, the OIG published the Provider Self-Disclosure Protocol (which was subsequently replaced in 2013 and further amended in 2021 and renamed the Health Care Fraud Self-Disclosure Protocol) to establish a process for persons to voluntarily identify, disclose, and resolve instances of potential fraud involving federal healthcare programs and provide guidance on how to investigate this conduct, quantify damages, and report the conduct to OIG to resolve liability under OIG's civil monetary penalty authorities. We have a variety of financial relationships with physicians who refer patients to our facilities, including employment contracts, independent contractor agreements, professional service agreements, leases and joint ventures. We provide financial incentives to recruit physicians to relocate to communities served by our facilities. These incentives for relocation include minimum revenue guarantees and, in some cases, loans. The OIG is authorized to publish regulations outlining activities and business relationships that would be deemed not to violate the Anti-kickback Statute. These regulations are known as "safe harbor" regulations. Failure to comply with the safe harbor regulations does not, by itself, make conduct illegal, but instead the safe harbors delineate standards that, if complied with, protect conduct that might otherwise be deemed in violation of the Anti-kickback Statute. We intend for all our business arrangements to be in full compliance with the Anti-kickback Statute and seek to structure each of our arrangements with physicians to fit as closely as possible within an applicable safe harbor. However, not all of our business arrangements fit wholly within safe harbors, so we cannot guarantee that these arrangements will not be scrutinized by government authorities or, if scrutinized, that they will be determined to be in compliance with the Anti-kickback Statute or other applicable laws.

Eliminating Kickbacks in Recovery Act

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

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

Stark Law

The federal Stark law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship if those entities provide certain "designated health services" unless an exception applies. The Stark law also prohibits entities that provide designated health services reimbursable by Medicare and Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires entities to refund amounts received for items and services provided pursuant to a prohibited referral on a timely basis. "Designated health services" include, among other things, inpatient and outpatient hospital services, laboratory services and radiology services. A violation of the Stark law may result in (i) a denial of payment, (ii) substantial civil monetary penalties that are subject to annual adjustments for inflation for each violation or circumvention scheme and (iii) exclusion from participation in the Medicare and Medicaid programs and other governmental healthcare programs. In addition, violations of the Stark law could also result in penalties under the False Claims Act.

There are ownership and compensation arrangement exceptions to the self-referral prohibition. There are also exceptions for many of the customary financial arrangements between physicians and facilities, including employment contracts, leases and recruitment agreements, and there is a "whole hospital exception," which allows a physician to make a referral to a hospital if, among other things, the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. The Affordable Care Act significantly modified the requirements of the whole hospital exception and placed a number of restrictions on the ownership structure, operations, and expansion of physician owned hospitals. Two of our facilities are subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations.

In recent years, CMS has issued a number of proposed and final rules modifying and/or clarifying the Stark law exceptions. For example, on November 20, 2020, HHS published two final rules related to the Anti-kickback Statute and the Stark law that are intended to reduce regulatory barriers to care coordination and ease unnecessary compliance burdens for physicians and other healthcare providers. Among other things, the rules create new Anti-kickback Statute safe harbors and Stark law exceptions for value-based and cyber-technology arrangements and provide new guidance and clarification as to how the Anti-kickback Statute and Stark law will be interpreted and enforced by the OIG and CMS, respectively. We cannot predict the impact that the final rules will have on our facilities and our operations or whether the recent trend toward reducing provider compliance burdens will continue in the future. We also anticipate that there will be further changes to the regulations that implement the Anti-kickback Statute and/or the Stark law, and those changes may require us to modify our activities.

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

False Claims Act

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

Regulatory Environment

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

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

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

In addition to the changes mentioned above, the Affordable Care Act created False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. On February 11, 2016, CMS published a final rule that provides clarification around the meaning of overpayment identification and generally establishes a six-year lookback period for Medicare Part A and Part B providers and suppliers. On December 27, 2022, CMS issued a proposed rule that, if adopted, would have, among other things, materially revised the meaning of overpayment identification and, thereby, would have created uncertainty related to the timing of a provider's repayment obligation; however, CMS has decided not to proceed with the proposed changes at this time. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments, accurately prepare cost reports and timely resolve credit balances. In light of the provisions of FERA and the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law, including technical violations of certain fraud and abuse laws, and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

State Laws

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

Emergency Medical Treatment and Active Labor Act

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

On July 11, 2022, in response to an executive order issued by President Biden in the wake of the Dobbs Decision that overturned the Roe Decision, HHS issued guidance on the applicability of EMTALA to the performance of abortion services when needed for emergency care. In its guidance HHS stated that EMTALA requires providers to provide stabilizing care to all individuals with an emergency medical condition, including providing abortion services when necessary, regardless of the state where they live. HHS also reiterated that EMTALA preempts directly conflicting state abortion laws that may restrict or ban abortions. A number of lawsuits have been filed challenging the enforceability of HHS's guidance in states with abortion laws. We cannot predict the outcome of these and other lawsuits, or how the federal and state government agencies will ultimately enforce EMTALA or related state laws in light of HHS's EMTALA guidance or the impact that such guidance will have on our operations or the cost of providing services in the communities we serve.

Administrative Simplification Provisions and Privacy and Security Requirements

We are subject to the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***") which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. Additionally, we are subject to the privacy, security and breach notification regulations promulgated under HIPAA and the Health Information Technology for Economic and Clinical Health Act (the "***HITECH Act***"), which are designed to protect the confidentiality, availability and integrity of protected health information ("***PHI***") and establish an array of patient rights with respect to such information. The HIPAA privacy, security and breach notification regulations apply to covered entities, which include health plans, healthcare clearinghouses, and healthcare providers that conduct certain standard transactions (such as billing insurance) electronically. In addition, certain provisions of the privacy, security and breach notification regulations apply to business associates, which are entities that perform certain functions or activities on behalf of covered entities that require access to or the use or disclosure of protected health information. In certain circumstances, a covered entity may be held liable for the actions of its business associate if HHS determines an agency relationship exists between the covered entity and the business associate under federal agency law.

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

HIPAA enforcement actions arise from audits, complaints, and breach notifications. Violations of the HIPAA regulations may result in criminal penalties and substantial civil monetary penalties subject to a limit for violations of the same requirement in a calendar year, based on the level of culpability associated with the violation. The civil monetary penalties are also subject to annual inflation adjustments. In addition, state attorneys general are authorized to bring civil actions seeking either injunction or damages up to $25,000 for violations of the same requirement in a calendar year in response to HIPAA violations that affect their state residents. HHS has the discretion in many cases to resolve HIPAA violations through informal means without the imposition of penalties. However, the HIPAA privacy, security and breach notification regulations have and will continue to impose significant costs on our facilities in order to comply with these standards. In recent years, enforcement of the HIPAA regulations has increased significantly, and we expect the increased level of enforcement to continue in the future.

Our facilities continue to remain subject to other applicable federal or state laws that are more restrictive than the HIPAA privacy and security regulations, which could impose additional penalties on us. For example, the federal government and some states impose laws governing the use and disclosure of health information pertaining to substance use disorder and/or mental health treatment that are more stringent than the rules that apply to healthcare information generally. In addition, the FTC uses its consumer protection authority to initiate enforcement actions against companies whose inadequate data security programs may expose consumers to fraud, identity theft and privacy intrusions, including the security programs of entities subject to the HIPAA regulations. Other state data privacy and security laws also may be applicable to certain data held by our facilities of residents of such states, such as the California Consumer Privacy Act of 2018, as amended by the California Privacy Rights Act of 2023, the Virginia Consumer Data Protection Act, the Colorado Privacy Act, and the Utah Consumer Privacy Act, as well as other similar laws that are selected to go into effect in the future (for example, the Indiana Consumer Data Protection Act, the Iowa Consumer Data Protection Act, the Montana Consumer Data Privacy Act, the Oregon Consumer Privacy Act, the Tennessee Information Protection Act, and the Texas Data Privacy and Security Act). These laws provide for civil penalties, and, in some cases, a private right of action, for violations. These laws and other proposed state privacy bills could have far-reaching effects and require that we modify our data processing practices and policies and incur substantial costs and expenses in order to comply.

Corporate Practice of Medicine and Fee-Splitting

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

Facility Licensure, Certification, and Accreditation

All of our facilities must comply with various federal, state and local licensing and certification regulations and undergo periodic inspection by licensing agencies to certify compliance with such regulations. The initial and continued licensure of our facilities and certification to participate in government healthcare programs depends upon many factors including various state licensure regulations relating to quality of care, environment of care, equipment, services, staff training, personnel and the existence of adequate policies, procedures and controls. Federal, state and local agencies survey our facilities on a regular basis to determine whether the facilities are in compliance with regulatory operating and health standards and conditions for participating in government healthcare programs.

Most of our general acute care hospitals and IRFs maintain accreditation from private entities, such as The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities ("***CARF***"). The Joint Commission accredits a broad variety of healthcare organizations, including hospitals and behavioral health organizations. CARF accredits behavioral health organizations providing mental health and alcohol and drug use and addiction services, rehabilitation services, as well as opiate treatment programs, and other types of healthcare programs. These accreditation programs are intended generally to improve the quality, safety, outcomes and value of healthcare services provided by accredited facilities. Certain federal and state licensing agencies as well as many government and private healthcare payment programs require that providers be accredited as a condition of licensure, certification or participation. Accreditation is typically granted for a specified period, ranging from one to three years, and renewals of accreditation generally require completion of a renewal application and an on-site renewal survey.

The Controlled Substances Act and Drug Enforcement Administration ("***DEA***") regulations require every person who dispenses controlled substances to be registered with the DEA at each principal place of business or professional practice where the person dispenses controlled substances, subject to limited exceptions. Each hospital or clinic must hold a DEA registration at each location and may be subject to similar state registration requirements. In addition, our facilities are subject to a variety of federal and state statutes and regulations that govern operational issues related to pharmaceuticals and controlled substances, such as those related to packaging, storing, and dispensing of pharmaceutical drugs, inventory control and recordkeeping requirements for controlled substances, and other standards intended to prevent diversion of controlled substances. The DEA, the DOJ, HHS, and state boards of pharmacy have broad enforcement powers, may conduct audits and investigations and can impose substantial fines and other penalties, including revocation of registration.

Certificates of Need

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

Not-for-Profit Hospital Conversion Legislation

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

Environmental Regulation

Our healthcare operations generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Our operations, as well as our purchases and sales of healthcare facilities, are also subject to compliance with various other environmental laws, rules and regulations. Such compliance costs are not significant, and we do not anticipate that such compliance costs will be significant in the future. However, regulations limiting greenhouse gas emissions and energy inputs may increase in coming years, which may increase our costs associated with compliance, disrupt and adversely affect our operations and could materially adversely affect our financial performance.

Compliance Program

We maintain a company-wide ethics and compliance program designed to ensure that we maintain high standards of ethical conduct in the operation of our business and to meet or exceed applicable federal guidance and industry standards. We continually implement written policies and procedures for all of our employees to promote compliance with all applicable laws, regulations and Company policies and to encourage a "culture of compliance" within the Company and its facilities. The organizational structure of our ethics and compliance program includes oversight by our Board of Directors (the "***Board***") and compliance committees at the Company and facility levels. We have compliance officers and personnel at the Company level and at our facilities. Other features of our compliance program include initial and periodic ethics and compliance training, systems for identifying and tracking compliance issues (including databases and hotlines for employees to report, without fear of retaliation, any suspected legal or ethical violations), regular auditing and monitoring of compliance issues, including coding audits and reviews of our financial relationships with physicians, and prompt review and resolution of identified issues.

Our compliance program also oversees the implementation and monitoring of the standards set forth by HIPAA for privacy. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our healthcare facilities and oversight at the Company level.

Risk Management and Insurance

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("***SIR***") and deductible levels. At December 31, 2023, our SIR for professional liability claims is $15 million per claim at the majority of our acute care hospitals. Additionally, we participate in state-specific professional liability programs in New Mexico and Pennsylvania. We have a $25,000 deductible for professional liability at each of our IRFs and a $100,000 deductible at each of our BHFs. At December 31, 2023, our deductible for workers' compensation claims at each of our acute care and BHFs was $1 million per claim in all states in which we operate except for Montana, Ohio and Washington. We participate in state-specific programs for our workers' compensation claims arising in these states. There is no deductible for workers' compensation claims at our IRFs. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

We also maintain directors' and officers', property, some professional liability and other types of insurance coverage with unrelated commercial carriers. Our directors' and officers' liability insurance coverage for current officers and directors is a program that protects us as well as the individual director or officer. We maintain property insurance through unrelated commercial insurance companies.

We operate a captive insurance company under the name Point of Life Indemnity, Ltd. This captive insurance company, which is licensed by the Cayman Islands Monetary Authority and is a wholly-owned subsidiary of Lifepoint, issues malpractice indemnity policies to some subsidiaries employing physicians and advanced practice providers.

Item 1A. ***Risk Factors.***

Any of the following risks could materially and adversely affect our business, financial condition, results of operations or cash flow. In addition, the risks described below are not the only risks that we face. The following information should be read in conjunction with "Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Report. Additional risks and uncertainties not currently known to us or those that we currently view to be immaterial could also materially and adversely affect our business, financial condition, results of operations or cash flow.

Risk Factor Summary

The following is a summary of the principal risks that could adversely affect our business, financial condition, results of operations or cash flow.

Business and Operational Risks

- Changes in reimbursement rates, methods or timing of payment by federal or state programs may reduce our Medicare or Medicaid payments and adversely affect our revenues, results of operations and cash flow.
- Changes to Medicaid supplemental payment programs may materially and adversely affect our results of operations and cash flow.
- Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may adversely affect our revenues, results of operations and cash flow.
- Uncertainty regarding the Affordable Care Act or future healthcare reform may adversely affect our business, financial condition, results of operations and cash flow.
- COVID-19 and resulting legislation may continue to affect our operations, business and financial condition.
- We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations, or it could diminish the anticipated value of the acquired facility.
- We are subject to risks associated with outsourcing functions to third parties, including risks associated with the protection of patient data.
- We conduct a significant portion of our operations through joint ventures. We cannot provide assurances that relationships with our joint venture partners will remain strong, which could negatively affect our joint ventures, affiliations and other strategic alliances as well as our overall business.
- If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.
- Deterioration in the collectability of "patient due" accounts could adversely affect our revenues, results of operations and cash flow.
- Other hospitals and inpatient and outpatient facilities provide services similar to those which we offer. In addition, physicians and other healthcare practitioners provide services in their offices that could be provided in our facilities. These factors increase the level of competition we face and may therefore adversely affect our revenues, results of operations and cash flow.
- We may have difficulty acquiring or divesting facilities on favorable terms. Furthermore, our business could be negatively affected if acquisitions or divestitures are not successfully completed or if contingent liabilities materialize in connection with such transactions.
- If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results and cash flow could be negatively impacted.
- Under each of the 2021 Master Lease (defined below) and the Springstone Master Lease, a default with respect to one facility could cause a default under all of the facilities subject to the 2021 Master Lease or the Springstone Master Lease, respectively, which could have a material adverse effect on our business, financial condition, results of operations and cash flow.
- Because many of the facilities we operate are subject to long-term leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities and incur substantial costs in restoring the premises.
- Many non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies to generate organic growth and improve operating results at our facilities.
- Our financial condition, results of operations and cash flow may be adversely affected by changing economic conditions, including interest rates and inflation.
- Supply chain issues of the medical supplies, equipment and pharmaceuticals used in our facilities could adversely affect our operations.
- Our cash and cash equivalents could be adversely affected if the financial institutions in which we hold our cash and cash equivalents fail.
- Factors associated with global climate change, including evolving and increasing regulations, increasing global concern and stakeholder scrutiny about climate change, and extreme weather conditions could adversely affect our business, reputation, results of operations and financial position.
- Our operations could be adversely impacted by civil unrest, acts of war or terrorism, other criminal activities, infectious disease outbreaks or other unexpected events outside our control.

Credit and Liquidity Risks

- Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations or fund strategic initiatives, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments.
- Our debt agreements contain restrictions that will limit our flexibility in operating our business.
- We are dependent on cash flow generated by our subsidiaries to service our indebtedness.
- We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.

- Our ability to obtain, and the terms of any, financing or refinancing will be dependent on the condition of the financial markets and our financial condition and operating performance. Any inability to obtain refinancing as our debt matures could materially and adversely affect our financial condition.
- Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.
- Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.
- We may not be able to generate sufficient cash flow through operations or successfully access other capital resources to fund all of our capital expenditure programs and commitments.
- Our ability to utilize our net operating loss carryforwards ("***NOLs***") may be limited, and we may not be able to utilize our NOLs as a result of recent U.S. federal tax reform legislation.

Human Capital Risks

- Factors related to our employment of physicians could affect our financial performance.
- Our operations and ability to deliver healthcare services efficiently may be adversely affected if we are unable to recruit and retain quality physicians, nurses and other healthcare professionals.
- Our performance and labor costs may be adversely affected by challenging labor market conditions and the shortage of qualified nurses and other healthcare personnel.
- Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and subject to the terms of collective bargaining agreements.
- We are dependent on our executive management team and the loss of the services of one or more members of our executive management team could have a material adverse effect on our business.

Regulatory and Legal Risks

- We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may adversely affect our revenues, results of operations and cash flow.
- We may be subjected to actions brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the False Claims Act's "qui tam" or "whistleblower" provisions.
- We may be subjected to liabilities because of malpractice and other legal claims brought against our facilities or healthcare providers associated with, or employed by, our facilities or affiliated entities. If we become subject to these claims, we could be required to pay significant damages, which may not be covered by insurance.
- As a result of reviews of claims to Medicare and Medicaid for our services, we may experience delayed payments or incur additional costs and may be required to repay amounts already paid to us.
- Controls designed to reduce inpatient services may adversely affect our revenues, results of operations and cash flow.
- If we do not manage admissions in the IRFs that we operate or manage in compliance with a 60% threshold, reimbursement for services rendered by us in these facilities will be based upon less favorable rates.
- Certificate of need laws and regulations regarding licenses, ownership and operation may impair our future expansion in some states. In states without certificate of need laws, competing providers of healthcare services are able to expand and construct facilities without the need for significant regulatory approval.
- Failure to implement and use certified health information technology in an effective and timely manner could adversely affect our operations and result in reduced Medicare and Medicaid reimbursement and government enforcement actions.
- The industry emphasis on value-based purchasing and bundled payment arrangements may negatively affect our revenues.
- The implementation of participation and quality measurement requirements under the MACRA's Merit-Based Incentive Payment System may affect our revenues.
- If current or future laws or regulations force us or cause us to restructure our arrangements with physicians and other providers, we may incur additional costs, lose contracts and suffer a reduction in net revenue under existing contracts, and we may need to refinance our debt or obtain consent from our lenders.
- We care for a large number of vulnerable individuals with complex needs and any incident involving one or more of our patients or the failure by one or more of our facilities to provide appropriate care could adversely affect our business, financial condition, results of operations or cash flow.

Data Security and Privacy Risks

- A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.
- If access to our information systems or those provided by our third-party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.
- If we fail to comply with our obligations under license or technology agreements with third parties, we may be required to pay damages and we could lose license rights that are critical to our business.
- The constant growth and development of technology, including the increased use of Artificial Intelligence, presents risks and challenges to our operations that could give rise to legal or regulatory action, damage our reputation or otherwise materially harm of our business.

Business and Operational Risks

Changes in reimbursement rates, methods or timing of payment by federal or state programs may reduce our Medicare or Medicaid payments and adversely affect our revenues, results of operations and cash flow.

For the years ended December 31, 2023, 2022 and 2021, approximately 56.5%, 56.9% and 56.1% of our revenues, respectively, related to patients participating in Medicare and Medicaid programs, collectively. Numerous factors could materially decrease, or delay timing of, Medicare and Medicaid payments to our facilities and, accordingly, adversely affect our revenues, results of operations and cash flow. These factors include statutory and regulatory changes, administrative rulings and determinations concerning patient and provider eligibility and requirements for utilization review. Furthermore, the Affordable Care Act and related federal laws provide for material scheduled reductions in the growth rate of Medicare and Medicaid program spending, including reductions in market basket updates and Medicare and Medicaid DSH funding. Additionally, a number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures or reform their Medicaid programs, including enrolling Medicaid recipients in managed care programs or converting to modified block grant funded programs. States also may impose additional taxes on hospitals to help finance the state's Medicaid programs.

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

MSPs are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid DSH and UPL payments. Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the additional costs incurred by hospitals in treating these patients. The total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law. Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an UPL above which states may not receive federal matching dollars.

The Affordable Care Act called for significant reductions in Medicaid DSH funding to account for decreases in uncompensated care anticipated under the health insurance coverage expansion. Subsequent changes in the law have delayed the implementation of these reductions until FFY 2024. Reductions in Medicaid DSH payments may take place without increases in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

UPL programs have expanded in recent years and certain of our hospitals receive payments under such programs. Because services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, as states increase their use of managed care Medicaid programs, UPL MSPs could be reduced. UPL funding and matching federal funds may also be reduced or eliminated as a result of state or local governmental legislation, state changes to historical funding levels or related taxes, compliance reviews by CMS, or changes to federal Medicaid funding affecting such programs. We cannot predict whether MSP programs will continue, and, if continued, whether we will qualify for such programs, or guarantee that revenues recognized from these programs will not decrease.

Changes in payer mix, the financial condition of payers and healthcare cost containment initiatives may adversely affect our revenues, results of operations and cash flow.

The amounts we receive for services provided to patients are determined by a number of factors, including the payer mix of our patients and the reimbursement methodologies and rates utilized by our payers. We have seen shifts of patients from commercial and private insurance to Medicare and Medicaid programs and from "traditional" fee-for-service Medicare and Medicaid programs to managed Medicare and Medicaid programs. Reimbursement rates generally are lower for (i) Medicare and Medicaid beneficiaries than they are for patients whose care is covered by commercial and private insurance and (ii) managed Medicare and Medicaid beneficiaries than they are for traditional Medicare and Medicaid beneficiaries. Broad economic factors, including those resulting from inflationary pressures, supply chain disruptions, labor shortages, increased unemployment and underemployment rates and reduced consumer spending and confidence, may impact our revenue mix. We also experience demographic pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs. Our revenues, results of operations and cash flow may be adversely affected by these shifts.

In addition, our revenues from negotiated rates with HMOs, PPOs, insurance companies, employers and other private payers may decline based on renegotiations and the respective bargaining power of these parties. Also, consolidation among private payers may increase their bargaining power over fee structures. As a result, payers increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk related to paying for care provided. These changes include moving away from a percent of charge payment structure to a fixed payment for an episode of care, which typically reduces our payment rate and limits our ability to raise prices going forward. Furthermore, low-cost plans purchased through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices, restrict or exclude our facilities or impose significantly higher cost sharing obligations for care provided by our facilities if they are classified in a disfavored tier. In addition, other healthcare providers, including some with greater financial resources, greater geographic coverage or a wider range of services, may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care plans to contract with us. As payments are reduced, if we are excluded from more payer networks or if the scope of services covered by payers is limited, there could be a material adverse effect on our revenues, results of operations and cash flow.

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

Uncertainty regarding the Affordable Care Act or future healthcare reform may adversely affect our business, financial condition, results of operations and cash flow.

The Affordable Care Act dramatically altered the U.S. healthcare system, and we have expended substantial cost and effort to prepare for and comply with the Affordable Care Act. The net effect of the Affordable Care Act on our business continues to be subject to a number of variables, including the law's complexity, its changing and often incomplete implementation of regulations and interpretive guidance, and the sporadic implementation of the numerous programs designed to improve access to and the quality of healthcare services. Additionally, the Affordable Care Act has been the subject of numerous legal challenges and legislative efforts to delay, defund or repeal the implementation or amend significant provisions of the Affordable Care Act. We cannot predict the outcome of lawsuits regarding the implementation of various aspects of the Affordable Care Act and whether the U.S. Supreme Court will decide to hear additional cases related to the Affordable Care Act in the future. We also cannot predict the impact that the current or future Presidential administrations and Congresses, including that of the upcoming 2024 Presidential election, will have on the implementation and enforcement of the provisions of the Affordable Care Act or any future healthcare reform legislation or initiatives, including "Medicare-for-all" or other single-payer proposals.

COVID-19 and resulting legislation may continue to affect our operations, business, and financial condition.

As a front-line provider of health care services, COVID-19 has affected and may continue to affect our facilities, employees, patients, communities, business operations and financial performance. Although vaccines are widely available in the U.S., the extent to which COVID-19 impacts will continue is difficult to predict due to factors beyond our control, such as the vaccination rates in the communities we serve, the number and severity of the variants of the virus that emerge, the effectiveness of the vaccines against the virus and those variants, the unknown extent of the long-term health effects of COVID-19, and the effects of COVID-19 on macroeconomic conditions.

In response to the COVID-19 pandemic, federal and state governments passed legislation, promulgated regulations and took other administrative actions intended to assist healthcare providers during the public health emergency and to provide financial relief. The CARES Act, the Paycheck Protection Program and Health Care Enhancement Act, the Consolidated Appropriations Act and the ARP authorized funding to be distributed to eligible healthcare providers through the Public Health and Social Services Emergency Fund (the "***Emergency Fund***"). These funds were intended to reimburse eligible providers, including public entities and Medicare- and/or Medicaid-enrolled providers and suppliers, for lost revenues and healthcare related expenses attributable to COVID-19. Recipients are not required to repay these funds, provided that they attest to and comply with certain terms and conditions. However, the Company is required to submit reports for all of its providers that received and retained payments from the Emergency Fund, which are closely monitored by HHS. As a result we may be subject to or incur costs from related government actions including payment recoupment, audits and additional inquiries by governmental authorities.

We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. Also, if we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations or it could diminish the anticipated value of the acquired facility.

We may be unable to timely and effectively integrate facilities that we acquire with our ongoing operations. Many of the facilities we have acquired had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced delays in improving the operating margins or effectively integrating the operations of our acquired facilities, and we may experience such delays in implementing operating procedures and systems in newly or future acquired facilities. Integrating an acquired facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow, distract management and other key personnel, negatively impact our ability to attract, retain and motivate current and prospective employees, subject us to increased regulatory oversight, and result in legal proceedings. Additionally, we may experience delays in reimbursement from governmental and third-party payers as a result of the change of ownership of our acquired facilities.

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

Facilities we have acquired or facilities we acquire in the future, may have unknown or contingent liabilities for historical activities or conditions, including liabilities for failure to comply with laws and regulations, retroactive payment adjustments or recoupments from payer and Emergency Fund audits, medical and general professional malpractice liabilities, unfunded pension liabilities, workers' compensation or other employee-related liabilities, previous tax or environmental liabilities, regulatory and compliance related liabilities, and unacceptable business or accounting practices. Although we endeavor to obtain contractual indemnification from sellers covering these matters in connection with some acquisitions, we have not obtained contractual indemnifications in connection with all of them, and any indemnification obtained from sellers may be insufficient to cover material claims or liabilities for past activities of acquired businesses and the sellers may have insufficient funds to satisfy any claims or liabilities for which we may otherwise be entitled to be reimbursed.

We typically retain and rely on existing local management teams at newly acquired facilities to implement changes to operating procedures and systems. Integrating local management teams can involve cultural and systems challenges that may demand a disproportionate share of our resources and senior management's attention, and we may experience turnover of providers and other key personnel. Our acquisitions have become, and may continue to become larger, and may occur in communities with competing facilities. As a result, the issues surrounding integration may become more complex, expensive and time-consuming and may have a greater impact on our financial performance when we experience delays or difficulties.

Our growth has placed, and will continue to place, increased demands on our management, operational and financial information systems and other resources. Furthermore, expansions into new geographic markets and diversification of services and service lines may require us to comply with new and unfamiliar legal and regulatory requirements, which could impose substantial obligations on us and our management, cause us to expend additional time and resources, and increase our exposure to penalties or fines for non-compliance with such requirements. To accommodate our past and anticipated future growth, and to compete effectively, we will need to continue to improve our management, operational and financial information systems and to expand, train, manage and motivate our workforce. Our personnel, systems, procedures or controls may not be adequate to support our operations in the future. Further, focusing our financial resources and management attention on the expansion and diversification of our operations may negatively impact our financial results. Any failure to improve our management, operational and financial information systems, or to expand, train, manage or motivate our workforce, could reduce or prevent our growth.

We are subject to risks associated with outsourcing functions to third parties, including risks associated with the protection of patient data.

We outsource selected business functions to third parties, including electronic health record software and data hosting, revenue cycle management, patient access, billing, cash collections, payment compliance and support services, project implementation, supply chain management, payroll system services and a portion of our cybersecurity management. We take steps to monitor and regulate the performance of the independent third parties to whom we delegate selected functions. Arrangements with third-party service providers may make our operations vulnerable if vendors fail to satisfy their obligations to us as a result of their performance, changes in their own operations, financial condition, or other matters outside of our control. We may also face legal, financial or reputational harm for the actions or omissions of such providers, including for violations of HIPAA and other privacy and security laws applicable to healthcare providers and the Cures Act information blocking regulations, and we may not have effective recourse against the providers for those harms. While we evaluate the information security programs and defenses of such third parties, we cannot be certain that our evaluations will identify all or any potential information security weaknesses, or that such third parties' information security protocols are or will be sufficient to withstand or adequately respond to a cyber-attack or other information security incident. The expanding role of third-party providers may also require changes to our existing operations and the adoption of new procedures and processes for retaining and managing these providers, as well as redistributing responsibilities as needed. Effective management, development and implementation of our outsourcing strategies are important to our business and strategy. If there are delays or difficulties in enhancing business processes or our third-party providers do not perform as anticipated, we may not fully realize on a timely basis the anticipated economic and other benefits of the outsourcing projects or other relationships we enter into with key vendors, which could result in substantial costs, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us. Terminating, transitioning or renegotiating arrangements with key vendors or failure to renegotiate on favorable terms could result in additional costs and a risk of operational delays, potential errors and possible control issues as a result of the termination or during the transition or renegotiation phase.

We conduct a significant portion of our operations through joint ventures. We cannot provide assurances that relationships with our joint venture partners will remain strong, which could negatively affect our joint ventures, affiliations and other strategic alliances as well as our overall business.

We are a party to a number of joint ventures, affiliations and other strategic alliances as part of our business strategy. We expect to enter into similar transactions in the future, including joint ventures where we may have a noncontrolling interest**.** Any changes in our relationships with our joint venture partners could disrupt ongoing business, negatively affect results of operations or cash flow and distract management and other key personnel. In the event of a material disagreement with any of our joint venture partners or the breach of any of our joint venture agreements, a joint venture may be subject to dissolution, unwinding or purchase of either party's interest, which could adversely affect our revenues, results of operations or cash flow, or result in reputational harm.

As a general matter, our joint venture partners may have investment and operational goals that are not aligned with our company-wide objectives, including the timing, terms and strategies for future growth and development opportunities, and we could reach an impasse on certain decisions, which may hinder our ability to pursue preferred strategies for growth and development, could require significant resources and attention from management and key employees to resolve and could have an adverse effect on our operations, cash flow and revenue growth. In addition, our joint venture relationships with not-for-profit partners and the agreements that govern these relationships are structured based on current provisions of the Internal Revenue Code of 1986, as amended (the "***Code***") (and the Treasury Regulations thereunder), published rulings by the Internal Revenue Service ("***IRS***"), as well as case law relevant to joint ventures between for-profit and not-for-profit entities. Material changes in these legal authorities could adversely affect our relationships with not-for-profit partners and related joint venture arrangements.

Furthermore, joint ventures in which we have a noncontrolling equity interest and noncontrolling investments may involve a lesser degree of control over business operations, thereby potentially increasing the financial, legal, operational and compliance risks associated with the joint venture or noncontrolling investment. We may be dependent on joint venture partners or management who may have business interests, strategies or goals that are inconsistent with ours. Business decisions or other acts or omissions of the joint venture partner or management may adversely affect the value of our investment, result in litigation or regulatory action against us or result in reputational harm to us. To the extent another party makes decisions that negatively impact the joint venture or internal control issues arise within the joint venture, we may have to take responsive or other actions or we may be subject to penalties, fines or other related actions for these activities.

If our fair value declines or if our estimated future cash flows decrease, a material non-cash charge to earnings from impairment of our goodwill or our long-lived assets could result.

As of December 31, 2023, we had approximately $4.2 billion of goodwill and other intangible assets and approximately $3.4 billion of property and equipment, net of accumulated depreciation. We expect to recover the carrying values of our goodwill and other long-lived assets through our future cash flows. We evaluate the carrying value of our goodwill at least annually, based on our fair value determined using a discounted cash flow analysis and consideration of certain market inputs, to determine whether it is impaired. We evaluate our long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows. If the carrying value of our goodwill or our long-lived assets is impaired, we may incur a material non-cash charge to earnings.

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

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

If we experience growth in self-pay volume and revenue, including increased acuity levels for uninsured patients and increases in co-payments and deductibles for insured patients, our revenues, results of operations and cash flow could be adversely affected. Although we have experienced a reduction in uninsured patients since 2014 as a result of the Affordable Care Act and the expansion of state Medicaid programs, we are unable to predict whether that trend will continue in light of the repeal of the penalties associated with the individual mandate, the cessation of the cost sharing reduction payments to insurers, the decision by some states not to expand their Medicaid programs, and the availability and utilization of employer-sponsored health plans. In addition, the risk of collection from insured patients (and the amounts due) has increased, and will likely continue to increase, as a result of more individuals being enrolled in insurance plans with high deductibles and high co-payments, including those purchased on the Exchanges. Furthermore, our ability to improve co-insurance collections and collections from self-pay patients may be limited by legislative developments, such as federal and state legislation designed to reduce "surprise billing," or by other regulatory or investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

An increase in the proportion of our accounts receivable being comprised of uninsured accounts and a deterioration in the collectability of these both insured and uninsured accounts could adversely affect our revenues, results of operations and cash flow. Even if the Affordable Care Act remains implemented in its current form, we may continue to experience bad debts and be required to provide uninsured discounts and charity care for patients who choose not to purchase coverage, are undocumented immigrants who are not permitted to enroll in the Exchanges or government healthcare programs or live in states that do not expand or maintain the expansion of their Medicaid programs.

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

Competition among hospitals and other healthcare service providers, including inpatient and outpatient facilities, has intensified in recent years. We also have acquired, and may continue to acquire, larger facilities in more concentrated population centers, which experience greater competition for healthcare services. We compete with other facilities, including larger tertiary and quaternary care centers located in metropolitan areas. Although the facilities with which we compete may be a significant distance away from our facilities, patients in our markets may migrate on their own to, may be referred by local providers to, or may be required by their health plan to travel to these facilities. Furthermore, some of the facilities with which we compete may offer more or different services than those available at our facilities, may have more advanced equipment or technology or may have a medical staff that is perceived to be better qualified. We also compete with facilities and health systems that are implementing physician and other provider alignment strategies, such as employing providers, acquiring physician practice groups and participating in ACOs or other clinical integration models, which may impact our competitive position. Also, many of the facilities that compete with our facilities are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions and are eligible to participate in the 340B Program. These facilities, in most instances, are also exempt from paying sales, property and income taxes and have the ability to issue tax-exempt bonds for financing.

Quality of care, value-based purchasing, and price transparency have also become significant trends and competitive factors in the healthcare industry. CMS makes public the performance data relating to multiple quality measures that facilities submit in connection with their Medicare payment. CMS also requires every Medicare participating hospital to establish and update annually a public online listing of the hospital's standard charges for items and services and has issued regulations that significantly increase hospital charge reporting requirements. If the publicly-available performance and charge data become a primary factor in where patients choose to receive care, and if competing facilities have lower charges or better results than our facilities on those measures, our revenues and/or patient volumes could decline.

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

We may have difficulty acquiring or divesting facilities on favorable terms. Furthermore, our business could be negatively affected if acquisitions or divestitures are not successfully completed or if contingent liabilities materialize in connection with such transactions.

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

The cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired facility's results of operations, allocation of purchase price, effects of subsequent legislation and limitations on rate increases. As part of our acquisition strategy, we may commit to making significant capital improvements at acquired facilities. Such improvements may be difficult to achieve in the anticipated timeframe, if at all, due to a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions.

Our ability to engage in certain acquisitions in several states may be limited due to exclusivity, non-competition and non-solicitation provisions that we have agreed to in connection with our joint ventures, leases and previous acquisitions and divestiture transactions. Additionally, certain acquisitions may require the consent of and collaboration with our joint venture partners based upon the applicable governing documents. If we cannot obtain the cooperation of our joint venture partners in certain instances, we may not be able to pursue these opportunities.

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

In recent years, the legislatures and attorneys general of several states have sought to exercise more active oversight authority regarding sales of facilities by tax-exempt entities. For example, as a condition to approving an acquisition involving a non-profit hospital, the state attorney general of a state in which an acquisition takes place may require us to maintain specific service lines or provide charity care at certain minimum levels for set periods of time after closing of the acquisition, regardless of profitability. Additionally, the federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive, and antitrust enforcement in the healthcare industry is currently a priority of the FTC and the DOJ, including with respect to hospital and physician practice acquisitions. This heightened scrutiny may increase the cost and difficulty, or prevent the completion, of transactions in the future. Our failure to acquire facilities consistent with our growth plans could prevent us from increasing our revenues.

We regularly evaluate the potential disposition of assets and facilities that may no longer help us attain our objectives. When we decide to sell assets or facilities, we may encounter difficulties in finding buyers or alternative exit strategies on acceptable terms or in a timely manner, which could delay the accomplishment of our strategic objectives. Certain of our facilities are subject to master leases which, in general, may make it more difficult for us to dispose of facilities or terminate facility leases subject to the terms of such master leases, including under the terms of our Master Lease Agreement, dated December 23, 2021, entered into with certain affiliates of MPT (as amended from time to time, the "***2021 Master Lease***") and the Springstone Master Lease. We may also dispose of assets or a facility at a price, or on terms, less desirable than we anticipated. In addition, we may experience greater dis-synergies than expected. After reaching an agreement with a buyer for the disposition of assets or a facility, we will be subject to satisfaction of pre-closing conditions as well as to necessary regulatory and governmental approvals on acceptable terms, which, if not satisfied or obtained, may prevent us from completing the transaction. Dispositions may also involve continued financial involvement in the divested facilities, such as through continuing equity ownership, guarantees, indemnities, transition service agreements or other financial and commercial obligations, and inability to avoid retention of certain regulatory and compliance risks. There can be no assurance that the anticipated benefits of our future divestiture strategies will be realized. Furthermore, we may be exposed to contingent liabilities in connection with completed divestitures. Finally, certain acquisition agreements and joint venture arrangements contain covenants that restrict our ability to dispose of certain facilities without first seeking consent of a joint venture partner or other third parties, which may affect our ability to take advantage of business opportunities that may be in our interest. If we do not realize the anticipated benefits of such divestitures, if contingent liabilities related to such divestitures materialize or if we are unable to divest certain properties on favorable terms or at all, this could have a material adverse effect on our results of operations and cash flow.

If we are unable to implement successfully standardized processes, policies and systems throughout our facilities, our operating results and cash flow could be negatively impacted.

We have initiated a multi-year business initiative to standardize certain processes, policies and systems throughout our facilities, including migrating our multiple IT platforms to an integrated ERP. If we do not allocate and effectively manage the resources necessary to build and sustain the proper IT infrastructure and implement an integrated ERP system, or if we fail to achieve the expected benefits from this initiative, it may impact our ability to operate profitably and efficiently, as well as comply in a timely manner with changing regulatory requirements and with the requests of patients, payers and business partners. The failure to transition to these systems on time, or anticipate necessary readiness and training needs, could lead to business disruption, management attention may be diverted, we may see increased operational costs while operating multiple systems, and loss of revenue. In addition, the operating results of newly acquired facilities could be impacted if such facilities are not integrated on a timely and effective basis into our new systems. The actions we take to resolve compliance or regulatory issues within acquired facilities may affect our revenue, results of operations or cash flow.

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

Under each of the 2021 Master Lease and the Springstone Master Lease, a default with respect to one facility could cause a default under all of the facilities subject to the 2021 Master Lease or the Springstone Master Lease, respectively, which could have a material adverse effect on our business, financial condition, results of operations and cash flow.

Upon certain defaults under each of the 2021 Master Lease and the Springstone Master Lease, even if such default relates to one facility under the 2021 Master Lease or the Springstone Master Lease, as the case may be, the applicable lessors may terminate the 2021 Master Lease or Springstone Master Lease in its entirety with respect to all of the facilities governed by such 2021 Master Lease or Springstone Master Lease, as the case may be. Under each of the 2021 Master Lease and the Springstone Master Lease, the portfolio of facilities supporting each of the 2021 Master Lease and the Springstone Master Lease is subject to financial covenants, including required minimum lease coverage and fixed charge coverage ratios. The failure to meet or obtain a waiver of such covenants or otherwise cure such non-compliance with such financial covenants in the 2021 Master Lease or the Springstone Master Lease in the future could result in an event of default under the 2021 Master Lease or the Springstone Master Lease, as the case may be.

Other events that could trigger a default under the 2021 Master Lease or the Springstone Master Lease if not cured within the time periods required by the 2021 Master Lease or the Springstone Master Lease, as the case may be, include, without limitation, (i) failure to pay rent or other amounts due under the 2021 Master Lease or the Springstone Master Lease, as the case may be, (ii) failure to comply with the non-financial covenants under the 2021 Master Lease or the Springstone Master Lease, as the case may be, (iii) the bankruptcy of any facility lessee under the 2021 Master Lease or the Springstone Master Lease or the guarantor of the facility lessees under the 2021 Master Lease or the Springstone Master Lease, as the case may be, (iv) termination of any licenses necessary for operation of a facility or required for certification under Medicare or Medicaid for any facility leased under the 2021 Master Lease or the Springstone Master Lease, as the case may be, (v) a change of control in violation of the 2021 Master Lease or the Springstone Master Lease, as the case may be, and (vi) a default under any material documents between any lessee of the facilities and any lessor of any facility leased under the 2021 Master Lease or the Springstone Master Lease, as the case may be. A default under the 2021 Master Lease or the Springstone Master Lease that results in a termination of the 2021 Master Lease or the Springstone Master Lease, as the case may be, would cause us to lose the ability to operate all of the facilities subject to the 2021 Master Lease or the Springstone Master Lease, respectively, and to incur substantial costs in restoring the premises, which could have a material adverse effect on our business, financial condition, results of operations and cash flow.

If the 2021 Master Lease or the Springstone Master Lease is terminated prior to its expiration because of a default and the lessor exercises its rights thereunder, in addition to losing the ability to operate our facilities, we may be liable for (i) damages and charges such as continued lease payments through the end of the lease term (or such shorter period as provided in the 2021 Master Lease or the Springstone Master Lease, as the case may be, or by law) and (ii) maintenance costs for the leased property leased under the 2021 Master Lease or the Springstone Master Lease, as the case may be. Upon termination of the 2021 Master Lease or the Springstone Master Lease, as the case may be, we will be obligated to restore the applicable premises to its original condition and repair all damage caused by the installation or removal of our personal property, ordinary wear and tear excepted. We also have restoration obligations with respect to certain casualty and condemnation events. In addition, upon termination of the 2021 Master Lease or the Springstone Master Lease, the lessor will have the option to purchase all of the applicable lessee's personal property at fair market value.

The 2021 Master Lease and the Springstone Master Lease are not cross-defaulted to one another.

Because many of the facilities we operate are subject to long-term leases, failure to comply with the terms of such leases or failure to renew such leases could cause us to lose the ability to operate these facilities and incur substantial costs in restoring the premises.

The rights to use many of our facilities are based upon long-term leases, including the 2021 Master Lease and the Springstone Master Lease. Pursuant to the terms of these leases, we are required to pay all rent due and comply with all other lessee obligations. As of December 31, 2023, the remaining term of these leases (including renewal options) generally ranged from less than one year up to 47 years. A pledge of our interest in some of these leases may also require the consent of the respective lessor and its lenders. As a result, we may not be able to sell, assign, transfer or convey our interest in certain facilities subject to such leases in the future absent consent of such third parties even if such transactions may be in our best interest. Most of the leases require that, upon the expiration or termination of the leases, we must surrender any improvements to the land to lessor. In addition, some of our leases include early termination provisions. We are typically responsible for all taxes, insurance, assessments and maintenance obligations under the leases. The leases also generally require the lessee to either reconstruct or restore the premises to its original condition following a casualty and to apply in a specified manner any proceeds received in connection therewith. In some leases, the lessor has the option to purchase some or all of the assets owned by us and used in connection with the operation of the applicable facility. Accordingly, failure to comply with the terms of such leases, the invalidity of or default or termination under such leases could cause us to lose the ability to operate these facilities altogether and incur substantial costs in restoring the premises, which could have a material adverse effect on our business, financial condition, results of operations and cash flow.

Many non-urban communities in which we operate continue to face challenging economic conditions and demographic trends, which may materially and adversely impede our business strategies to generate organic growth and improve operating results at our facilities.

Many non-urban communities in which we operate continue to face challenging economic conditions, including high levels of unemployment and unfavorable demographic trends, which may impede our business strategies to generate organic growth and improve operating results at our facilities. These challenging economic conditions have been further exacerbated recently by inflationary pressures and other negative macroeconomic pressures. The economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of large employers, especially manufacturing or similar facilities. These employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our facilities for care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or similar facilities located in or near many of the non-urban communities in which our facilities primarily operate, could cause affected employees to move elsewhere for employment or lose insurance coverage that was otherwise available to them.

When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to (i) defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for facilities, or (ii) purchase a high-deductible insurance plan or no insurance at all, which increases a facility's dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms, which are generally more costly settings for us to administer care.

Additionally, non-urban communities are experiencing a much slower rate of growth, if any, as compared to more concentrated population centers. As a result, we may experience payer mix pressures as aging populations in our non-urban communities shift from commercial insurance programs to Medicare or managed Medicare programs.

Our financial condition, results of operations and cash flow may be adversely affected by changing economic conditions, including interest rates and inflation.

In recent years, the U.S. market has experienced cyclical or episodic downturns, and worldwide economic conditions remain uncertain and volatile, as a result of current geopolitical conditions including the Israel-Hamas War, the ongoing Russia-Ukraine War and conflict between China and Taiwan, instability in the U.S. and global banking systems, increased inflation, the downgrading of the U.S.'s credit rating and the possibility of a recession. A decline in economic conditions, such as recession, economic downturn, and/or inflationary conditions in the U.S. can adversely and negatively impact our patients in a manner that could adversely affect our financial condition, results of operations and cash flow. Further, broad economic factors in connection with a potential economic recession or slowdown, including increased unemployment rates, increased inflation rates and decrease in disposable income and wages, could also negatively affect our payer mix, increase the relative proportion of lower margin services we provide and reduce patient volumes, as well as diminish our ability to collect outstanding receivables.

In addition, government actions intended to reduce inflation, including raising the federal funds rate, will increase our cost of borrowing, which in turn could make it more difficult to obtain financing for our operations or investments on favorable terms.

Supply chain issues of the medical supplies, equipment and pharmaceuticals used in our facilities could adversely affect our operations.

We are dependent on various medical supplies, equipment and pharmaceuticals used in our facilities to conduct our operations. Supply chain issues, such as shortages, delivery delays, manufacturing disruptions, and other supply chain interruptions affecting such supplies, equipment and pharmaceuticals, and price increases of such supplies, equipment, pharmaceuticals and raw materials could adversely impact our results of operations.

Our cash and cash equivalents could be adversely affected if the financial institutions in which we hold our cash and cash equivalents fail.

We regularly maintain cash balances at third-party financial institutions in excess of the Federal Deposit Insurance Corporation insurance limit. If a depository financial institution in which we hold our cash and cash equivalents fails or if a depository institution is subject to other adverse conditions in the financial or credit markets, and impacts access to our invested cash or cash equivalents, our operating liquidity and financial performance could be adversely affected.

Factors associated with global climate change, including evolving and increasing regulations, increasing global concern and stakeholder scrutiny about climate change and extreme weather conditions could adversely affect our business, reputation, results of operations and financial position.

There has been an increased focus from regulators and stakeholders on environmental, social, and governance ("***ESG***") matters. Our failure or perceived failure to achieve our ESG goals, maintain ESG practices, or comply with emerging ESG regulations that meet evolving regulatory or stakeholder expectations could adversely affect public perception of our business, employee morale or patient or stakeholder support, expend corporate resources, result in substantial costs and expenses, result in legal or regulatory proceedings against the Company and negatively impact our financial condition and results of operations. Damage to our reputation may reduce demand for our services and thus have an adverse effect on our future financial performance, as well as require additional resources to rebuild our reputation.

Global climate change also presents both immediate and long-term physical risks (such as extreme weather conditions) and risks associated with the transition to a low-carbon economy (such as regulatory or technology changes). These changes could result in, for example, temporary declines in the number of patients seeking our services, closures of our hospitals and related facilities, and supply chain disruptions, as well as increased costs of products, commodities and energy (including utilities), and disruptions in our information systems, which in turn could negatively impact our business and results of operations. In addition, certain of our operations and facilities are located in regions that may be disproportionately impacted by the physical risks of climate change (including hurricanes and flooding), and we face the risk of losses incurred as a result of physical damage to our hospitals and related facilities and business interruptions caused by such events. We maintain property insurance coverage to address the impact of physical damage to our facilities and for business interruption losses. However, such insurance coverage may be insufficient to cover all losses and we may experience a material, adverse effect on our results of operations that is not recoverable through our insurance policies. Additionally, if we experience a significant increase in climate-related events that result in material losses we may be unable to obtain similar levels of property insurance coverage in the future or at rates that are significantly higher than our current rates. Changes in consumer preferences and additional legislation and regulatory requirements, including those associated with the transition to a low-carbon economy, may increase costs associated with compliance, the operation of our facilities and supplies. Regulations limiting greenhouse gas emissions and energy inputs may also increase in coming years, which may adversely impact us through increased compliance costs for us and our suppliers and vendors.

Our operations could be adversely impacted by civil unrest, acts of war or terrorism, other criminal activities, infectious disease outbreaks or other unexpected events outside our control.

Our operations are always subject to adverse impacts resulting from civil unrest, acts of war, hostilities or acts of terrorism or other criminal activities. Such events may result in a temporary decline in the number of patients who seek our services or in our employees' ability to perform their job duties. In addition, such events may temporarily interrupt our ability to provide our services. The occurrence of any such event and/or a disruption of our operations as a result may adversely affect our financial condition, results of operations and cash flow.

Additionally, as evidenced by the COVID-19 pandemic, the occurrence of a pandemic, epidemic, outbreak of an infectious disease or other public health crisis in an area in which we operate could adversely affect our operations, business, and financial condition. In reaction to such a crisis or the fear of exposure to infection, patients might cancel elective procedures or fail to seek needed care at our facilities, which could result in reduced patient volumes and operating revenues, potentially over an extended period of time. Furthermore, a pandemic, epidemic or outbreak might adversely affect our operations by causing a temporary shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. Additionally, such a crisis could diminish the public trust in healthcare facilities, especially hospitals that fail to accurately or timely diagnose, or are treating (or have treated) patients affected by infectious diseases, and negatively affect the reputation at our facilities.

Although we have disaster plans in place and operate pursuant to infectious disease protocols, the extent to which the potential emergence of a pandemic, epidemic or outbreak would impact our business and operations is difficult to predict and would depend on many factors beyond our control, including the speed of the contagion, the development and implementation of effective preventative measures and possible treatments, the scope of governmental and other restrictions on travel and other activities, and public reactions to these factors.

Credit and Liquidity Risks

Our substantial indebtedness could materially and adversely affect our ability to raise additional capital to fund our operations or fund strategic initiatives, limit our ability to react to changes in the economy or our industry and prevent us from making debt service payments.

We are a highly leveraged company. As of December 31, 2023, we had total outstanding debt of approximately $6.3 billion, excluding finance lease obligations and unamortized debt issuance costs. Our substantial indebtedness could have important consequences for the Lenders and Holders of our indebtedness. For example, it could:

- limit our ability to borrow money for our working capital, capital expenditures, debt service requirements, strategic initiatives or other purposes;
- make it more difficult for us to satisfy our obligations with respect to our indebtedness and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the agreements governing our indebtedness;
- require us to dedicate a substantial portion of our cash flow from operations to the payment of interest and the repayment of our indebtedness, thereby reducing funds available to us for other purposes;
- limit our flexibility in planning for, or reacting to, changes in our operations or business;
- make us more highly leveraged than some of our competitors, which may place us at a competitive disadvantage;
- make us more vulnerable to downturns in our business, our industry or the economy;
- restrict us from making strategic acquisitions, engaging in development activities, introducing new technologies or exploiting business opportunities;
- compel us to make non-strategic divestitures;
- limit, along with the financial and other restrictive covenants in our indebtedness, among other things, our ability to borrow additional funds or dispose of assets;
- prevent us from raising the funds necessary to repurchase all notes tendered to us upon the occurrence of certain changes of control, which failure to repurchase would constitute an event of default under the Indentures governing the Notes; or
- expose us to the risk of increased interest rates, as certain of our borrowings, including borrowings under the ABL Facility and the Term Loan Facility, are at variable rates of interest.

In addition, the Indentures and the Credit Agreements contain restrictive covenants that limit or will limit our ability to engage in activities that may be in our long-term best interest. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of substantially all of our existing and future indebtedness.

Our debt agreements contain restrictions that will limit our flexibility in operating our business.

The Indentures and the Credit Agreements contain, and any other existing or future indebtedness of ours would likely contain, a number of covenants that will impose significant operating and financial restrictions on us, including restrictions on our and our subsidiaries ability to, among other things:

- incur additional debt, guarantee indebtedness or issue certain preferred shares;
- pay dividends on or make distributions in respect of, or repurchase or redeem, our capital stock or make other restricted payments;
- prepay, redeem or repurchase certain debt;
- make loans or certain investments;
- sell certain assets;
- create liens on certain assets;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates;
- alter the businesses we conduct;
- enter into agreements restricting our subsidiaries' ability to pay dividends; and
- designate our subsidiaries as unrestricted subsidiaries.

As a result of these covenants, we will be limited in the manner in which we conduct our business, and we may be unable to engage in favorable business activities or finance future operations or capital needs.

In addition, the ABL Facility requires us to maintain a minimum fixed charge coverage ratio at any time when the average availability is less than the greater of $65.0 million and 10% of the lesser of the aggregate amount of revolving facility commitments and the borrowing base at such time. In that event, we must satisfy a minimum fixed charge ratio of 1.0 to 1.0. At December 31, 2023, we were in compliance with this financial maintenance covenant.

A failure to comply with the covenants under the Indentures, the Credit Agreements or any of our other future indebtedness could result in an event of default, which, if not cured or waived, could have a material adverse effect on our business, financial condition, results of operations and cash flow. In the event of any such default, the Lenders thereunder:

- will not be required to lend any additional amounts to us;
- could elect to declare all borrowings outstanding, together with accrued and unpaid interest and fees, to be due and payable and terminate all commitments to extend further credit;
- could require us to apply all of our available cash to repay these borrowings; or
- could effectively prevent us from making debt service payments on the Notes (due to a cash sweep feature under the ABL Facility).

Such actions by the Lenders could cause cross defaults under our other indebtedness. If we were unable to repay those amounts, the Lenders and Holders under the ABL Facility, the Term Loan Facility, the 4.375% Secured Notes, the 9.875% Secured Notes and the 11.0% Secured Notes could proceed against the collateral granted to them to secure the ABL Facility, the Term Loan Facility or the 4.375% Secured Notes, the 9.875% Secured Notes and the 11.0% Secured Notes, respectively. If any of our outstanding indebtedness under the ABL Facility, the Term Loan Facility, Notes or any of our other existing or future indebtedness were to be accelerated, there can be no assurance that our assets would be sufficient to repay such indebtedness in full.

We are dependent on cash flow generated by our subsidiaries to service our indebtedness.

We are a holding company with no operations and are dependent on our operating subsidiaries' cash flow and their ability to make such cash available to us to meet our financial obligations, including principal and interest payments related to the ABL Facility, the Term Loan Facility and the Notes. Unless they are guarantors of the indebtedness, our subsidiaries do not have any obligation to pay amounts due on such indebtedness or to make funds available for that purpose. Our subsidiaries may not be able to, or may not be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each subsidiary is a distinct legal entity and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries. While our debt agreements will limit the ability of our restricted subsidiaries to incur consensual restrictions on their ability to pay dividends or make other intercompany payments to us, these limitations are subject to certain qualifications and exceptions. In the event that we do not receive distributions from our subsidiaries, we may be unable to make required principal and interest payments on our indebtedness.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness that may not be successful.

Our ability to pay principal and interest and to satisfy our other debt obligations will depend upon, among other things:

- our future financial and operating performance, which will be affected by prevailing economic, industry and competitive conditions and financial, business, legislative, regulatory and other factors, many of which are beyond our control; and
- our future ability to borrow under the ABL Facility, the availability of which depends on, among other things, the borrowing base and our complying with the covenants in the credit agreement governing the ABL Facility.

We cannot assure you that our business will generate cash flow from operations, or that we will be able to draw under the ABL Facility or otherwise, in an amount sufficient to fund our liquidity needs, including the payment of principal and interest on the ABL Facility, the Term Loan Facility and the Notes.

If our cash flows and capital resources are insufficient to service our indebtedness, we may be forced to reduce or delay capital expenditures, sell assets, seek additional capital or restructure or refinance our indebtedness, including the Notes and any indebtedness under the Credit Agreements. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations.

Our ability to obtain, and the terms of any, financing or refinancing will be dependent on the condition of the financial markets and our financial condition and operating performance. Any inability to obtain refinancing as our debt matures could materially and adversely affect our financial condition.

Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition and performance at such time. Disruptions or prolonged downturns in the financial markets may cause us to seek alternative sources of potentially less attractive financing or refinancing. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. In addition, the terms of existing or future debt agreements, including the ABL Facility, the Term Loan Facility and the Indentures, may restrict us from adopting some of these alternatives. In the absence of such operating results and resources, we could face substantial liquidity problems and might be required to dispose of material assets or operations to meet our debt service and other obligations. We may not be able to consummate those dispositions for fair market value or at all. Furthermore, any proceeds that we could realize from any such dispositions may not be adequate to meet our debt service obligations then due. The Sponsor and its affiliates have no continuing obligation to provide us with debt or equity financing. Our inability to generate sufficient cash flow to satisfy our debt obligations, or to refinance our indebtedness on commercially reasonable terms or at all, could result in a material adverse effect on our business, financial condition and results of operations and could negatively impact our ability to satisfy our obligations under our indebtedness.

If we cannot make scheduled payments on our indebtedness, we will be in default, and the Lenders under the Term Loan Facility and the Holders of the Notes could declare all outstanding principal and interest to be due and payable, the Lenders under the ABL Facility could terminate their commitments to loan money, our secured lenders (including the Lenders under the ABL Facility and the Holders of the Notes) could foreclose against the assets securing their loans and the Notes and we could be forced into bankruptcy or liquidation.

Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

Interest rates are highly sensitive to many factors that are beyond our control, including general economic conditions and policies of various governmental and regulatory agencies and, in particular, the Federal Reserve Board. If the Federal Reserve Board increases the federal funds rate, which it has recently done in an effort to help counter inflation, overall interest rates will likely rise. Interest rate increases would increase the interest costs on our borrowings under the ABL Facility and the Term Loan Facility, which have variable rates of interest and expose us to interest rate risk. Assuming the revolving credit facility is fully drawn, each 1% change in assumed blended interest rates would result in an approximately $40 million change in aggregate annual interest expense on indebtedness under the ABL Facility and the Term Loan Facility.

Despite our substantial indebtedness, we may still be able to incur significantly more debt, which could intensify the risks described above.

We and our subsidiaries may be able to incur substantial indebtedness in the future. Although the terms of the Credit Agreements and the Indentures contain restrictions on our and our subsidiaries' ability to incur additional indebtedness, these restrictions are subject to a number of important qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. As of December 31, 2023, we had $682 million available for additional borrowing under the ABL Facility (after giving effect to any letters of credit issued thereunder (which were approximately $63 million as of December 31, 2023)), all of which would be secured. In addition to the Notes and our borrowings under the Credit Agreements, the covenants under any other existing or future debt instruments could allow us to incur a significant amount of additional indebtedness and, subject to certain limitations, such additional indebtedness could be secured. The more leveraged we become, the more we, and in turn our security holders, will be exposed to certain risks described above under "—Our debt agreements contain restrictions that will limit our flexibility in operating our business."

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

We require substantial capital resources to fund our growth strategy and ongoing capital expenditure programs, including capital expenditure programs for renovation, expansion and construction at our facilities and the addition of equipment and technology at our facilities. We often commit to significant capital expenditures well in advance of the time these expenditures will be made. Additionally, we are subject to annual capital expenditure commitments in connection with several of our facilities. At December 31, 2023, we estimated our total remaining annual capital expenditure commitments to be approximately $540 million. The majority of this amount represents long-term commitments that are computed as a percentage of revenues at the applicable facility. Our cash flows and available capital resources may be insufficient to fund our capital expenditure programs and commitments, and we may be forced to reduce or delay planned and required capital expenditures. Additionally, we may experience delays or impediments in satisfying the schedule for capital expenditures and these commitments because of a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions, adverse weather conditions, shortages of labor or materials or other unforeseen problems or delays. The failure to satisfy our capital expenditure commitment obligations could also damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities, lessors or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions. Additionally, as a result, if our cash flows and available capital resources are not sufficient to fund all of our anticipated capital expenditures, it may be necessary for us to give priority to contractual capital expenditure commitment obligations over other elective capital expenditure programs.

Our ability to utilize our NOLs may be limited, and we may not be able to utilize our NOLs as a result of recent U.S. federal tax reform legislation.

As of December 31, 2023, we had federal NOLs of approximately $47 million with an indefinite carryforward period and subject to annual usage limitations under Section 382 of the Code. In addition, we had state and local NOLs of approximately $2 billion that expire at various dates between 2023 and 2042 or have an indefinite carryforward period. To the extent available and not otherwise utilized, we intend to use any NOLs to reduce the applicable federal and state corporate income tax liability associated with our operations. However, our ability to utilize our NOLs is based on the extent to which we generate future taxable income and on prevailing corporate income tax rates, and we cannot provide any assurance as to when and to what extent we will generate sufficient future taxable income to realize our deferred tax assets, whether in whole or in part. Furthermore, the utilization of our NOLs may become subject to an annual limitation under Section 382 of the Code (and similar state provisions) in the event of certain cumulative changes in the ownership interest of significant shareholders in excess of 50 percent over a three-year period. This could limit the amount of NOLs that can be utilized annually to offset taxable income. The amount of the annual limitation is determined based on the value of a company immediately prior to the ownership change. Subsequent ownership changes may further affect the limitation in future years. For these reasons, our ability to utilize our NOLs may be limited.

Human Capital Risks

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

Our subsidiaries employ a large number of physicians. Physician employment by health systems and healthcare facilities, where permissible, is a trend in the industry and has become more common as a result of actual and potential reductions in payment amounts for physician services and increasing operating costs to physicians. Employed physicians generally present more direct risks to us than those presented by independent members of our hospitals' medical staffs, such as risks of unsuccessful physician integration, challenges associated with physician practice management and compliance risks arising from the increased billing and coding activities associated with the employment of physicians, the possibility of legal claims under federal and state employment law, and governmental scrutiny of physician employment arrangements. Employed physicians also require us to incur additional expenses, such as increased salary and benefit costs, medical malpractice expense and rent expense. Payments received by us for services provided by our employed physicians, the physicians to whom our facilities have provided recruitment assistance, and the physician members of our medical staffs could be adversely affected as physician payment methodologies move toward pay-for-performance similar to what hospital payment models are doing. The combination of payment cuts, potential liabilities and increased expenses could have an adverse effect on our results of operations and cash flow.

Our operations and ability to deliver healthcare services efficiently may be adversely affected if we are unable to recruit and retain quality physicians, nurses and other healthcare professionals.

The success of our business operations and the efficiency with which we deliver healthcare services depends on the number and quality of our physicians and other healthcare providers such as nurses, pharmacists and lab technicians, and management and other non-physician personnel responsible for the day-to-day operations of each of our facilities. Our ability to recruit and retain quality providers and personnel, in turn, depends on several factors, including the actual and perceived quality of services furnished by our facilities, our ability to meet demands for new technology, our ability to identify and communicate with providers who want to practice in our communities and our ability to provide competitive financial compensation packages. Our failure to recruit and retain qualified physicians, nurses and other medical support staff, and management and non-physician personnel could have a material adverse effect on our revenues, results of operations and cash flow.

Federal and state laws and regulations may impact our ability to hire and retain and increase our costs of employing qualified physicians, nurses and other medical support personnel. For example, a significant portion of the providers serving our facilities are native to countries other than the U.S. Our ability to recruit such providers and their ability and willingness to remain and work in the U.S. are impacted by immigration laws and regulations. Changes in immigration or naturalization laws, regulations, or procedures may adversely affect our ability to hire or retain providers and may adversely affect our costs of doing business or our ability to deliver services in our communities. In addition, the states in which we operate have adopted or could adopt mandatory nurse staffing ratios, or could increase mandatory nurse staffing ratios. State-mandated nurse staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. Also, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the federal physician self-referral law (commonly referred to as the Stark law), the Anti-kickback Statute, state anti-kickback and self-referral statutes, and related regulations. The Stark law requires, among other things, that recruitment assistance can only be provided to physicians who meet certain geographic and practice requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit physicians currently in practice in the community beyond recruitment costs actually incurred by them. All arrangements with physicians must also be fair market value and commercially reasonable. In addition, some of the states in which we operate limit or restrict our ability to enter into non-compete agreements or enforce restrictive covenants with physicians we employ, which may impact our ability to hire and retain qualified physicians in those states. Also, on January 5, 2023, the FTC issued a proposed rule that would ban employers from imposing post-termination non-competes on its workers (whether employees or independent contractors), subject to certain exceptions, and require employers to rescind existing non-competes and actively inform workers that they are no longer in effect. The proposed rule may not apply to non-profit hospitals, which could create a competitive disadvantage for us in our hiring and retention efforts. The FTC's proposed rule follows President Biden's July 9, 2021 executive order in which the administration encouraged the FTC to ban or limit non-compete agreements. Although we cannot predict whether the FTC's proposed rule will be adopted in its current form, any limitation or ban on our ability to enter into non-compete agreements with employed or contracted physicians, nurses and other medical support personnel may impact our ability to hire and retain qualified physicians, nurses and other medical support personnel and may adversely affect our costs of doing business or our ability to deliver services in our communities.

In addition to these legal requirements, there is competition from other communities and facilities for these providers, and this competition continues after the provider is practicing in one of our communities. For example, integrated ACOs and other kinds of "narrow" provider networks or organizations may exclude our providers from their plans' networks of healthcare providers. These contracting networks often organize hospitals, providers and ancillary healthcare providers into exclusive networks involving fewer healthcare providers. If our affiliated providers are excluded from such networks, we may have difficulty recruiting new providers or retaining existing providers.

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

Our performance and labor costs may be adversely affected by challenging labor market conditions and the shortage of qualified nurses and other healthcare personnel.

The nationwide shortage of nurses and other clinical staff and support personnel has been a significant operating issue facing healthcare providers, including at certain of our facilities. This shortage has required, and may continue to require, us to enhance wages and benefits to recruit and retain nurses and other medical support personnel, recruit personnel from foreign countries, and utilize more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. In some of our markets, employers across various industries have increased their minimum wage, which has created more competition for this sector of employees.

We cannot predict the degree to which we will be affected by the future availability or cost of attracting and retaining talented medical support staff. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to either recruit and retain qualified hospital management, nurses and other medical support personnel or control our labor costs could harm our results of operations.

Labor union activity could raise costs and interfere with our operations. Certain of our employees are union members and subject to the terms of collective bargaining agreements.

Increased or ongoing labor union activity could adversely affect our labor costs or otherwise adversely impact us. Several of our facilities, including those in which we have a non-controlling interest, have unionized employees. When a new collective bargaining agreement with a union must be negotiated, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur, and our operations could be disrupted or our labor costs increased as a result of these disruptions. Our labor costs also could increase significantly if a substantial number of other employees at our facilities unionize. If our labor costs increase, we may not be able to raise our payer rates sufficiently or commensurately in order to offset these increased costs. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained.

The terms of the collective bargaining agreements also set forth certain requirements related to the respective facility's employment practices, seniority, hours of work, overtime, holidays, use and redemption of paid time off, extended illness bank, vacation scheduling, compensation, pay practice, health and non-health benefits, leaves of absence, grievance procedures, disability accommodations and the facility's drug and alcohol policies. If these facilities fail to fulfill any of these requirements, it could result in discussions with union representatives or the filing of a grievance that could be costly and time-consuming for those facilities. Furthermore, the terms of the collective bargaining agreements constrain our flexibility with respect to these and other employee issues. The inability to negotiate future collective bargaining agreements on favorable terms with these employees or with other unionized employees could have a material adverse effect on our business, financial condition, results of operations and cash flow.

We are dependent on our executive management team and the loss of the services of one or more members of our executive management team could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our executive management team. In addition, we depend on the ability of our executive officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our executive management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our executive management team, we could experience a significant disruption in our operations and failure of the affected facilities to adhere to their respective business plans.

Regulatory and Legal Risks

We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may adversely affect our revenues, results of operations and cash flow.

All participants in the healthcare industry are required to comply with numerous overlapping laws and regulations at the federal, state and local government levels. These laws and regulations require that healthcare facilities and providers meet various requirements, including those relating to relationships with referral sources, the adequacy and quality of medical care, inpatient admission criteria, privacy and security of health information, standards for equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, the use and storage of pharmaceuticals and controlled substances and other standards intended to prevent diversion of controlled substances, compliance with building codes and environmental protection, among other matters. Many of the laws and regulations applicable to the healthcare industry are complex and may be violated inadvertently, and there are numerous enforcement authorities, including CMS, the OIG, the DOJ, the DEA, state attorneys general, and contracted auditors, as well as private plaintiffs.

There are also heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. Recent enforcement actions have focused on, among other things, financial arrangements between hospitals and providers, billing for services without adequately documenting the medical necessity for such services and billing for services outside the coverage guidelines for such services. Hospital services, IRF services and certain other ancillary services that our facilities provide, such as physical therapy services, continue to be focal areas of the OIG and other governmental fraud and abuse programs, as described in the OIG Work Plan. Dealing with investigations can be time and resource consuming and can divert management's attention from the business. Any such investigation or settlement could increase our costs or otherwise have an adverse effect on our business. In addition, because of the potential for large monetary exposure under the False Claims Act, which provides for treble damages and substantial civil monetary penalties for each separate false claim or statement, healthcare providers often resolve allegations without admissions of liability for significant and material amounts to avoid the uncertainty of damages and penalties that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree, settlement agreement or corporate integrity agreement. These additional requirements can result in significant additional and ongoing expenditures. Given the significant size of actual and potential settlements, it is expected that the government will continue to devote substantial resources to investigating healthcare facility and provider compliance with the healthcare payment rules and fraud and abuse laws. Over the past several years, certain of our facilities have received inquiries and subpoenas from various governmental agencies regarding these matters, and we are also subject to various claims and lawsuits relating to these and other matters.

The laws and regulations with which we must comply continually change. In the future, different interpretations or enforcement of these laws and regulations could subject our business practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws and regulations, many of these laws and regulations are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable laws and regulations. If we fail to comply with applicable laws and regulations, we could suffer substantial civil or criminal penalties, including the loss of our licenses to operate our facilities or loss of our ability to participate in the Medicare, Medicaid and other governmental programs.

Additionally, we are subject to a variety of different federal, state and local employment and wage and hour laws. While we strive to comply with those laws, if we fail to do so, we may be subject to lawsuits by governmental authorities or private plaintiffs (including employee class action lawsuits). In addition, the IRS and/or state taxing authorities may successfully challenge positions taken on our tax returns.

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

Finally, we communicate with patients, with prior consent, through short message service ("***SMS***") text messages. While we obtain consent from these individuals to send text messages and limit the content of those messages, federal or state regulatory authorities or private litigants may claim that the notices and disclosures we provide, form of consents we obtain, or our SMS texting practices are not adequate or violate applicable law. In addition, we must ensure that our SMS texting practices comply with regulations and agency guidance under the Telephone Consumer Protection Act (the "***TCPA***"), a federal statute that protects consumers from unwanted telephone calls, faxes and text messages, HIPAA, and all applicable state data privacy and security laws and regulations. While we strive to adhere to strict policies and procedures that comply with the TCPA, the Federal Communications Commission, as the agency that implements and enforces the TCPA, may disagree with our interpretation of the TCPA and impose penalties and other consequences for noncompliance. Determination by a court or regulatory agency that our SMS texting practices violate the TCPA could subject us to civil penalties and could require us to change some portions of our business. Even an unsuccessful challenge by patients or regulatory authorities of our activities could result in adverse publicity and could require a costly response from and defense by us.

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

The False Claims Act prohibits healthcare facilities and providers, as well as other entities or individuals from, among other things, knowingly submitting false claims for payment to the federal government, or knowingly causing the submission of such claims. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are generally entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. We are required to provide information to our employees and certain contractors about state and federal false claims laws and whistleblower provisions and protections. Defendants found to be liable under the False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus substantial civil monetary penalties, that are subject to annual inflation adjustments, for each separate false claim.

There are many potential bases for liability under the False Claims Act, including reckless or intentional acts or omissions. The government has used the False Claims Act to prosecute Medicare and other government healthcare program violations such as coding errors, billing for services not provided, submitting false cost reports, falsely certifying meaningful use of certified health information technology, and providing care that is not medically necessary or that is substandard in quality. The Affordable Care Act also (i) created potential False Claims Act liability for failing to report and repay identified overpayments within sixty (60) days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later, and (ii) provided that claims submitted in connection with patient referrals that result from violations of the Anti-kickback Statute constitute false claims for the purposes of the False Claims Act. Violations of the Stark law can result in False Claims Act liability, as well. In addition, a number of states have adopted their own false claims and whistleblower provisions whereby a private party may file a civil lawsuit in state court.

Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws, many of these laws are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable fraud and abuse laws.

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

We may be subjected to medical malpractice lawsuits and other legal actions arising out of the operations of our facilities and the activities of our employed or affiliated providers, including regulatory proceedings and private litigation (including employee class action lawsuits) concerning our application of various federal and state labor laws, rules and regulations governing a variety of workplace wage and hour issues. As a matter of policy, we typically notify patients of any potential harms they may have suffered at our facilities, regardless of whether such notifications are required by law and notwithstanding our uncertainty as to the severity of such harms or whether they even took place. This may lead to class actions or other multi-plaintiff lawsuits or whistleblower reports. These actions may involve large claims and significant defense costs and, if we or our facilities are found liable, any judgments against us may be material. Furthermore, some states in which we operate do not impose caps on non-economic malpractice damages and, even in the states that have imposed caps on such damages, litigants may seek recoveries under alternative theories of liability that might not be subject to such caps. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement whether or not we believe we are liable. Amounts we pay to settle any of these matters also may be material.

Although we maintain professional and general liability insurance with unrelated commercial insurance carriers, each individual plaintiff's claim is generally subject to a deductible or SIR insurance program administered in-house by our risk department with assistance from our insurance brokers. As a result, we are effectively self-insured for claims or portions of claims that are less than our deductible or SIR amounts and for claims or portions of claims that are not covered by insurance or exceed policy limits. Any successful claim against us that is within our deducible or SIR amounts or that is not covered by insurance or exceeds our policy limits could have an adverse effect on our financial condition, results of operations or cash flow.

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

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

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare and Medicaid for payment for our services. These post-payment reviews may increase as a result of government cost-containment initiatives, including, without limitation, enhanced medical necessity reviews for patients admitted as inpatients to general acute care hospitals for certain procedures and audits of claims under the RAC programs to detect overpayments not identified through existing claims review mechanisms. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those claims most likely to contain overpayments, such as incorrectly coded services, short stays, incorrect payment amounts, non-covered services and duplicate payments. The claims review strategies used by the RACs generally include a review of high dollar claims, including, for example, inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals.

In addition, CMS and the states use UPICs to perform post-payment audits of claims and identify Medicare and Medicaid overpayments. Third party audits or investigations of Medicare or Medicaid claims could result in increases or decreases in operating revenues to be recognized in periods subsequent to when the related services were performed, which may have a material adverse effect on our results of operations and cash flow.

Controls designed to reduce inpatient services may adversely affect our revenues, results of operations and cash flow.

Over the last several years, payers have instituted policies and procedures to reduce or limit the use of inpatient services. Controls imposed by Medicare, Medicaid, and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for payment are properly filed. In the hospital context, these provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by QIOs, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of the MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. QIOs may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider that is in substantial noncompliance with quality standards be excluded from participation in the Medicare program.

Utilization review is also a requirement of most non-governmental managed care organizations and other third-party payers. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Additionally, in some states in which we operate, commercial third-party payers and Medicaid managed care plans have instituted policies that retroactively limit or deny patient coverage for emergency department and certain other services provided at hospitals or services provided at other inpatient facilities if the payers believe the services could have been provided in less expensive settings. For example, such payers are increasingly seeking to pay relatively low "triage fees" for patients seen in emergency departments when the payers retrospectively determine the patients' treatment did not qualify as an emergency service. Significant limits on the scope of services reimbursed or on the amounts paid for such services may adversely affect our revenues, results of operations and cash flow.

If we do not manage admissions in the IRFs that we operate or manage in compliance with a 60% threshold, reimbursement for services rendered by us in these facilities will be based upon less favorable rates.

IRFs and ARUs are subject to a Medicare requirement that 60% or more of the patients admitted to the facilities have one or more specific conditions in order to qualify for reimbursement under the IRF PPS. If that compliance threshold is not maintained, the IRFs and ARUs will be reimbursed by Medicare at IPPS rates applicable to acute care hospitals. That likely would lead to reduced revenue in the IRFs and ARUs that we operate or manage and also may lead customers of IRFs and ARUs to attempt to renegotiate the terms of their contracts or terminate their contracts. Our inability to appropriately manage admissions in our IRFs and ARUs in compliance with applicable thresholds could have a material adverse effect on our business, financial position, results of operations and cash flow.

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

Some states require prior approval for the purchase, construction and expansion of healthcare facilities, based on the state's determination of need for additional or expanded healthcare facilities or services. Certain states in which we operate facilities require a certificate of need for the purchase, construction or expansion of hospital facilities, capital expenditures exceeding a prescribed amount, changes in bed capacity or services, or for other hospital-related activities. We may not be able to obtain certificates of need required for expansion activities or to effectively compete with competing healthcare providers in the future. In addition, all of the states in which we operate facilities require hospitals, other healthcare facilities, and most healthcare providers to maintain one or more licenses. If we fail to obtain any required certificate of need or license, our ability to operate or expand operations in those states could be impaired.

In the states in which we operate that do not require certificates of need for the purchase, construction and expansion of hospital facilities, competing healthcare facilities face lower regulatory barriers to entry and expansion. If competing healthcare entities are able to purchase, construct or expand healthcare facilities without the need for regulatory approval, we may face decreased market share and revenues in those markets.

Failure to implement and use certified health information technology in an effective and timely manner could adversely affect our operations and result in reduced Medicare and Medicaid reimbursement and government enforcement actions.

The federal government has adopted laws and regulations intended to promote the adoption of health information technology, advance the interoperability of medical record systems, and support the access, exchange, and use of electronic health information. For example, under the Medicare Promoting Interoperability Programs (formerly the Medicare EHR Incentive Program), eligible hospitals, critical access hospitals and eligible professionals that do not successfully demonstrate meaningful use of certified electronic health record technologies every year (absent a hardship exception) may be subject to a downward payment adjustment under Medicare. In addition, health information technology that is certified by CMS is subject to an annual certification process. While we generally have no control over whether the health information technology we have implemented will continue to maintain CMS certification, we routinely monitor and evaluate our health information technology for compliance with the applicable CMS certification standards. Failure of our health information technology to maintain CMS certification could result in reduced Medicare and Medicaid reimbursement. Also, the Cures Act and its implementing regulations impose regulatory obligations, including new Medicare conditions of participation on hospitals and critical access hospitals, related to the access and exchange of electronic health information and prohibit information blocking, which includes any practice that is unreasonable and likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information, by healthcare providers and certain other entities, unless required by law or otherwise permitted by an exception in the applicable regulations. Failure to comply with these requirements could subject us to financial penalties or other disincentives or reputational damage. Complying with these and future initiatives related to healthcare technology and interoperability may also require us to change our operations or incur additional costs related to investments in information technology and EHR system software upgrades, and our payers may not adequately reimburse us for these costs and investments.

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

There is a trend in the healthcare industry toward value-based purchasing of healthcare services and bundled payment arrangements. Value-based purchasing programs include both public reporting of quality data and payment limitations tied to the incidence of preventable adverse events or the quality and efficiency of care provided by facilities. For example, Medicare, Medicaid and many large commercial payers may require facilities to report certain quality data to receive full payment updates or avoid payment reductions. They may also impose payment reductions in connection with HACs and excessive readmissions for certain conditions designated by HHS. Our revenue may be negatively impacted by the application of one or more of these measures. Bundled payment arrangements generally set target payment amounts for all healthcare services provided to patients during particular episodes of care. They are intended to create incentives for physicians, hospitals and other providers to work together to provide higher quality and more coordinated care at a lower cost. We currently participate in a few ACOs as well as a number of bundled payment programs, and we expect value-based purchasing programs, including programs that condition payment on patient outcome measures, to become more common and to involve a higher percentage of our payment amounts. We are unable at this time to predict how this trend will affect our results of operations and cash flow, but it could negatively affect our revenues.

The implementation of participation and quality measurement requirements under the MACRA's Merit-Based Incentive Payment System may affect our revenues.

Under MACRA, CMS updates payment rates for physician and practitioner services on an annual basis, and implements the QPP that rewards value and outcomes through participation in traditional MIPS, an APM program, or, beginning with the 2023 performance year, MVPs. MIPS measures provider performance under four categories: quality, improvement activities, promoting interoperability and cost, and annually establishes a point threshold for each category and overall performance. The results of the measurement are used to establish a positive, negative, or neutral payment adjustment for the physician or practitioner for claims that are submitted two years after the applicable MIPS measurement period. The MIPS adjustment has a more significant impact on payment for physician and practitioner services than the annual inflationary update to the Medicare PFS.

Physicians participate in traditional MIPS unless they are participants of specific forms of APM report MVPs, are newly enrolled in Medicare, or see a low volume of Medicare patients (i.e., no more than 200 Medicare Part B patients in a calendar year, 200 covered professional services to Medicare Part B patients, or $90,000 in charges for Medicare Part B professional services). Groups or eligible clinicians who choose not to participate and fall within specified circumstances may request an exception through a hardship application and incur no MIPS impact on Medicare payments. CMS permits hardship applications, including, in the 2022 performance year, hardships based on circumstances arising from COVID related operational issues, through which clinicians can request reweighing of any or all performance categories if they encounter an extreme and uncontrollable circumstance or a public health emergency. MIPS eligible clinicians or Group Practices are subject to a sliding scale payment adjustment of minus to plus 9% per claim in CY 2022 and beyond. In addition, MIPS eligible clinicians with exceptional performance may receive up to 10% bonus payment from $500 million specifically allocated for this purpose through the end of CY 2024. MIPS is a budget neutral program, and, as a result, any upward payment adjustments that are made for highly performing clinicians are offset by downward payment adjustments for others. Providers participating in an APM may be eligible for more advantageous adjustments under MIPS (or avoid any negative adjustment) and receive a 5% bonus. At this time, we have limited participation in APMs.

If an eligible clinician has not been satisfactorily participating in MIPS (and is not qualified to participate in an APM), his or her claims for Medicare Part B services are likely to be subject to negative payment adjustments in CY 2023 (which was based on CY 2021 performance) and CY 2024 (which was based on CY 2022 performance). For participating eligible clinicians that meet or exceed the MIPS threshold or APM requirements, claims for payment are likely to be subject to positive adjustments as well as a share of an additional pool of bonus payments. At this time, and as CMS continues to modify MIPS payment policies, it is unclear how MIPS will impact our overall physician payments under the Medicare program. If we have not timely and effectively implemented policies and procedures, quality programs and appropriate clinician contracting to ensure compliance with MACRA and other QPP requirements, we would experience a negative effect on future revenues related to Medicare Part B claims.

MACRA requires that CMS publish each eligible clinician's MIPS score and performance category scores on its Physician Compare website. Publishing of MIPS scores could have an adverse reputational effect on us if our employed physicians have low scores or scores that are lower than those of the other clinicians in the relevant communities.

If current or future laws or regulations force us or cause us to restructure our arrangements with physicians and other providers, we may incur additional costs, lose contracts and suffer a reduction in net revenue under existing contracts, and we may need to refinance our debt or obtain consent from our lenders.

A number of laws impact our relationships with our physicians and other providers. There is a risk that state authorities in some jurisdictions may find that our contractual relationships with our physicians violate laws prohibiting the corporate practice of medicine and fee-splitting. These laws generally prohibit the practice of medicine by lay entities or persons and are intended to prevent unlicensed persons or entities from interfering with or inappropriately influencing the physician's professional judgment. They may also prevent the sharing of professional services income with non-professional or business interests. In states that have enacted corporate practice of medicine and fee-splitting prohibitions, we believe that we have structured our physician contracts in an effort to remain compliant with such laws. A regulatory agency, however, could still make a determination that our arrangements constitute a corporate practice of medicine or fee splitting violation. A review or action by regulatory authorities or the courts could force us to terminate or modify our contractual relationships with physicians and affiliated medical groups or revise them in a manner that could be materially adverse to our business.

In addition, we have also entered into a number of joint venture arrangements with physicians and other potential sources of referrals (e.g., hospitals and hospital operators) that are subject to state and federal fraud and abuse laws, including the Anti-kickback Statute and False Claims Act. See "—We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in criminal and civil sanctions, exclusion from government healthcare programs and even greater scrutiny that may reduce our revenues and profitability." To the extent applicable, regulatory agencies may view these transactions as prohibited arrangements that must be restructured, or discontinued, or for which we could be subject to other significant penalties, including debarment, suspension or exclusion from state and federal government healthcare programs. Although compliance programs can mitigate the risk of investigation and prosecution for violations of these laws, the risks cannot be entirely eliminated. Any action against us for violation of these laws, even if we successfully defend against it, could cause us to incur significant legal expenses and loss of revenue from those joint ventures and divert our management's attention from the operation of our business.

We care for a large number of vulnerable individuals with complex needs and any incident involving one or more of our patients or the failure by one or more of our facilities to provide appropriate care could adversely affect our business, financial condition, results of operations or cash flow.

Many of our patients, including those in our behavioral health facilities, have complex medical conditions or special needs, are vulnerable and often require a substantial level of care and supervision. There is a risk that one or more patients could be harmed by one or more of our employees, either intentionally, through negligence or by accident. Further, individuals cared for by us have in the past engaged, and may in the future engage, in behavior that results in harm to themselves, our employees or to one or more other individuals, including members of the public. Further, because many of the patients we treat, including those in our behavioral health facilities, suffer from severe mental health and chemical dependency disorders, patient incidents, including deaths, sexual abuse, assaults and theft, occur from time to time. If one or more of our facilities experiences an adverse patient incident or is found to have failed to provide appropriate patient care, loss of accreditation, license revocation or other adverse regulatory action could be taken against us. Any such patient incident or adverse regulatory action could result in damage to our reputation, governmental investigations, judgments or fines and could adversely affect our business, financial condition, results of operations or cash flow.

Data Security and Privacy Risks

A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

We rely extensively on our information systems and certain systems operated by us and third-parties to manage clinical, financial and employee data, communicate with our patients, payers, vendors and other third parties and summarize and analyze operating results. These systems are at risk from cybersecurity attacks, ransomware attacks, denial-of-service attacks, and other intrusions, including attempts to gain unauthorized access to and theft of our confidential data, misuse, corruption or destruction of confidential data and damage, disruptions or shutdowns of these systems due to viruses, malware, ransomware, malicious code, employee error or malfeasance, and other electronic security breaches. Our and our third-party vendors' systems, which transmit and store sensitive and confidential data, including personally identifiable information ("***PII***") and other PHI of our patients, employees and others, and our proprietary and confidential business performance and other data, will continue to be a target for attempts to gain unauthorized access and data theft due to the valuable nature of the information they contain, as well as at risk for accidental exposure. In addition, certain third-party medical devices and equipment are used at our facilities, and may be vulnerable to cybersecurity attacks or other breaches which could negatively impact our systems or our patients.

Cybersecurity breaches and other unauthorized access to our data can sometimes be difficult to discern, and any delays in detection may lead to increased harm. Such attacks or breaches are common in the healthcare sector and could result in the compromise of health information or other data subject to protection by HIPAA and other laws and regulations or disrupt our IT systems or business. We and our third-party vendors have been subject to security and privacy incidents in the past and there can be no assurance that we and our third-party vendors will not be subject to material cyber-attacks or security breaches in the future, or that the preventive actions we take to reduce the risk of such incidents and protect our IT and data will be sufficient. We continue to develop our cybersecurity practices and controls to protect our systems. However, regardless of the nature, extent and timing of our actions, these measures may not prevent security breaches. If our services are subject to cyber-attacks that impair or deny the ability of patients to access our services, current and potential patients may become unwilling to provide us the information necessary for them to become users of our services or may curtail or stop using our services. As cyber-threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures and to investigate and remediate any information security vulnerabilities. As we are subjected to cyber-attacks and possible security breaches in the future, this could have an adverse impact on our business, reputation, financial condition and results of operations, as well as expose us to class action lawsuits and regulatory investigation, action, and penalties. We also cannot be sure that our existing insurance coverage will continue to be available on acceptable terms or will be available in sufficient amounts to cover one or more large claims related to a security breach, or that the insurer will not deny coverage as to any future claim. See "Governmental Regulation—Administrative Simplification Provisions and Privacy and Security Requirements."

The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. If, in spite of our security and compliance efforts we or any of our business associates were to experience a breach, loss, or other compromise of PHI or PII, such event could disrupt our operations, result in increased data protection costs, damage our reputation, or result in regulatory penalties, legal claims and civil or criminal liability under HIPAA and other state and federal laws, which could have a material adverse effect on our results of operations. In addition, failure to comply with state and federal data breach notification and reporting laws could result in additional regulatory penalties, legal claims and civil or criminal liability, which could have a material adverse effect on our financial condition, results of operations and cash flow.

If access to our information systems or those provided by our third-party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

Our business depends heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and to develop new systems in order to keep pace with continuing changes in information processing technology. In addition to our own systems, we rely on multiple third-party providers of financial, clinical, supply chain, patient accounting and network information services and, as a result, we face operational challenges in maintaining multiple provider platforms and facilitating the interface of such systems with one another. The third-party providers may not have appropriate controls to protect confidential information. We do not control the information systems of third-party providers, and in some cases we may have difficulty accessing information archived on third-party systems, which could subject us to liability for failure to respond to legal, regulatory or payer obligations or information requests.

For example, we use, directly or indirectly through our third-party vendors, information technology systems provided by Change Healthcare (the "***Change Systems***") for various business and administrative support functions, including revenue cycle management. On February 21, 2024, we were notified by Change Healthcare of a cybersecurity incident impacting the Change Systems (the "***Change Systems Incident***"), and our access to such systems was disabled. As of the date of this Report, Change Healthcare has not provided an estimated timeframe for resuming functionality of the Change Systems. We continue to work directly with Change Healthcare, our third-party vendors, and other parties to identify and implement solutions intended to minimize the operational and financial impact on us caused by the Change Systems Incident. We have implemented, and plan to continue to implement, alternative systems where available to help mitigate the potential impact of delays in the timing of remittances from payors. While the Change Systems Incident has yet to be resolved, to date, it has not adversely impacted patient care at our facilities, and we expect it will not have a material impact on our business, financial condition or results of operations. However, we cannot predict the ultimate outcome of the Change Systems Incident and whether our efforts to minimize its impact will be successful.

Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, flood, hurricane, telecommunications failure, terrorist attack or other catastrophic event. If these systems fail or are interrupted, if our access to these systems is limited in the future or if providers develop systems more appropriate for more urban healthcare markets and not suited for our facilities, our operations could suffer.

We intend to expand our operations, including by acquiring more facilities, which will require us to integrate and transition certain existing information systems. In addition, as new information systems are developed in the future and we enter into agreements with new third-party providers, we will need to integrate these systems into our existing systems. Evolving industry and regulatory standards, such as the HITECH Act, HIPAA and EHR meaningful use regulations, also may require changes to our information systems in the future. System conversions are costly, time consuming and disruptive for providers, staff and, in some cases, patients. If such conversions occurred on a large scale or if we are unable to properly integrate other information systems or expand or update our current information systems, the costs and disruptions could have a material adverse effect on our revenues, results of operations and cash flow.

If we fail to comply with our obligations under license or technology agreements with third parties, we may be required to pay damages and we could lose license rights that are critical to our business.

We license certain intellectual property, including technologies and software from third parties, that is important to our business, and in the future we may enter into additional agreements that provide us with licenses to valuable intellectual property or technology. If we fail to comply with any of the obligations under our license agreements, we may be required to pay damages and the licensor may have the right to terminate the license. Termination by the licensor would cause us to lose valuable rights, and could prevent us from selling our solutions and services, or adversely impact our ability to commercialize future solutions and services. Our business would suffer if any current or future licenses terminate, if the licensors fail to abide by the terms of the license agreement, if the licensors fail to enforce licensed intellectual property against infringing third parties, if the licensed intellectual property are found to be invalid or unenforceable, or if we are unable to enter into necessary license agreements on acceptable terms or at all. Any of the foregoing could have an adverse effect on our business, financial condition, or results of operations and cash flow.

The constant growth and development of technology, including the increased use of Artificial Intelligence, presents risks and challenges to our operations that could give rise to legal or regulatory action, damage our reputation or otherwise materially harm of our business.

Emerging technology is a consistent subject of new laws or regulations and evolving interpretations and applications of laws and regulations. If we fail to comply with these laws, we may be subject to penalties, fines or criminal or civil liability. The development and use of artificial intelligence ("***AI***") presents new risks and challenges that can impact our operations if we incorporate AI into our operations, or if used by our third-party vendors. While we aim to develop and use AI responsibly and attempt to mitigate ethical and legal issues presented by its use, we may ultimately be unsuccessful in identifying or resolving issues before they arise. AI technologies are complex and rapidly evolving and the technologies that we develop or use may ultimately be flawed. Moreover, AI technology is subject to rapidly evolving domestic and international laws and regulations, which could impose significant costs and obligations on the Company. For example, in 2023 the Biden Administration issued a new, executive order on safe, secure and trustworthy AI. Emerging regulations may pertain to data privacy, data protection, and the ethical use of AI, as well as clarifying intellectual property considerations. Our use of AI could give rise to legal or regulatory action, increased scrutiny or liability, damage our reputation or otherwise materially harm our business. Additionally, if we fail to keep pace with rapidly evolving AI technological developments, our competitive position and business results may be negatively impacted.

Item 1B. Unresolved Staff Comments.

Not applicable.

Item 1C. Cybersecurity.

Risk Management and Strategy

We have developed cybersecurity and data privacy programs designed to enable and safeguard the confidentiality, integrity and availability of our information systems and data by providing proactive security expertise and risk assessments, creating and maintaining a resilient and secure environment, and fostering a culture of security awareness and compliance throughout our organization. Our programs are largely aligned to, among others, the U.S. National Institute of Standards and Technology Cybersecurity Framework to assess, identify and manage material risks from cybersecurity threats. We regularly assess and improve our programs to address the changing landscape of potential threats and the needs of our business. These threats include cybersecurity attacks, ransomware attacks, denial-of-service attacks, unauthorized access and misuse, and theft of our sensitive and confidential data. Our information systems, and those of other companies in our industry, will continue to be targets for cybersecurity incidents due to the valuable nature of the information they contain. In addition, we are at risk for accidental or unauthorized exposure of our data and are subject to the privacy, security and breach notification regulations promulgated under HIPAA, the HITECH Act and other federal and state privacy, security, and consumer protection laws. Through our programs, we routinely conduct cybersecurity and data privacy training with our employees and conduct cybersecurity awareness and phishing campaigns.

We engage with third parties to separately conduct cyber assessments on a recurring basis and assist with containment and remediation efforts. In addition, third-party technology and analytics are utilized to identify potential vulnerabilities. We recognize that third-party service providers can be subject to cybersecurity incidents that could, in turn, impact us. To manage third-party risk, we maintain a third-party risk management program, which is designed to assess the security controls of our third-party service providers. The assessment methodology is based on risk and relies on the data, access, connectivity, and criticality of the services that the third party offers.

We have in place a cybersecurity incident response plan to enable us to assess and address cybersecurity incidents. We regularly review and update our response plan based on evaluations of the cybersecurity landscape and our business needs. Under our response plan, designated executive and senior leadership are responsible for initially assessing the severity of incidents and any continuing threats, managing any damage to our information systems, engaging third parties to assist our response, and escalating to the Audit Committee of the Board (the "***Audit Committee***") as appropriate. We periodically perform tabletop exercises to test our incident response procedures to identify and address gaps and promote team awareness.

Our cybersecurity efforts are led by our Chief Information Officer and our Chief Security & Privacy Officer. Each of our cybersecurity leaders has more than 15 years of information technology oversight or information security experience, and our Chief Security & Privacy Officer holds an Executive Chief Information Security Officer (CISO) certificate.

To date, we have not experienced a cybersecurity incident or data breach that has materially affected us or our business strategy, results of operations, or financial condition. However, no assurances can be given that such an event will not occur in the future. See Item 1A, Risk Factors—Data Security and Privacy Risks—"A cybersecurity attack or security breach could cause a loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law or other theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business" and "If access to our information systems or those provided by our third-party vendors is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer."

Governance

Our management is responsible for assessing and managing material risks posed to us from cybersecurity threats, and the Audit Committee oversees management's efforts. Pursuant to the charter of the Audit Committee, the Board has delegated to the Audit Committee responsibility for: (i) overseeing and periodically reviewing management's processes and procedures for assessing, identifying and managing material risks to us from cybersecurity threats and the effectiveness of our information security processes and procedures; (ii) periodically evaluating the knowledge, experience and capabilities of the members of the Audit Committee and management with respect to cybersecurity risk and information security processes and procedures; and (iii) evaluating the nature, scope, timing and impact to us of any material cybersecurity incidents.

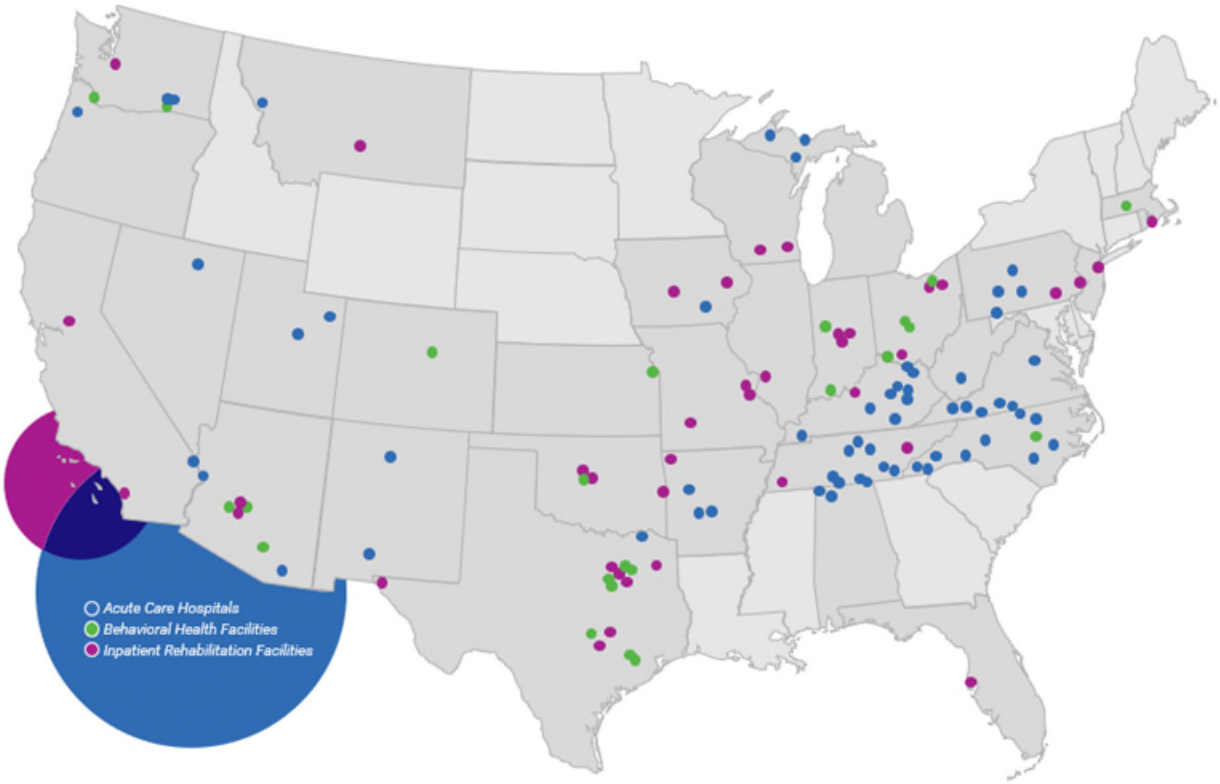
In carrying out its responsibility, management provides updating reports to the Audit Committee and/or our Board at their regularly scheduled meetings, with topics including management's information security efforts to prevent, detect, mitigate and remediate cybersecurity incidents, as well trends in the information security space that impact us or our industry. Our cybersecurity incident response plan requires management to report timely cybersecurity incidents that have the potential to materially impact our business strategy, results of operations or financial condition to our Audit Committee for their evaluation of the nature, scope, timing and impact to us of such incidents.

Item 2. ***Properties.***

The following tables and map present certain information with respect to our consolidated facilities as of December 31, 2023:

Service Line	Facilities	Licensed Beds	States
Acute Care	60	8,216	18
Inpatient Rehabilitation [(a)]	39	1,929	19
Behavioral Health	23	1,741	10
	122	11,886	31

(a) Excludes two non-consolidated IRFs.



Facilities

Facility Name	City	Service Line	Licensed Beds
Alabama			
North Alabama Medical Center	Florence	Acute Care	263
Shoals Hospital	Muscle Shoals	Acute Care	198
Arizona			
Canyon Vista Medical Center	Sierra Vista	Acute Care	100
Copper Springs	Avondale	Behavioral Health	72
Copper Springs East	Gilbert	Behavioral Health	72
Cornerstone El Dorado Behavioral Hospital	Tucson	Behavioral Health	106
Dignity Health East Valley Rehabilitation Hospital	Chandler	Inpatient Rehabilitation	50
Dignity Health East Valley Rehabilitation Hospital - Gilbert	Gilbert	Inpatient Rehabilitation	40
Havasu Regional Medical Center	Lake Havasu City	Acute Care	171
Valley View Medical Center	Fort Mohave	Acute Care	84

Facility Name	City	Service Line	Licensed Beds
Arkansas			
Mercy Rehabilitation Hospital Fort Smith	Fort Smith	Inpatient Rehabilitation	50
National Park Medical Center	Hot Springs	Acute Care	163
Rogers Rehabilitation Hospital	Rogers	Inpatient Rehabilitation	36
Saline Memorial Hospital	Benton	Acute Care	177
St. Mary's Regional Medical Center	Russellville	Acute Care	170
California			
Palomar Health Rehabilitation Institute	Escondido	Inpatient Rehabilitation	52
UC Davis Rehabilitation Hospital	Sacramento	Inpatient Rehabilitation	52
Colorado			
Denver Springs	Denver	Behavioral Health	96
Florida			
Tampa Rehabilitation Hospital	Tampa	Inpatient Rehabilitation	80
Illinois			
Anderson Rehabilitation Institute	Edwardsville	Inpatient Rehabilitation	34
Indiana			
Brentwood Springs	Evansville	Behavioral Health	48
Community Rehabilitation Hospital	Indianapolis	Inpatient Rehabilitation	60
Community Rehabilitation Hospital South	Greenwood	Inpatient Rehabilitation	44
Community Rehabilitation Hospital West	Brownsburg	Inpatient Rehabilitation	40
Sycamore Springs	Evansville	Behavioral Health	48
Iowa			
Mercy Iowa City Rehabilitation Hospital	Coralville	Inpatient Rehabilitation	40
MercyOne Clive Rehabilitation Hospital	Clive	Inpatient Rehabilitation	50
Ottumwa Regional Health Center	Ottumwa	Acute Care	217
Kansas			
Cottonwood Springs	Olathe	Behavioral Health	72
Kentucky			
Bluegrass Community Hospital	Versailles	Acute Care	25
Bourbon Community Hospital	Paris	Acute Care	58
Clark Regional Medical Center	Winchester	Acute Care	69
Fleming County Hospital	Flemingsburg	Acute Care	25
Frazier Rehabilitation Hospital - Brownsboro	Louisville	Inpatient Rehabilitation	40
Georgetown Community Hospital	Georgetown	Acute Care	75
Jackson Purchase Medical Center	Mayfield	Acute Care	107
Lake Cumberland Regional Hospital	Somerset	Acute Care	295
Meadowview Regional Medical Center	Maysville	Acute Care	100
Spring View Hospital	Lebanon	Acute Care	75
Massachusetts			
Valley Springs Behavioral Health Hospital	Holyoke	Behavioral Health	150
Michigan			
UP Health System - Bell	Ishpeming	Acute Care	25
UP Health System - Marquette	Marquette	Acute Care	222
UP Health System - Portage	Hancock	Acute Care	96
Missouri			
Mercy Rehabilitation Hospital Springfield	Springfield	Inpatient Rehabilitation	60
Mercy Rehabilitation Hospital St. Louis	Chesterfield	Inpatient Rehabilitation	90
Mercy Rehabilitation Hospital South	St. Louis	Inpatient Rehabilitation	50
Montana			
Community Medical Center	Missoula	Acute Care	151
The Rehabilitation Hospital of Montana	Billings	Inpatient Rehabilitation	34
Nevada			
Northeastern Nevada Regional Hospital	Elko	Acute Care	75
New Jersey			
Atlantic Rehabilitation Institute	Madison	Inpatient Rehabilitation	38

Facility Name	City	Service Line	Licensed Beds
New Mexico			
Los Alamos Medical Center	Los Alamos	Acute Care	47
Memorial Medical Center of Las Cruces	Las Cruces	Acute Care	199
North Carolina			
Central Carolina Hospital	Sanford	Acute Care	137
Frye Regional Medical Center	Hickory	Acute Care	355
Harris Regional Hospital	Sylva	Acute Care	86
Haywood Regional Medical Center	Clyde	Acute Care	153
Maria Parham Medical Center	Henderson	Acute Care	205
Person Memorial Hospital	Roxboro	Acute Care	98
Rutherford Regional Medical Center	Rutherfordton	Acute Care	143
Swain County Hospital	Bryson City	Acute Care	48
Triangle Springs	Raleigh	Behavioral Health	77
Wilson Medical Center	Wilson	Acute Care	384
Ohio			
Beckett Springs	Cincinnati	Behavioral Health	96
Columbus Springs Dublin	Dublin	Behavioral Health	72
Columbus Springs East	Columbus	Behavioral Health	72
Highland Springs	Cleveland	Behavioral Health	72
Liberty Rehabilitation Hospital	Cincinnati	Inpatient Rehabilitation	36
University Hospitals Avon Rehabilitation Hospital	Avon	Inpatient Rehabilitation	50
University Hospitals Rehabilitation Hospital	Beachwood	Inpatient Rehabilitation	50
Oklahoma			
Mercy Rehabilitation Hospital Oklahoma City	Oklahoma City	Inpatient Rehabilitation	66
Mercy Rehabilitation Hospital Oklahoma City South	Oklahoma City	Inpatient Rehabilitation	36
Oakwood Springs	Oklahoma City	Behavioral Health	72
Oregon			
Willamette Valley Medical Center	McMinnville	Acute Care	60
Pennsylvania			
Conemaugh Memorial Medical Center	Johnstown	Acute Care	539
Lancaster Rehabilitation Hospital	Lancaster	Inpatient Rehabilitation	59
Meyersdale Medical Center	Meyersdale	Acute Care	20
Miners Medical Center	Hastings	Acute Care	25
Nason Medical Center	Roaring Spring	Acute Care	45
St. Mary Rehabilitation Hospital	Langhorne	Inpatient Rehabilitation	50
Rhode Island			
Rehabilitation Hospital of Rhode Island	North Smithfield	Inpatient Rehabilitation	82
Tennessee			
Baptist Memorial Rehabilitation Hospital	Germantown	Inpatient Rehabilitation	53
Knoxville Rehabilitation Hospital	Knoxville	Inpatient Rehabilitation	57
Riverview Regional Medical Center	Carthage	Acute Care	35
Southern Tennessee Regional Health System - Lawrenceburg	Lawrenceburg	Acute Care	99
Southern Tennessee Regional Health System - Pulaski	Pulaski	Acute Care	95
Southern Tennessee Regional Health System - Sewanee	Sewanee	Acute Care	46
Southern Tennessee Regional Health System - Winchester	Winchester	Acute Care	152
Starr Regional Medical Center - Athens	Athens	Acute Care	190
Starr Regional Medical Center - Etowah	Etowah	Acute Care	88
Sumner Regional Medical Center	Gallatin	Acute Care	167
Trousdale Medical Center	Hartsville	Acute Care	25

Facility Name	City	Service Line	Licensed Beds
Texas			
Carrollton Springs	Carrollton	Behavioral Health	78
Central Texas Rehabilitation Hospital	Austin	Inpatient Rehabilitation	50
El Paso Rehabilitation Hospital	El Paso	Inpatient Rehabilitation	36
Longview Rehabilitation Hospital	Longview	Inpatient Rehabilitation	36
Mesa Springs	Fort Worth	Behavioral Health	72
Paris Regional Medical Center	Paris	Acute Care	154
Rock Springs	Georgetown	Behavioral Health	72
Temple Rehabilitation Hospital	Temple	Inpatient Rehabilitation	36
Texas Rehabilitation Hospital of Arlington	Arlington	Inpatient Rehabilitation	40
Texas Rehabilitation Hospital of Fort Worth	Fort Worth	Inpatient Rehabilitation	66
Texas Rehabilitation Hospital of Keller	Keller	Inpatient Rehabilitation	36
WellBridge Healthcare Greater Dallas	Plano	Behavioral Health	48
WellBridge Healthcare Fort Worth	Fort Worth	Behavioral Health	48
Westpark Springs	Houston	Behavioral Health	72
Woodland Springs	The Woodlands	Behavioral Health	96
Utah			
Ashley Regional Medical Center	Vernal	Acute Care	39
Castleview Hospital	Price	Acute Care	39
Virginia			
Clinch Valley Medical Center	Richlands	Acute Care	175
Fauquier Health	Warrenton	Acute Care	210
Sovah Health - Danville	Danville	Acute Care	250
Sovah Health - Martinsville	Martinsville	Acute Care	220
Twin County Regional Hospital	Galax	Acute Care	141
Wythe County Community Hospital	Wytheville	Acute Care	100
Washington			
CHI Franciscan Rehabilitation Hospital	Tacoma	Inpatient Rehabilitation	60
Lourdes Health - Medical Center	Pasco	Acute Care	95
Lourdes Health - Counseling Center	Pasco	Behavioral Health	58
Ranier Springs	Vancouver	Behavioral Health	72
Trios Health - Southridge Hospital	Kennewick	Acute Care	111
West Virginia			
Raleigh General Hospital	Beckley	Acute Care	300
Wisconsin			
Pro Health Rehabilitation Hospital of Wisconsin	Waukesha	Inpatient Rehabilitation	40
UW Health Rehabilitation Hospital	Madison	Inpatient Rehabilitation	50
			11,886

We own or lease and operate medical office buildings, clinics and other ancillary properties in conjunction with many of our acute care hospitals. These medical office buildings and clinics are primarily occupied by physicians who practice at our hospitals. Additionally, we lease office space in Brentwood, Tennessee and Louisville, Kentucky for our HSC. All of our facilities are suitable for their respective uses and are generally adequate for our present needs.

Item 3. ***Legal Proceedings.***

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

The information set forth under "Legal Proceedings and General Liability Claims" in Note 13 to our accompanying consolidated financial statements included elsewhere in this Report, is incorporated herein by reference.

Item 4. ***Mine Safety Disclosures.***

Not applicable.

PART II

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

All of our equity securities are held by Holdings, an indirect subsidiary of DSB Parent L.P., a Delaware limited partnership (the "***Parent***"). As of December 31, 2023, our Sponsor and certain co-investors beneficially owned approximately 97.6% of the capital units of the Parent with the remaining approximate 2.4% owned by our or our affiliates' current or former directors, members of management, employees and certain other service providers, and/or our affiliates. Because our equity securities are privately held, there is no established public trading market for our equity securities.

Equity Compensation Plan Information

Refer to Note 12 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by the Parent to certain of our current and former service providers.

Recent Sales of Unregistered Securities

There have been no recent sales of unregistered equity securities of the Company within the period covered by this Report.

Item 6. [Reserved.]

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

The following is management's discussion and analysis of our financial condition and results of operations for the years ended December 31, 2023 and December 31, 2022. We recommend that you read this discussion together with our accompanying consolidated financial statements and related notes included elsewhere in this Report.

Refer to Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations" in our Annual Report for the year ended December 31, 2022 for management's discussion and analysis of changes in financial condition and results of operations as of and for the years ended December 31, 2022 and 2021.

Overview

We are a leading provider of healthcare serving patients, clinicians, communities and partner organizations across the healthcare continuum. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a growing diversified healthcare delivery network, which at December 31, 2023 was comprised of 60 community hospital campuses, 39 IRFs, 23 BHFs, and additional sites of care that include ARUs, outpatient centers and post-acute care facilities. As of December 31, 2023, we operated 122 healthcare facilities in 31 states throughout the U.S. with approximately 12,000 licensed beds and approximately 50,000 dedicated employees.

We seek to fulfill our mission of *Making Communities Healthier*® and strive to create places where people choose to come for healthcare, physicians and providers want to practice and employees want to work. Additionally, we are committed to upholding our core values, which are champion patient care; do the right thing; embrace individuality; act with kindness; and make a difference together. Together, our shared mission, vision and values guide our work and unite our employees across our organization.

We generated revenues of $9,111 million and $8,020 million for the years ended December 31, 2023 and 2022, respectively. For the years ended December 31, 2023 and 2022, approximately 56.5% and 56.9% of our revenues, respectively, related to patients participating in Medicare and Medicaid programs, collectively. Payments made to our facilities pursuant to the Medicare and Medicaid programs for services rendered are often less than our costs for such services. As a result, we rely largely on payments made by private or commercial payers, together with certain limited services provided to Medicare recipients, to generate an operating profit. The healthcare industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payers. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our facilities.

Developments, Trends and Operating Environment

Rehabilitation Expansion

We have continued to expand our rehabilitation business since closing the Kindred Transaction. Following the transactions described below, as of December 31, 2023, our consolidated inpatient rehabilitation operations include 39 IRFs with approximately 1,900 beds across 19 states. For additional information regarding the Everest Operational IRF Transaction and the Everest Developing IRFs (defined below), refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Everest Operational IRFs Acquisition

On January 24, 2023, a wholly-owned, indirect subsidiary of ours entered into a definitive agreement with entities affiliated with Everest, to acquire four IRFs (the "***Everest Operational IRFs***") located in Arkansas, Texas, and Ohio (the "***Everest Operational IRF Transaction***") for an aggregate purchase price of approximately $38 million. The closing of the Everest Operational IRF Transaction was consummated on March 1, 2023. Effective September 28, 2023, we contributed the Everest Operational IRF located in Rogers, Arkansas to a new joint venture between us and Mercy Hospital Northwest Arkansas. We maintain a controlling interest in the joint venture and continue to consolidate the facility in our consolidated financial statements.

Everest Developing IRFs Acquisitions.

In connection with the closing of the Everest Operational IRF Transaction, certain of our affiliated entities entered into a definitive agreement with entities affiliated with Everest to acquire six IRFs under development by Everest in Texas and Florida (the "***Everest Developing IRFs***") for an aggregate purchase price of approximately $60 million. The acquisition of the first of the Everest Developing IRFs, located in El Paso, Texas (the "***El Paso IRF***"), was consummated on August 1, 2023. We anticipate closing the acquisitions of the remaining five Everest Developing IRFs on a rolling basis beginning in the second quarter of 2024.

De Novo IRFs Openings

During the two years ended December 31, 2023, our consolidated joint ventures have opened six de novo IRFs with approximately 300 beds (which does not include Saint Thomas Rehabilitation Hospital listed below), as summarized below.

Facility Name	Location	Opening Date	Beds
Frazier Rehabilitation Hospital - Brownsboro	Louisville, KY	July 18, 2023	40
UC Davis Rehabilitation Hospital	Sacramento, CA	May 18, 2023	52
Community Rehabilitation Hospital West	Indianapolis, IN	May 16, 2023	40
Dignity Health East Valley Rehabilitation Hospital - Gilbert	Gilbert, AZ	December 21, 2022	40
Mercy Rehabilitation Hospital South	St. Louis, MO	December 6, 2022	50
Saint Thomas Rehabilitation Hospital (a)	Nashville, TN	June 14, 2022	40
Tampa Rehabilitation Hospital	Tampa, FL	May 17, 2022	80

(a) We hold a noncontrolling ownership interest in Saint Thomas Rehabilitation Hospital and have accounted for it as an equity investment in accordance with Accounting Standards Codification ("***ASC***") 323, "Investments – Equity Method and Joint Ventures" ("***ASC 323***").

Behavioral Health Expansion

During the twelve months ended December 31, 2023, we significantly expanded our behavioral health presence through the transactions described below. Following such transactions, as of December 31, 2023, our consolidated behavioral health operations include 23 BHFs with approximately 1,700 beds across ten states. For additional information regarding the Springstone Transaction and El Dorado Transaction, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Springstone Transaction

On August 26, 2022, we entered into a definitive agreement with (i) entities affiliated with MPT and (ii) BH EIK Management, LP, a management company owned by Springstone Management, for the Lifepoint Member to acquire a majority ownership interest in Springstone from Springstone Management and to acquire a promissory note issued by Springstone to an affiliate of MPT. Springstone was a national behavioral health provider with 18 BHFs and 37 outpatient locations across nine states. The transaction closed on February 7, 2023, at which time we funded $229 million in cash and certain of our subsidiaries entered into the Springstone Master Lease with respect to the 18 BHFs. The Springstone Master Lease has an initial 20-year term with two optional five-year renewal periods. We accounted for the Springstone Master Lease as a finance lease in accordance with ASC 842, "Leases" ("***ASC 842***") and established an initial finance lease obligation of $546 million as of the closing date. In connection with the transaction, MPT retained a noncontrolling equity interest in Springstone, subject to the Put/Call Agreement. On January 25, 2024, MPT DS delivered to the Lifepoint Member a put option notice pursuant to the Put/Call Agreement, notifying the Lifepoint Member of its exercise of the put right under the Put/Call Agreement. In accordance with the Put/Call Agreement, the Lifepoint Member is obligated to acquire all of the equity interests of Springstone owned by MPT DS. We expect to close on the purchase of MPT DS's equity interest in Springstone during the three months ended March 31, 2024 for a purchase price of approximately $12 million, following which we will own all of the outstanding equity interests of Springstone.

Cornerstone El Dorado Transaction

On January 20, 2023, we acquired El Dorado, a 54-bed BHF located in Tucson, Arizona for $35 million in cash.

De Novo BHF Opening

During the year ended December 31, 2023, our consolidated joint venture opened one de novo BHF, as summarized below.

Facility Name	Location	Opening Date	Beds
Valley Springs Behavioral Health Hospital	Holyoke, MA	August 14, 2023	150

Joint Venture for Highpoint Health System

On December 1, 2023, we formed a joint venture with an affiliate of Ascension Saint Thomas to expand access to high quality care and services in Northern Middle Tennessee (the "***Highpoint Joint Venture***"). Pursuant to a contribution agreement between the parties, at the closing we contributed our ownership interest in the Highpoint Health System in exchange for a controlling interest in the Highpoint Joint Venture. The Highpoint Health System is a regional health system comprised of Sumner Regional Medical Center, a 167-bed acute care hospital located in Gallatin, Tennessee; Sumner Station Emergency Room and Outpatient Services, a free standing emergency department and outpatient services center located in Gallatin, Tennessee; Trousdale Medical Center, a 25-bed critical access hospital located in Carthage, Tennessee; and Riverview Regional Medical Center, a 25-bed critical access hospital located in Carthage, Tennessee; and more than 15 affiliated clinics and sites of care. At the closing, Ascension Saint Thomas contributed $19 million of cash (which was distributed to us) and brand licensing rights to the Highpoint Joint Venture in exchange for a noncontrolling equity interest in the Highpoint Joint Venture. We also entered into management agreements with the Highpoint Joint Venture pursuant to which we provide certain management and administrative services to the facilities for a percentage of their net revenues. We maintain a controlling interest in the Highpoint Joint Venture and continue to consolidate the results in our consolidated financial statements. For additional information regarding the Highpoint Joint Venture, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Kindred Transaction

On June 18, 2021, we entered into the Kindred Purchase Agreement for us and/or one or more affiliated assignees to acquire, directly or indirectly, Kindred, a leading specialty hospital company that operated facilities providing post-acute care, rehabilitation services and behavioral health services throughout the U.S. At the closing of the Kindred Transaction on December 23, 2021, a new healthcare company was established operating under the name ScionHealth, which is separate from Lifepoint; we acquired the IRF, behavioral health, contract rehabilitation service and certain support center businesses of Kindred; we separated and transferred the equity and assets comprising 18 select acute care hospitals to ScionHealth; and we acquired the Class B Units, with an aggregate value of $350 million, which are perpetual non-convertible, non-voting units that accrue cumulative dividends at the rate of 10.00% per annum and, upon liquidation, are entitled to a return of their nominal value issue price of $350 million plus accrued, unpaid dividends. Our acquisition of Kindred's inpatient rehabilitation and contract rehabilitation service business (including 28 IRFs with 1,447 beds), behavioral health business (including two BHFs with 96 beds), and certain support center businesses transformed us into a more diversified healthcare platform, well-positioned to advance healthcare delivery in communities across the country. For additional information regarding the Kindred Transaction, refer to "Item 1. Business–Recent Updates to our Business–Kindred Transaction" and Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

In connection with the Kindred Transaction, we have entered into a number of transition services agreements ("***TSAs***") and other ancillary agreements with ScionHealth and its subsidiaries. For the year ended December 31, 2023, in connection with the TSAs, we were reimbursed by ScionHealth for certain costs incurred on their behalf of $47 million, and paid ScionHealth $2 million for certain costs incurred on our behalf. For the year ended December 31, 2022, in connection with the TSAs, we were reimbursed by ScionHealth for certain costs incurred on their behalf of $61 million, and paid ScionHealth $3 million for certain costs incurred on our behalf. We had a net receivable of $124 million and $84 million recorded under the caption "Other current assets" in our accompanying consolidated balance sheet as of December 31, 2023 and December 31, 2022, respectively.

In addition, we and ScionHealth are parties to a number of commercial services agreements, pursuant to which we provide ScionHealth with therapy services, rehabilitation unit and behavioral health unit management, consulting and development services, among other commercial services. For the twelve months ended December 31, 2023 and December 31, 2022, we recorded revenues related to these commercial services agreements of $63 million and $55 million, respectively.

Divestitures

Effective September 29, 2023, we sold our 75% equity interest in the joint venture that owned Clark Memorial Hospital ("***Clark Memorial***"), a 236-bed acute care facility located in Jeffersonville, Indiana, and Scott Memorial Hospital ("***Scott Memorial***"), a 25-bed acute care facility located in Scottsburg, Indiana, to Norton Healthcare, the minority owner of such joint venture. We received net cash proceeds from the transaction of $37 million, including certain net working capital accounts.

Effective May 1, 2022, we sold Colorado Plains Medical Center ("***Colorado Plains***"), a 50-bed acute care facility located in Fort Morgan, Colorado, and Western Plains Medical Complex ("***Western Plains***"), a 99-bed acute care facility located in Dodge City, Kansas, to an unrelated third party. We received cash proceeds from the transaction of $135 million, including net working capital, of which $63 million was utilized to settle a finance lease obligation related to Western Plains.

The results of operations of the foregoing divested facilities are excluded from the discussion and analysis of our results of operations for the years ended December 31, 2023 and 2022 on a "same-facility" basis. See "Non-GAAP Measures" below for such "same-facility" results. For additional information regarding our recent divestitures, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Debt Refinancing Activities

On August 14, 2023, we completed the offering of $800 million in aggregate principal amount of our 9.875% Secured Notes. The 9.875% Secured Notes will mature on August 15, 2030. The net proceeds from the offering of the 9.875% Secured Notes, together with cash on hand, were used to purchase or redeem all $600 million aggregate principal amount of our then outstanding 6.75% Senior Secured Notes due 2025 (the "***6.75% Secured Notes***"), which were scheduled to mature on April 15, 2025, repay $200 million of outstanding borrowings under our Term Loan Facility and pay related fees and expenses in connection with the 9.875% Secured Notes offering.

On September 28, 2023, we executed an amendment to our ABL Facility (the "***ABL Facility Amendment***") that provided for $80 million in last-out revolving credit commitments (collectively, the "***ABL Last-Out Revolving Credit Facility***"), with a maturity date of January 27, 2028, which was incremental to the $800 million revolving commitments under the ABL Facility.

Effective October 10, 2023, we entered into an Incremental Assumption and Amendment Agreement No. 4, which amended and restated the Term Loan Facility in its entirety to provide for a new, senior secured term loan credit facility in an aggregate principal amount of $1,850 million, maturing on November 16, 2028. Prior to amendment, the Term Loan Facility consisted of outstanding principal amount of $3,015 million and was scheduled to mature on November 16, 2025.

On October 10, 2023, we completed the offering of $1,100 million in aggregate principal amount of our 11.0% Secured Notes. The 11.0% Secured Notes will mature on October 15, 2030. The net proceeds from the offering, together with proceeds of $1,850 million under the amendment and restatement of the Term Loan Facility and cash on hand, were used to repay in full all $3,015 million of outstanding borrowings under the Term Loan Facility and pay related fees and expenses in connection with the 11.0% Secured Notes offering.

As a result of our recent debt refinancing activities, we extended the tenor of approximately $3.8 billion of senior secured debt, previously maturing in 2025, to periods in 2028 and 2030, and our nearest term debt maturity is now in 2026. For additional information regarding our debt refinancing activities, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Non-Core Real Estate Financing Transaction

Effective September 19, 2023, we and certain of our subsidiaries (such subsidiaries, the "***Lifepoint OpCos***") entered into the Master Transaction Agreement (the "***Master Transaction Agreement***") with DSB Holdings, Inc., an indirect parent company of Lifepoint ("***DSB Holdings***"), Realpoint Properties, LLC, a subsidiary of DSB Holdings ("***Realpoint***"), and certain of Realpoint's subsidiaries (such subsidiaries, the "***Realpoint PropCos***"). Under the terms of the Master Transaction Agreement, the Lifepoint OpCos contributed to the Realpoint PropCos, by deed or 99-year ground lease as applicable, 36 medical office buildings, one skilled nursing facility and one assisted living facility. In connection with the Non-Core Real Estate Financing Transaction (as defined in this Report), the applicable Lifepoint OpCos entered into separate triple-net leases for the contributed properties, which have a 15-year term and aggregate initial base rent of approximately $25 million per year, subject to a 3% annual escalator. We accounted for the leases with Realpoint as operating leases under ASC 842 and recognized $219 million of right-of-use operating lease assets and right-of-use operating lease obligations in the accompanying consolidated balance sheet as of December 31, 2023. In connection with the Non-Core Real Estate Financing Transaction, under the Master Transaction Agreement, Realpoint distributed approximately $225 million in cash to us, and we retained approximately $169 million of Class B preferred interests in Realpoint, having a liquidation preference of approximately $169 million with a 9.5% annual preferred return, and approximately 2% of the outstanding Class A common interests in Realpoint. In addition, we entered into asset management agreements with Realpoint or the Realpoint PropCos, as applicable, under which we will provide certain administrative and management services to them in exchange for management fees of approximately $0.3 million per year, in the aggregate, subject to a 3% annual escalator. We refer to these transactions, collectively, as the "***Non-Core Real Estate Financing Transaction***." For additional information regarding the Non-Core Real Estate Financing Transaction, refer to Note 7 to our accompanying consolidated financial statements included elsewhere in this Report.

Legislative and Regulatory Developments in Response to COVID-19

Numerous legislative and regulatory actions, including the CARES Act and related stimulus legislation, were taken in an attempt to provide businesses, including healthcare providers, with relief from and to combat the negative effects of the COVID-19 pandemic.

In addition to the financial relief that was provided by the federal government under the CARES Act and other legislation that was passed by Congress during the public health emergency, CMS and many state governments issued a number of waivers or temporarily suspended a number of healthcare facility licensure and reimbursement requirements in order to provide hospitals, skilled nursing facilities, and other types of healthcare providers with increased flexibility to meet the challenges presented by the COVID-19 pandemic. For example, CMS temporarily waived the enforcement of certain requirements of the Stark law to enable hospitals to treat patients in temporary locations and to obtain services from physicians in a more efficient and timely manner. Likewise, many states suspended the enforcement of certain certificate of need and licensure requirements to ensure that hospitals and other healthcare providers had sufficient capacity to treat COVID-19 patients. Our facilities utilized the waivers and regulatory flexibility that were provided to the extent necessary to appropriately respond to the COVID-19 pandemic. On May 11, 2023, the COVID-19 public health emergency ended. As a result, many of the flexibilities and waivers issued in response to the COVID-19 public health emergency are no longer in effect.

Results of Operations

Certain Definitions

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

Adjusted EBITDA. EBITDA adjusted to exclude unusual items and other adjustments required or permitted in calculating debt covenant compliance under the Indentures governing the Notes and/or the Credit Agreements. We believe that this inclusion of supplementary adjustments to EBITDA applied in presenting Adjusted EBITDA are appropriate to provide additional information to investors about the impact of certain non-cash, non-recurring or unusual items that we do not expect to continue or to continue at the same level in the future and other items.

Admissions. The total number of patients admitted to our facilities for inpatient treatment.

Case mix index. Refers to the acuity or severity of illness of an average patient at our acute care facilities.

Consolidated. Consolidated information includes the results of all facility operations and corporate overhead costs generated during our applicable periods of ownership, including the results of our new acquisitions, new facility openings and our completed divestitures.

EBITDA. Earnings before interest, taxes, depreciation and amortization.

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

Outpatient factor. The sum of gross inpatient revenue and gross outpatient revenue divided by gross inpatient revenue.

Patient days. The total number of days of care provided to patients admitted to our facilities for inpatient treatment.

Same-facility. Same-facility information includes the results of the same facilities operated during the entire three months and years ended December 31, 2023 and 2022, as if the Springstone Transaction had occurred on January 1, 2022. Same-facility information excludes the results of certain de novo facilities opened in 2022 and 2023, facilities acquired through the Everest Operational IRF Transaction, Everest Developing IRFs, and the El Dorado Transaction, and our completed divestitures.

Summary

The following table summarizes our consolidated results of operations for the years ended December 31, 2023 and 2022 (dollars in millions):

	Years Ended December 31,			
	2023		2022	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 9,111	100.0 %	$ 8,020	100.0 %
Salaries and benefits	4,466	49.0	4,016	50.1
Supplies	1,306	14.3	1,243	15.5
Other operating expenses, net	2,456	27.0	2,025	25.2
Depreciation and amortization	330	3.6	323	4.0
Interest expense, net	679	7.5	480	6.0
Debt refinancing costs	52	0.6	-	-
Other transaction-related costs	28	0.3	46	0.6
Other non-operating losses (gains), net	12	0.1	(8)	(0.1)
	9,329	102.4	8,125	101.3
Loss before income taxes	(218)	(2.4)	(105)	(1.3)
Provision for income taxes	52	0.6	100	1.3
Net loss	(270)	(3.0)	(205)	(2.6)
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(66)	(0.7)	(66)	(0.8)
Net loss attributable to Lifepoint Health, Inc.	$ (336)	(3.7) %	$ (271)	(3.4) %

Revenues

The following table summarizes our key revenue metrics on a consolidated basis for the years ended December 31, 2023 and 2022:

	Years Ended December 31,		Increase	% Increase
	2023	2022	(Decrease)	(Decrease)
Number of facilities (at end of period) (a)	122	96		
Revenues (in millions)	$ 9,111	$ 8,020	$ 1,091	13.6%
Patient days	1,962,779	1,541,709	421,070	27.3%
Admissions	308,111	248,646	59,465	23.9%
Equivalent admissions	787,035	636,886	150,149	23.6%
Revenues per equivalent admission	$ 11,576	$ 12,593	$ (1,017)	(8.1)%
Case mix index	1.47	1.47	-	-%
Total surgeries	318,662	306,655	12,007	3.9%
Emergency department visits	1,270,530	1,275,070	(4,540)	(0.4)%

(a) Excludes two non-consolidated IRFs accounted for as equity method investments in accordance with ASC 323.

For the year ended December 31, 2023, our consolidated revenues increased $1,091 million, or 13.6%, to $9,111 million compared to $8,020 million for the prior year. The increase in our consolidated revenues was attributable to the impact of our acquisitions completed in 2023, increases in our acute care hospital admissions and equivalent admissions and increases in revenues associated with MSPs. Refer to *"Supplemental Results of Operations on a Same-Facility Basis"* included elsewhere in this Report for a more comparable analysis of our key revenue metrics.

Our revenues by payer and approximate percentages of revenues on a consolidated basis were as follows for the years ended December 31, 2023 and 2022:

	Years Ended December 31,			
	2023		2022	
	% of Revenues		% of Revenues	
Medicare	37.4	%	40.1	%
Medicaid	19.1		16.8	
HMOs, PPOs and other private insurers	37.9		37.1	
Self-pay	0.7		0.7	
Other (a)	4.7		5.1	
Revenue from contracts with customers	99.8		99.8	
Rental income	0.2		0.2	
Revenues	100.0	%	100.0	%

(a) Includes revenues from managed ARUs and ancillary goods and services.

Salaries and Benefits

For the year ended December 31, 2023, our consolidated salaries and benefits expense was $4,466 million, or 49.0% of revenues, compared to $4,016 million, or 50.1% of revenues, for the prior year. The increase in our consolidated salaries and benefits expense was primarily attributable to improvements in same facility volumes, including a 4.4% increase in admissions, a 7.8% increase in equivalent admissions and a 4.9% increase in total surgeries, as well as, but to a lesser extent, as a result of increases due to our 2023 acquisitions. As a percentage of revenues, our consolidated salaries and benefits expense decreased primarily as a result of continued reductions in contract labor expenses across our acute care hospital markets during the year ended December 31, 2023 compared to the prior year.

Supplies

For the year ended December 31, 2023, our consolidated supplies expense was $1,306 million, or 14.3% of revenues, compared to $1,243 million, or 15.5% of revenues, for the prior year. The decrease in our consolidated supplies expense as a percentage of revenues was primarily attributable to our 2023 acquisitions in the rehabilitation and behavioral health lines of business, which incurred less supply costs as a percentage of revenues compared to the majority of our acute care hospital markets.

Other Operating Expenses, Net

Other operating expenses include, among other things, contract services, professional fees, rents and leases, repairs and maintenance, utilities, insurance, non-income taxes, other income and other expenses. For the year ended December 31, 2023, our consolidated other operating expenses were $2,456 million, or 27.0% of revenues, compared to $2,025 million, or 25.2% of revenues, for the prior year. The increase in our other operating expenses was primarily attributable to our 2023 acquisitions, as well as increases in contract services, professional fees and provider taxes associated with our MSPs.

Depreciation and Amortization

For the year ended December 31, 2023, our consolidated depreciation and amortization expense was $330 million, or 3.6% of revenues, compared to $323 million, or 4.0% of revenues, for the prior year. The increase in our consolidated depreciation and amortization expense was primarily attributable to our 2023 acquisitions.

Interest Expense, Net

For the year ended December 31, 2023, our consolidated interest expense was $679 million, or 7.5% of revenues, compared to $480 million, or 6.0% of revenues, for the prior year. The increase in our interest expense was primarily attributable to rising variable interest rates as compared to the prior year as well as higher fixed interest rate instruments as a result of our recent debt refinancing activities. We expect our interest expense to continue to increase in the near-term as a result of our recent debt refinancing activities. For a further discussion of our debt and corresponding interest expense, refer to Notes 3 and 10 to our accompanying consolidated financial statements included elsewhere in this Report.

Debt Refinancing Costs

For the years ended December 31, 2023, we recognized debt refinancing costs of $52 million in connection with our recent debt refinancing activities. For a further discussion of our recent debt refinancing activities, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Other Transaction-Related Costs

For the years ended December 31, 2023, we recognized transaction and advisory-related costs of $28 million, primarily in connection with the Springstone Transaction, the Non-Core Real Estate Financing Transaction and other business development activities, including those discussed in Note 2 to our accompanying consolidated financial statements included elsewhere in this Report. For a further discussion of the Non-Core Real Estate Financing Transaction, refer to Note 7 to our accompanying consolidated financial statements included elsewhere in this Report.

For the year ended December 31, 2022, we incurred transaction-related costs of $46 million, primarily related the Springstone Transaction, the Kindred Transaction and other business development activities, including those discussed in Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Other Non-Operating Losses (Gains), Net

For the year ended December 31, 2023, we recognized a net other non-operating loss of $12 million, primarily related to the divestitures of Clark Memorial and Scott Memorial. For the year ended December 31, 2022, we recognized a net other non-operating gain of $8 million, primarily comprised of gains related to our divestitures of Colorado Plains and Western Plains and the repurchase of a portion of our 9.75% Unsecured Notes, partially offset by losses recognized in connection with miscellaneous disposals of property and equipment. For additional information regarding our recent divestitures, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Income Taxes

For the years ended December 31, 2023 and 2022, we recognized a provision for income taxes of $52 million and $100 million, respectively. For additional information regarding income taxes, including a summary of the drivers, refer to Note 5 to our accompanying consolidated financial statements included elsewhere in this Report.

Non-GAAP Measures

Supplemental Results of Operations on a Same-Facility Basis

The following table summarizes our key supplemental results of operations for the three months and years ended December 31, 2023 and 2022 on a same-facility basis (as previously defined). GAAP does not allow for such a combination of results of operations; however, we believe this information is useful in evaluating our financial performance.

	Three Months Ended December 31,		Increase (Decrease)	% Increase (Decrease)
	2023	2022		
Number of facilities (at end of period) (a)	110	110		
Revenues (in millions)	$ 2,296	$ 2,097	$ 199	9.5%
Patient days	485,735	470,294	15,441	3.3%
Admissions	76,545	72,632	3,913	5.4%
Equivalent admissions	193,691	183,476	10,215	5.6%
Revenues per equivalent admission	$ 11,854	$ 11,427	$ 427	3.7%
Case mix index	1.47	1.46	0.01	0.7%
Total surgeries	77,242	74,091	3,151	4.3%
Emergency department visits	319,130	322,300	(3,170)	(1.0)%

	Years Ended December 31,		Increase (Decrease)	% Increase (Decrease)
	2023	2022		
Number of facilities (at end of period) (a)	109	109		
Revenues (in millions)	$ 8,872	$ 8,229	$ 643	7.8%
Patient days	1,891,344	1,857,619	33,725	1.8%
Admissions	298,162	285,463	12,699	4.4%
Equivalent admissions	769,766	714,390	55,376	7.8%
Revenues per equivalent admission	$ 11,525	$ 11,518	$ 7	0.1%
Case mix index	1.47	1.48	(0.01)	(0.7)%
Total surgeries	311,653	297,032	14,621	4.9%
Emergency department visits	1,237,408	1,222,363	15,045	1.2%

(a) Excludes two non-consolidated IRFs accounted for as equity method investments in accordance with ASC 323.

For the three months and year ended December 31, 2023, our same-facility revenues increased $199 million, or 9.5%, and $643 million, or 7.8%, respectively, compared to the same periods last year. The increase in our same-facility revenues was primarily attributable to an increase in equivalent admissions for the three months and year ended December 31, 2023 of 5.6% and 7.8%, respectively, compared to the same periods last year. The increase in our same-facility equivalent admissions was attributable to increases in inpatient admissions and total surgical volumes compared to the same periods last year. Additionally, our revenues per equivalent admission increased over the prior year primarily as a result of improvements in commercial pricing and reimbursement associated with MSPs.

EBITDA and Adjusted EBITDA

The following table presents a reconciliation of net loss to EBITDA and Adjusted EBITDA prepared in accordance with the calculations set forth in the Indentures and the Credit Agreements for the three months ended December 31, 2023 and 2022 and the twelve months ended December 31, 2023 and September 30, 2023 (in millions):

	Three Months Ended December 31,		Twelve Months Ended	
	2023	2022	December 31, 2023	September 30, 2023
Net income (loss)	$ 34	$ (167)	$ (270)	$ (471)
Interest expense, net	184	135	679	630
Income taxes	(105)	81	52	238
Depreciation and amortization	84	84	330	330
EBITDA	197	133	791	727
Debt refinancing costs (a)	34	-	52	18
Transaction-related costs (b)	-	19	28	47
Facility lease interest expense (c)	(28)	(12)	(97)	(81)
Divested operations (d)	-	-	14	16
One-time costs, non-cash and non-recurring items (e)	45	42	166	163
Subtotal	248	182	954	890
Pro forma run rate adjustments:				
Cost savings initiatives (f)	30	24	154	166
Strategic investments (g)	36	38	162	162
	66	62	316	328
Adjusted EBITDA	$ 314	$ 244	$ 1,270	$ 1,218

(a) Represents the exclusion of costs and non-cash charges associated with our recent debt refinancing activities during 2023. For a further discussion of our recent debt refinancing transactions, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

(b) Represents the exclusion of certain transaction-related expenses, including costs associated with the Non-Core Real Estate Financing Transaction, the Springstone Transaction, the Kindred Transaction, and other business development activities occurring during the applicable periods. For additional information regarding our recent business development activities, refer to Notes 2 and 7, respectively, to our accompanying consolidated financial statements included elsewhere in this Report.

(c) Represents cash interest expense in connection with certain finance leases. Pursuant to the terms of the financial covenants contained in our debt agreements, we are required to consider cash interest expense on facility-related finance leases within the calculation of Adjusted EBITDA.

(d) Represents the elimination of EBITDA losses associated with our divestitures of Clark Memorial and Scott Memorial. For additional information regarding our recent divestitures, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

(e) Represents the exclusion of certain one-time costs, non-cash and non-recurring items, including, but not limited to, incremental operating expenses associated with litigation-related expenses, employee severance and other restructuring charges, facility pre-opening costs and start-up related expenses, implementation costs related to various strategic initiatives, differences between cash payments and reported rent expense for facility operating leases, stock-based compensation expense, gains and losses related to disposals of property and equipment, and other non-operational items.

(f) Represents the unrealized savings associated with various discrete cost reduction initiatives across our business, including our transition to an enterprise business services model.

(g) Represents the estimated pro forma EBITDA impact attributable to various strategic investments we are making in the business, including (i) our IRF and BHF de novo pipeline, (ii) in-market investments in new or expanded acute care service lines, and (iii) our completed 2023 acquisitions, including the Springstone Transaction, the El Dorado Transaction and the Everest Operational IRF Transaction.

Leverage

The following table illustrates our indebtedness and certain leverage ratios prepared in accordance with the calculations set forth in the Indentures and the Credit Agreements as of and for the twelve months ended December 31, 2023 and September 30, 2023 (dollars in millions):

	December 31, 2023	September 30, 2023
Cash and cash equivalents	$ 90	$ 230
ABL Facility	$ 35	$ -
ABL Last-Out Revolving Credit Facility	80	80
Term Loan Facility	1,850	3,015
4.375% Secured Notes	600	600
9.875% Secured Notes	800	800
11.0% Secured Notes	1,100	-
Other Secured Debt	20	20
Total Secured Debt (a)	$ 4,485	$ 4,515
Net Secured Debt (a)	$ 4,395	$ 4,285
9.75% Unsecured Notes	$ 1,270	$ 1,270
5.375% Unsecured Notes	500	500
Total Debt (a)	$ 6,255	$ 6,285
Net Debt (a)	$ 6,165	$ 6,055
Adjusted EBITDA	$ 1,270	$ 1,218
Total Secured Debt (a) / Adjusted EBITDA	3.53x	3.71x
Net Secured Debt (a) / Adjusted EBITDA	3.46x	3.52x
Total Debt (a) / Adjusted EBITDA	4.93x	5.16x
Net Debt (a) / Adjusted EBITDA	4.85x	4.97x

(a) Excludes finance lease obligations, which are not considered indebtedness for purposes of calculating the ratios set forth in the Indentures and the Credit Agreements, as well as unamortized debt issuance costs.

As described above, effective October 10, 2023, we used the net proceeds of the amendment and restatement of the Term Loan Facility in an outstanding principal amount of $1,850 million and the offering of $1,100 million aggregate principal amount of the 11.0% Secured Notes, together with cash on hand, to prepay all $3,015 million of term loans then-outstanding under the Term Loan Facility.

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash generated by operations and borrowings under the ABL Facility. Our cash on hand, borrowings under the ABL Facility and total liquidity fluctuates from period to period, and intra-period, based on various factors, including the timing of payment by federal and state programs. Our primary uses of cash are working capital requirements, debt service requirements and capital expenditures. We expect our interest expense to continue to increase in the near-term as a result of our recent debt refinancing activities. We believe our cash flows from operations, combined with available cash and availability under the ABL Facility, will provide sufficient liquidity to fund our current obligations, projected working capital requirements, debt service requirements and capital spending requirements over the next twelve months and into the foreseeable future prior to the maturity dates of our outstanding long-term debt. We cannot assure you, however, that our business will generate sufficient cash flows from operations or that future borrowings will be available to us under the ABL Facility, which is subject to a borrowing base, in an amount sufficient to enable us to pay principal and interest on the ABL Facility, the Term Loan Facility and the Notes, or to fund other liquidity needs. Our ability to do so depends on prevailing economic conditions, many of which are beyond our control. In addition, upon the occurrence of certain events, such as a change of control, we could be required to repay or refinance our indebtedness. We cannot assure you that we will be able to refinance any of our indebtedness on commercially reasonable terms or at all. Any future acquisitions, joint ventures or other similar transactions will likely require additional capital, and there can be no assurance that any such capital will be available to us on acceptable terms or at all. Any refinancing of our indebtedness could be at higher interest rates and may require us to comply with more onerous covenants that could further restrict our business operations. See “Item 1A, Risk Factors—Credit and Liquidity Risks” included elsewhere in this Report.

The following table presents summarized cash flow information for the years ended December 31, 2023 and 2022 (in millions):

	2023	2022
Net cash provided by operating activities	$ 141	$ 82
Net cash used in investing activities	(494)	(138)
Net cash provided by (used in) financing activities	48	(402)
Change in cash and cash equivalents	$ (305)	$ (458)

Operating Activities

Net cash provided by operating activities for the years ended December 31, 2023 and 2022 was $141 million and $82 million, respectively. The increase in our net cash provided by operating activities was primarily attributable to improvements in various working capital accounts, partially offset by increases in interest payments.

Investing Activities

We invested $229 million and $227 million in purchases of property and equipment for the years ended December 31, 2023 and 2022, respectively. Refer to “—Capital Expenditures” below for further information.

During the year ended December 31, 2023, we invested $313 million, collectively, in business acquisitions, including the Springstone Transaction, the El Dorado Transaction, the Everest Operational IRF Transaction and the El Paso IRF acquisition. Lastly, we received cash proceeds of $37 million in connection with the divestitures of Clark Memorial and Scott Memorial.

During the year ended December 31, 2022, we received cash proceeds of $135 million in connection with the divestitures of Colorado Plains Medical Center and Western Plains Medical Complex. Additionally, during the year ended December 31, 2022, certain of our subsidiaries invested approximately $47 million for an aggregate $50 million principal amount of ScionHealth’s senior secured term loan.

For a further discussion of our acquisitions and divestitures, refer to Note 2 to our accompanying consolidated financial statements included elsewhere in this Report.

Financing Activities

Our net cash provided by financing activities for the year ended December 31, 2023 primarily consisted of cash provided by our debt refinancing activities, as well as cash proceeds related to our Non-Core Real Estate Financing Transaction, distributions to our joint venture partners and payments made under finance lease arrangements. For more information regarding our debt financing activities and Non-Core Real Estate Financing Transaction, refer to Notes 3 and 7, respectively, to our accompanying consolidated financial statements included elsewhere in this Report.

Our net cash used in financing activities for the year ended December 31, 2022 primarily consisted of repurchases of a portion of our 9.75% Unsecured Notes in connection with our Notes Repurchase Program (as defined in this Report), distributions to our joint venture partners and a cash distribution to our Parent to fund the repurchase of certain previously issued profit interest units and capital units held by certain of our former employees. Additionally, our net cash used in financing activities for the year ended December 31, 2022 included payments to terminate the finance lease obligations related to one of our acute care facilities that we continue to operate and Western Plains Medical Complex.

Capital Expenditures

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

The following table summarizes our capital expenditures as a percentage of revenues and as a percentage of depreciation expense for the years ended December 31, 2023 and 2022 (dollars in millions):

	2023		2022	
	Amount	% of	Amount	% of
Capital expenditures	$ 229	2.5 %	$ 227	2.8 %
Depreciation expense	$ 330		$ 323	
Ratio of capital expenditures to depreciation expense	69.4 %		70.3 %	

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

Capital Resources

We monitor the capital markets and our capital structure and make changes from time to time, with the goal of maintaining financial flexibility, preserving or improving liquidity and/or achieving cost efficiency. From time to time, we, our subsidiaries and our respective affiliates may elect to purchase, repurchase, acquire or retire portions of our outstanding debt, including any of the Notes, in open market purchases, privately negotiated transactions, tender offer transactions or otherwise, although there is no assurance we will do so. Any such purchase, repurchase, acquisition or retirement is dependent on a variety of factors, including prevailing market conditions, liquidity requirements, contractual restrictions and other factors. As a result of our recent debt refinancing activities, we extended the tenor of approximately $3.8 billion of senior secured debt, previously maturing in 2025, to periods in 2028 and 2030, and our nearest term debt maturity is now in 2026.

ABL Facility

As of December 31, 2023, we had $35 million in borrowings outstanding under the ABL Facility and approximately $63 million in letters of credit outstanding primarily related to the SIR level of our general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements. Amounts available for borrowing under the ABL Facility were approximately $682 million as of December 31, 2023.

The ABL Facility, initially effective as of November 16, 2018, provided for an aggregate principal amount of $800 million with a maturity of five years.

On January 27, 2023, we entered into an Incremental Assumption and Amendment Agreement No. 2, which amended and restated the ABL Facility. The ABL Facility, as amended and restated, has a stated maturity of five years; provided, that if more than $200 million aggregate principal amount of the Notes or the Term Loan Facility remain outstanding 91 days before the stated maturity thereof, then the ABL Facility will mature and the commitments under the facility will terminate on such date. The ABL Facility, as amended and restated, continues to provide revolving availability of $800 million, with a $150 million letter of credit sub-facility and a $40 million swingline sub-facility.

Availability under the ABL Facility continues to be subject to a borrowing base that is based on a specified percentage of eligible accounts receivable. Borrowings under the ABL Facility continue to be subject to the satisfaction of customary conditions, including the absence of a default and the accuracy of representations and warranties. For further information regarding the ABL Facility, including certain restrictive covenants and such amendment and restatement, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

ABL Last-Out Revolving Credit Facility

On September 28, 2023, we executed the ABL Facility Amendment that provided for the ABL Last-Out Revolving Credit Facility, $80 million in last-out revolving credit commitments, with a maturity date of January 27, 2028, which was incremental to the $800 million revolving commitments under the ABL Facility. The ABL Last-Out Revolving Credit Facility is required to be drawn before the revolving commitments under the ABL Facility, but cannot be repaid if any amount of the revolving commitment under the ABL Facility remains outstanding unless the applicable last-out revolving credit commitments are permanently reduced and certain other conditions are met. As of December 31, 2023, there was $80 million outstanding under the ABL Last-Out Revolving Credit Facility. For more information regarding the ABL Last-Out Revolving Credit Facility, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Term Loan Facility

Effective November 16, 2018, we entered into the Term Loan Facility, which is a senior secured term loan credit facility with a maturity of seven years. Effective October 10, 2023, we entered into an Incremental Assumption and Amendment Agreement No. 4, which amended and restated the Term Loan Facility in its entirety to provide for a new, senior secured term loan credit facility in an aggregate principal amount of $1,850 million, maturing on November 16, 2028. As of December 31, 2023, approximately $1,850 million was outstanding on the Term Loan Facility. For more information regarding the Term Loan Facility, including certain restrictive covenants, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

4.375% Secured Notes

On February 13, 2020, we issued the 4.375% Secured Notes in an aggregate principal amount of $600 million with a maturity of seven years. For further information regarding the 4.375% Secured Notes, including certain restrictive covenants, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

9.875% Secured Notes

Effective August 14, 2023, we issued the 9.875% Secured Notes in aggregate principal amount of $800 million with a maturity of seven years. For further information regarding the 9.875% Secured Notes, including certain restrictive covenants, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

11.0% Secured Notes

Effective October 10, 2023, we issued the 11.0% Secured Notes in aggregate principal amount of $1,100 million with a maturity of seven years. For further information regarding the 11.0% Secured Notes, including certain restrictive covenants, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

9.75% Unsecured Notes

On November 16, 2018, we issued the 9.75% Unsecured Notes in an aggregate principal amount of $1,425 million with a maturity of eight years. During year ended December 31, 2022, we repurchased $155 million aggregate principal amount of the 9.75% Unsecured Notes in connection with our Notes Repurchase Program. For further information regarding the 9.75% Unsecured Notes, including certain restrictive covenants, and our Notes Repurchase Program, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

5.375% Unsecured Notes

On December 4, 2020, we issued the 5.375% Unsecured Notes in an aggregate principal amount of $500 million with a maturity of eight years. For further information regarding the 5.375% Unsecured Notes, including certain restrictive covenants, refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report.

Other Secured Debt

On February 7, 2023, concurrently with the consummation of the Springstone Transaction, certain of the Company's subsidiaries entered into an amended and restated credit agreement with Capital One, N.A. as administrative agent and lender, which provides for a $35 million senior secured asset-based revolving credit facility ("***Other Secured Debt***") and matures on December 17, 2026. At December 31, 2023, approximately $20 million of Other Secured Debt was outstanding. Refer to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report for further discussion regarding Other Secured Debt.

Notes Repurchase Program

On June 3, 2022, the Executive Committee of our Board (the "***Executive Committee***") authorized the repurchase of up to $200 million aggregate principal amount of the Notes (the "***Notes Repurchase Program***"). During the year ended December 31, 2022, we repurchased $155 million aggregate principal amount of our 9.75% Unsecured Notes for an aggregate repurchase price of $144 million in connection with the Notes Repurchase Program. As of December 31, 2023, we had remaining authority to repurchase up to an additional $45 million aggregate principal amount of the Notes in accordance with the Notes Repurchase Program. Future repurchases, if any, under the Notes Repurchase Program will depend on a number of factors, including but not limited to market conditions.

Liquidity and Capital Resources Outlook

We continue to have ongoing capital expenditure commitments in connection with several of our facilities. At December 31, 2023, we estimated our total remaining capital expenditure commitments to be approximately $540 million. The majority of this amount represents long-term commitments that are computed as a percentage of revenues at the applicable facility. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the ABL Facility.

Our business strategy contemplates the selective acquisition of additional hospitals and other healthcare service providers, and we regularly review potential acquisitions. These acquisitions may, however, require additional financing. Our primary sources of liquidity are cash flows provided by our operations and our borrowings available under the ABL Facility. We believe that our internally generated cash flows and borrowing availability under the ABL Facility will be adequate to service existing debt, finance internal growth and fund capital expenditures and small to mid-size hospital acquisitions over the next twelve months and into the foreseeable future prior to maturity dates of our outstanding debt. Certain larger hospital acquisitions may, however, require additional financing.

Inflation

The healthcare industry is labor-intensive. Wages and other expenses increase during periods of inflation and when labor shortages in marketplaces occur. In addition, suppliers pass along rising costs to us in the form of higher prices. Private insurers pass along their rising costs in the form of lower reimbursement to us. Our ability to pass on these increased costs in increased rates is limited because of increasing regulatory and competitive pressures and the fact that the majority of our revenues are fee-based. Accordingly, inflationary pressures could have a material adverse effect on our results of operations. Additionally, there is uncertainty surrounding the impact of any monetary policy changes taken by the U.S. Federal Reserve and other central banks to address the structural risks associated with inflation.

Contractual Obligations and Material Cash Requirements

We have certain material contractual obligations which are recorded as liabilities in our consolidated financial statements, primarily including:

- long-term debt obligations (refer to "—Capital Resources" above and to Note 3 to our accompanying consolidated financial statements included elsewhere in this Report); and
- finance and operating lease obligations (refer to Note 7 to our accompanying consolidated financial statements included elsewhere in this Report).

Additionally, we have certain other material cash requirements related to items that are not recognized as liabilities in our consolidated financial statements, primarily including:

- capital expenditure commitments (refer to "—Capital Expenditures" above and to Note 13 to our accompanying consolidated financial statements included elsewhere in this Report);
- shared centralized resource model arrangements with various third parties to provide certain nonclinical business functions to us, including payroll, supply chain management and revenue cycle management;
- information technology services, including, but not limited to, financial, clinical, patient accounting and other information services;
- diagnostic imaging equipment maintenance and bio-medical services; and
- other minimum commitments to purchase miscellaneous goods or services under non-cancelable contracts.

Adoption of Recently Issued Accounting Standards

None.

Critical Accounting Estimates

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

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

Our critical accounting estimates include the following areas:

- Revenue recognition and accounts receivable;
- Goodwill impairment analysis;
- Accounting for income taxes; and
- Reserves for self-insurance claim.

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

Revenue Recognition and Accounts Receivable

We recognize revenues in the period in which performance obligations are satisfied. Generally, we bill patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. Amounts we receive for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, HMOs, PPOs and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in our financial statements are recorded at the net consideration to which we expect to be entitled to receive in exchange for providing patient care.

Approximately 95.1%, 94.7% and 98.0% of our patient revenues recognized during the years ended December 31, 2023, 2022 and 2021, respectively, related to discounted charges, which were comprised of the following sources (as a percentage of our revenues):

	2023	2022	2021
Medicare	37.4 %	40.1 %	37.7 %
Medicaid	19.1 %	16.8 %	18.4 %
HMOs, PPOs and other private insurers	37.9 %	37.1 %	41.3 %
Self-pay	0.7 %	0.7 %	0.6 %

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

We monitor our processes for calculating contractual allowances through:

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

Medicare and Medicaid

The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e. gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under the Medicaid program's prospective reimbursement systems, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates.

Discounts for retrospectively cost-based revenues are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under these programs are subject to adjustment based on administrative review and audit by third-party intermediaries, which can take several years to resolve completely.

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

HMOs, PPOs and Other Private Insurers

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

The process of determining the allowance requires us to estimate the amount expected to be received based on payer contract provisions, historical collection data as well as other factors and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts for managed care plans would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third-party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. We evaluate these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. We estimate the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that we utilize include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that we expect to collect. Because we provide care to patients regardless of their ability to pay, we have determined that the differences between the amounts we bill based on gross or discounted charges and the amounts we expect to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and we account for this variable consideration in accordance with the provisions of ASC 606, "Revenue from Contracts with Customers" ("***ASC 606***"). Self-pay accounts receivable are written off after collection efforts have been followed in accordance with our policies. The Company's revenue recognition and accounts receivable policies are discussed further in Note 1 to our accompanying consolidated financial statements included elsewhere in this Report.

Goodwill Impairment Analysis

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired businesses. Our goodwill included in our consolidated balance sheet as of December 31, 2023 was $4.2 billion. Refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report for a detailed roll forward of changes in our goodwill during the years ended December 31, 2023 and 2022.

In accordance with ASC 350, "Intangibles — Goodwill and Other" (***"ASC 350"***) goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment on October 1. In 2022, we were comprised of two distinct reporting units: (i) acute hospital operations and (ii) rehabilitation hospital operations. Due to the significance of the Springstone Transaction and the impact on our management team and business operations, we re-evaluated our reporting units in accordance with ASC 280, "Segment Reporting" ("***ASC 280***") and ASC 350 during 2023 and determined that we are now comprised of three distinct reporting units: (i) acute hospital operations (ii) rehabilitation hospital operations; and (iii) behavioral health operations.

For the annual impairment evaluation, we estimate fair values of our reporting units utilizing both a discounted cash flow ("***DCF***") analysis and a guideline public company analysis considering observable market data of the Company's industry peers. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates, profitability and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing the Company's assumptions. The cash flows employed in the DCF analysis are based on the Company's most recent financial budgets and business plans and, when applicable, various growth rates and profitability for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the reporting unit.

If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. Refer to Note 4 to our accompanying consolidated financial statements included elsewhere in this Report for further discussion of the results of our annual goodwill impairment evaluation procedures.

Accounting for Income Taxes

Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or subsequently increase or decrease this allowance, we must include an adjustment as part of the income tax provision in our results of operations. Our deferred tax asset balances in our consolidated balance sheets were $697 million and $488 million as of December 31, 2023 and 2022, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $441 million and $305 million as of December 31, 2023 and 2022, respectively.

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

The first step in determining the deferred tax asset valuation allowance is identifying reporting jurisdictions where we have a history of tax and operating losses or are projected to have losses in future periods as a result of changes in operational performance. We then determine if a valuation allowance should be established against the deferred tax assets for that reporting jurisdiction. The second step is to determine the amount of the valuation allowance. We will generally establish a valuation allowance equal to the net deferred tax asset (deferred tax assets less deferred tax liabilities) related to the jurisdiction identified in step one of the analysis. In certain cases, we may not reduce the valuation allowance by the amount of the deferred tax liabilities depending on the nature and timing of future taxable income attributable to deferred tax liabilities.

In assessing tax contingencies, we apply the provisions of ASC 740, "Income Taxes". We apply the recognition threshold and measurement of a tax position taken or expected to be taken in a tax return and follow the guidance on various matters such as derecognition, interest, penalties and disclosure. We classify interest and penalties as a component of income tax expense. During each reporting period, we assess the facts and circumstances related to recorded tax contingencies. If tax contingencies are no longer deemed probable based upon new facts and circumstances, the contingency is reflected as a reduction of the provision for income taxes in the current period.

Our deferred tax assets exceeded our deferred tax liabilities by $420 million as of December 31, 2023, excluding the impact of valuation allowances. Historically, we have not produced federal taxable income and are highly leveraged. As such, we believe it is likely that a significant component of our deferred tax assets will not be realized and thus have established a valuation allowance against these deferred tax assets as of December 31, 2023. In addition, we have subsidiaries with a history of tax losses in certain state jurisdictions, and, based upon those historical tax losses, we have assumed that the subsidiaries would not be profitable in the future for those states' tax purposes. If our assertion regarding the future profitability of those subsidiaries would have been different, then our deferred tax assets would be understated by the amount of the state valuation allowance of $182 million at December 31, 2023.

Reserves for Self-Insurance Claims

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding SIR and deductible levels. At December 31, 2023, our SIR for professional liability claims is $15 million per claim at the majority of our acute care hospitals. Additionally, we participate in state-specific professional liability programs in New Mexico and Pennsylvania. We have a $25,000 deductible for professional liability at each of our IRFs and a $100,000 deductible at each of our BHFs. At December 31, 2023, our deductible for workers' compensation claims at each of our acute care and BHFs was $1 million per claim in all states in which we operate except for Montana, Ohio and Washington. We participate in state-specific programs for our workers' compensation claims arising in these states. There is no deductible for workers' compensation claims at our IRFs. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

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

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

Our reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. Our reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. We have discounted our reserves for self-insured claims to their present value using a discount rate of 2.0% at December 31, 2023 and 1.8% at December 31, 2022. We select a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

The following table provides information regarding our reserves for self-insured claims at December 31, 2023 and 2022 (in millions):

	2023	2022
Undiscounted	$ 282	$ 308
Discounted (as reported)	$ 265	$ 293

As of December 31, 2023 and 2022, our reserves for self-insurance claims did not include any significant amounts for settled and unpaid claims. Our average lag time between the settlement and payment of a self-insured claim ranges from 1 to 2 weeks.

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

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

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

Ultimately, from an actuarial standpoint, the sensitivity in the estimates of reserves for self-insured claims is reflected in the various actuarial confidence levels. Our best estimate of our reserves for self-insured claims utilizes an actuarial central estimate, which employs a statistical confidence level that approximates 50%. Higher statistical confidence levels, while not representative of our best estimate, reflect reasonably likely outcomes upon the ultimate resolution of related claims. Using a higher statistical confidence level would increase the estimated reserves for self-insured claims. At a 75% statistical confidence level, our estimated reserve would increase by $21 million. Changes in our estimates of reserves for self-insured claims are non-cash charges and accordingly, do not impact our liquidity or capital resources.

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of our quarterly and semi-annual actuarial calculations resulted in changes to our reserves for self-insured claims for prior years. For the years ended December 31, 2023 and 2022 our related self-insured claims expense decreased by $5 million and increased by $5 million, respectively.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk.***

Market Risk

Market risk is defined as the risk of loss resulting from changes in market prices as a result of changes in interest rates, credit and liquidity or general economic conditions. Our principal market risks in the ordinary course of business are credit risk, liquidity risk and interest rate risk. We currently do not have direct exposure to either market risk from trading activities or foreign currency exchange rate risk.

Credit Risk

We define credit risk as the risk that amounts payable by uninsured patients and remaining patient responsibility amounts (deductibles and co-payments) for patient accounts where the primary insurance carrier has paid the amounts covered by the applicable agreements will not be paid. The provision for doubtful accounts relates primarily to amounts due directly from patients. While we have experienced a reduction in uninsured patients, the risk of collection from insured patients and the amounts due, may increase as more individuals are enrolled in insurance plans with larger deductibles and/or co-payments, including those purchased on insurance exchanges.

Liquidity Risk

We define liquidity risk as the risk that we will not meet our payment obligations in a timely manner or the risk that market conditions or institution-specific events may reduce our ability to raise funds from market counterparties. An adverse institution-specific event such as a major loss that causes a perceived or actual deterioration in our financial condition or an adverse systemic event could affect our funding liquidity.

Interest Rate Risk

Borrowings under the ABL Facility and the Term Loan Facility are at variable rates of interest and expose us to interest rate risk. As of December 31, 2023, we had total outstanding debt of approximately $6.3 billion, excluding finance lease obligations and unamortized debt issuance costs, of which approximately $2.0 billion, or 31.7%, was subject to variable rates of interest. If the interest rate on our variable rate long-term debt outstanding as of December 31, 2023 were to increase by 100 basis points during any annual period, our cash flows would be negatively impacted by approximately $20 million.

Item 8. ***Financial Statements and Supplementary Data.***

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

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

None.

Item 9A. ***Controls and Procedures.***

The information that would be required to be disclosed under Part II, Item 9A of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a**)** of each of the Indentures.

Item 9B. ***Other Information.***

None.

Item 9C. ***Disclosure Regarding Foreign Jurisdictions that Prevent Inspections.***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance.***

The following table provides information regarding our executive officers and the members of our Board (ages as of February 29, 2024):

Name	Age	Position(s)
David M. Dill	55	President, Chief Executive Officer, Director and Chairman
Michael S. Coggin	54	Executive Vice President and Chief Financial Officer
Jennifer C. Peters	52	Executive Vice President, Chief Administrative and Legal Officer
Jason Zachariah	46	Executive Vice President, Chief Operating Officer
Aaron Lewis	39	Executive Vice President, Growth and Integrated Solutions
Evan Bayh	68	Director
Heather Berger	46	Director
Norman Brownstein	80	Director
Nell Buhlman	57	Director
Christine Cahill	29	Director
Maxwell David	33	Director
William M. Lewis, Jr.	67	Director
Matthew H. Nord	44	Director
Wendell Pritchett	59	Director
Kenneth Shea	65	Director
G. Rodney Wolford	77	Director

David M. Dill became our Chief Executive Officer in November 2018 after serving in various roles at Legacy LifePoint Health, Inc. (***"Legacy Lifepoint"***) prior to its merger with RCCH HealthCare Partners (***"RCCH"***), including serving as President since January 2011, as Chief Operating Officer since April 2009, and as Executive Vice President from February 2008 to January 2011. Mr. Dill has also served on our Board as Chair since September 2021. He joined Legacy Lifepoint in July 2007 as Chief Financial Officer and continued to serve in that role until April 2009. Prior to that, from March 2006 he served as executive vice president of Fresenius Medical Care North America and as chief executive officer of one of two U.S. divisions of Fresenius Medical Care Services, a wholly-owned subsidiary of Fresenius Medical Care AG & Co. KGaA. Mr. Dill previously served as executive vice president, chief financial officer and treasurer of Renal Care Group, Inc., a publicly traded dialysis services company, from November 2003 until Renal Care Group, Inc. was acquired by Fresenius Medical Care in March 2006. From 1996 to November 2003, Mr. Dill served in various finance and accounting roles with Renal Care Group, Inc. Mr. Dill served as a member of the board of directors of Psychiatric Solutions, Inc., a behavioral health services company, from 2005 until 2010. Mr. Dill is a former chairman of the board for the Federation of American Hospitals ("***FAH***") and currently serves as a member of the FAH's board and Executive Committee. He also serves on the board of directors of R1 RCM, Inc. and the Nashville Health Care Council and previously served as its chairman, and serves on the boards of the American Heart Association's Greater Southeast Affiliate and is a member of the board of trustees for the Murray State University Foundation and the Montgomery Bell Academy.

Michael S. Coggin became our Executive Vice President and Chief Financial Officer in November 2018 after serving in various roles at Legacy Lifepoint, including as Executive Vice President, Chief Financial Officer and Chief Accounting Officer since September 2016 and Senior Vice President and Chief Accounting Officer from December 2008 until September 2016. From September 2007 until December 2008, Mr. Coggin served as chief financial officer of Specialty Care Services Group, a multi-service line healthcare provider primarily focused on providing perfusion and auto-transfusion services to hospitals. Mr. Coggin was a senior vice president in the finance, accounting and internal audit groups of Renal Care Group, Inc. from April 2004 until its acquisition by Fresenius Medical Care AG & Co. KGaA in March 2006. Following the acquisition, Mr. Coggin provided finance and accounting oversight for business units within the East Division of Fresenius. Prior to that time, Mr. Coggin was an audit manager at KPMG Peat Marwick in Nashville, Tennessee. Mr. Coggin will retire as our Executive Vice President and Chief Financial Officer effective March 31, 2024.

Jennifer C. Peters became our Executive Vice President and Chief Administrative and Legal Officer in July 2023 after serving as Executive Vice President and General Counsel since November 2018. Prior to that time, Ms. Peters served as Legacy Lifepoint's General Counsel since April 2017 and Corporate Secretary since June 2017 after previously serving as senior vice president and chief operations counsel of Legacy Lifepoint. Prior to joining the Company in November 2013, Ms. Peters served as general counsel, secretary and chief compliance officer for Simplex Healthcare from October 2010 through November 2013. Ms. Peters has also served as vice president and associate general counsel at Community Health Systems, Inc. In addition, Ms. Peters has experience as a hospital administrator.

Jason Zachariah was promoted to Executive Vice President, Chief Operating Officer in June 2022. Prior to his current role, Mr. Zachariah served as President, Integrated Solutions upon consummation of the Kindred Transaction in December 2021. Before joining Lifepoint, he served as president and chief operating officer of Kindred, where he led the company's hospital division, rehabilitation services and behavioral health operations until consummation of the Kindred Transaction. Prior to that, he served as president of Kindred's rehabilitation services and in various roles in the company's hospital division, including chief operating officer and executive director for the division's California/Arizona district. From 2003 until Mr. Zachariah joined Kindred, he served in various business development and manufacturing roles at GlaxoSmithKline Pharma GmbH and Abbott.

Aaron Lewis was promoted to Executive Vice President, Growth and Integrated Solutions in June 2022. Prior to his current role, Mr. Lewis served as Senior Vice President, Care Continuum and Business Transformation, and previously served the Company as Senior Vice President, Physician Enterprise and Strategic Growth. Before joining Lifepoint Health, Mr. Lewis served in multiple roles for RCCH, including Senior Vice President of Strategic Growth and Vice President, Operations and Strategic Alignments. Prior to his RCCH tenure, he held operational and development roles with Vanguard Health Systems, after beginning his career in investment banking for Merrill Lynch. Mr. Lewis has been appointed to serve as our Executive Vice President and Chief Financial Officer effective upon Mr. Coggin's retirement.

Senator Evan Bayh became a Director of the Company in September 2023. He serves as a senior advisor to Apollo. From 1999 to 2010, Senator Bayh was a member of the U.S. Senate, representing the State of Indiana. He served on six committees for the U.S. Senate – Banking, Housing and Urban Affairs; Armed Services; Energy and Natural Resources; the Select Committee on Intelligence; Small Business and Entrepreneurship; and the Special Committee on Aging. He also chaired two subcommittees. From 1989 until 1997, Senator Bayh served as the Governor of Indiana. He currently serves on the boards of RLJ Lodging Trust, Berry Global, Marathon Petroleum and Fifth Third Bank. Senator Bayh also served as a Distinguished Scholar and Executive at Large of the Paul H. O'Neill School of Public and Environmental Affairs at Indiana University. In 2022, President Biden appointed Senator Bayh to the Presidential Intelligence Advisory Board where he provides the President with an independent source of advice on the effectiveness with which the Intelligence Community is meeting the nation's intelligence needs. Senator Bayh received a B.S. in Economics with honors from Indiana University and a J.D. from the University of Virginia.

Heather Berger became a Director of the Company in September 2023. She is Partner and Head of Global Product at Apollo, where she leads product strategy, thought leadership and client relations across Apollo's global platform. Ms. Berger is a member of Apollo's Leadership Team. Ms. Berger is also on the board of AltFinance, a comprehensive program to introduce talented students of Historically Black Colleges and Universities (HBCUs) to the alts industry and to provide them training, support, and mentorship. Prior to joining Apollo in 2008, Ms. Berger worked in the Private Fund Group at Credit Suisse Securities (USA), where she was responsible for raising institutional capital for private equity funds. Prior thereto, she was with Capital Z Financial Service Partners, and its affiliate, where she focused on investor relationships and fundraising. Ms. Berger is a member of the Board of Trustees of The Spence School in New York. She has previously served on the board of directors of The Fresh Market and Presidio. Ms. Berger graduated cum laude from Duke University with a B.A. in Comparative Area Studies and French.

Norman Brownstein became a Director of the Company in April 2016. Mr. Brownstein is the founding member and chairman of the board of the law firm of Brownstein Hyatt Farber Schreck, LLP. Mr. Brownstein is nationally recognized for his extensive experience in real estate law, commercial transactions and public policy advocacy, which spans the economic spectrum, extending to telecommunications, financial services, agriculture, tax and healthcare interests. Mr. Brownstein's firm is one of the leading lobbying firms in the U.S. Mr. Brownstein serves on the board of directors of National Jewish Health and the Simon Wiesenthal Center, and during the past five years has also served as a director of Ardent Healthcare Services. Mr. Brownstein received a B.S. degree from the University of Colorado and a J.D. from the University of Colorado Law School.

Nell Buhlman became a Director of the Company in March 2022. Ms. Buhlman is the Chief Administrative Officer and Head of Strategy for Press Ganey Forsta, an international company that works with health systems to optimize the healthcare experience for patients, consumers, and staff. In her role, Nell has responsibility for enterprise growth and client strategy for provider, payer, life sciences and healthcare consumer solutions in the U.S. and abroad. Ms. Buhlman joined Press Ganey in 2010. Prior to the company's 2022 merger with Forsta, Ms. Buhlman served as Press Ganey's Chief Operating Officer, Chief Strategy Officer, Senior Vice President for Clinical Solutions, and Vice President for Product Strategy. Ms. Buhlman is a board member for the Hospital for Consumptives of Maryland (Eudowood Foundation), serves on the Parent Advisory Council for the Greater Baltimore Medical Center, and is an Executive in Residence for the Johns Hopkins Carey Business School. She also serves as a trustee for the WPW Foundation, a charitable organization that provides grants to nonprofits serving vulnerable women and children. Ms. Buhlman holds B.A. degree from Connecticut College and an MBA from Johns Hopkins Carey Business School.

Christine Cahill became a Director of the Company in March 2022. Ms. Cahill is a Principal in Apollo Global Management's Private Equity business, having joined in 2018. Prior to joining Apollo, Ms. Cahill worked in the Investment Banking division at Goldman Sachs. Ms. Cahill also serves on the board of Knight Health Holdings, LLC d/b/a ScionHealth. She also serves on the advisory board of Lune Holdings S.a.r.l. (parent of Kem One). Ms. Cahill graduated cum laude with high honors from Harvard College with a B.A. in Economics.

Maxwell David became a Director of the Company in December 2018. Mr. David is a Partner in Apollo Global Management's Private Equity business, having joined in 2014. Prior to that time, Mr. David was a member of the Investment Banking division of Bank of America Merrill Lynch. Mr. David serves on the board of directors of 25m Health, LLC, Camaro Parent, LLC (parent of CareerBuilder), Nexera Holdco, Inc. (parent of Newfi Lending) and Knight Health Holdings, LLC d/b/a ScionHealth. Mr. David previously served on the board of directors of Aris Mortgage Holding Company, LLC (parent of AmeriHome). Mr. David graduated cum laude from Dartmouth College with a B.A. in Economics.

William M. Lewis, Jr. became a Director of the Company in June 2023. He joined Apollo Global Management in November 2021 as a Partner and member of the Management Committee. Mr. Lewis also co-chairs Apollo's Partner Promotion Committee and its Expanding Opportunity Committee. Prior to joining Apollo, Mr. Lewis was a Managing Director and Chairman of Investment Banking at Lazard Ltd., which he joined in 2004, and where he advised a number of global corporations. In addition, Mr. Lewis chaired the firm's Managing Director Promotion Committee. Mr. Lewis was elected a Managing Director of Morgan Stanley in 1989 becoming the firm's first African-American Managing Director, and served as head or co-head of the firm's Global Corporate Finance Department, Global Mergers & Acquisitions Department and Global Banking Department. Mr. Lewis serves on the boards of ADT, Inc., Ariel Alternatives, LLC and formerly served on the boards of Freddie Mac, Darden Restaurants and Lazard Ltd. Mr. Lewis also serves on the boards of a number of not-for-profit organizations including Uncommon Schools, New Visions for Public Schools, New York Presbyterian Hospital, the New York City Police Foundation, the Posse Foundation, the Economic Club of New York, the National Bureau of Economic Research and Echoing Green. In the past, he has served as Co-Chairman of the NAACP Legal Defense Fund, Treasurer of the National Urban League, Chairman of A Better Chance and as a member of the boards of Phillips Academy, the American Museum of Natural History, the National Constitution Center, the Executive Committee of the USGA, Carnegie Endowment for International Peace, the New York Philharmonic, Morehouse College, the Central Park Conservancy, the NCAA Advisory Board, the Harvard Management Company (endowment), Harvard's Committee on Alumni Affairs and Development, Harvard's Task Force on Students and Chicago's Northwestern Memorial Hospital. Mr. Lewis graduated with honors in Economics from Harvard College and received his MBA from Harvard Business School in 1982.

Matthew H. Nord became a Director of the Company in December 2015 in connection with the consummation of the acquisition of RCCH by Apollo-managed funds and served as Chairman of the Board from December 2018 until September 2021. Mr. Nord is a Partner and Co-Head of Equity at Apollo, where he oversees the firm's private equity strategy and has led numerous investments across technology, healthcare and business services. Mr. Nord serves on Apollo's diversity, equity and inclusion committee and is a member of Apollo Women Empower (AWE). Mr. Nord is on the board of directors of TD Synnex, West Technology Group, ScionHealth and Tenneco. Mr. Nord previously served on the board of directors of ADT, Inc., from April 2016 to June 2022, Exela Technologies, Inc., from July 2017 to October 2019, where he was on the Nominating and Governance Committees, and Presidio, Inc., from November 2014 to December 2019, where he was on the Compensation and Nomination Committees. Prior to joining Apollo in 2003, Mr. Nord was a member of the Investment Banking division of Salomon Smith Barney Inc. Mr. Nord graduated summa cum laude from the University of Pennsylvania's Wharton School of Business with a B.S. in Economics. He also serves on the Montefiore Health System Board of Trustees, the Board of Advisors of the University of Pennsylvania's Stuart Weitzman School of Design and the Board of the Rock and Roll Hall of Fame Foundation.

Wendell Pritchett became a Director of the Company in September 2022. Dr. Pritchett serves as the James S. Riepe Presidential Professor of Law and Education at the University of Pennsylvania. He served as Provost of the University from 2017 to 2021 and as Interim President in 2022. Between 2009 and 2014, Dr. Pritchett served as Chancellor and Professor of Law and History at Rutgers University-Camden. Dr. Pritchett also sits on the boards of the publicly traded companies Toll Brothers and Clarivate, as well as several nonprofit organizations, including College Unbound, the Philadelphia Foundation, Reinvestment Fund, and Minerva University. He holds a B.A. in Political Science from Brown University, earned his J.D. from Yale Law School and his PhD from the University of Pennsylvania.

Kenneth Shea became a Director of the Company in June 2023. He brings more than 30 years of experience in investment banking, private investment, and operations experience, primarily focused on the real estate, gaming, lodging, and leisure sectors. He is currently a Co-Founder and Managing Principal of Manufactured Housing Partners, LLC, a private real estate investment fund focused on the acquisition and operation of manufactured housing communities, founded in 2022. Prior to that, he was an Investment Partner with Pilot Growth Equity, a venture capital firm focused on growth-stage technology companies, from 2020 to 2022. From 2014 to 2019, Mr. Shea served as a Senior Managing Director at Guggenheim Securities, LLC, where he ran the firm's real estate, gaming & leisure investment banking department. He previously served as President of Coastal Capital Management, LLC from 2009 to 2014, as a Managing Director of Icahn Capital LP from 2008 to 2009, and as a Senior Managing Director of Bear, Stearns & Co. Inc., where he was employed from 1996 to 2008 and ran the firm's gaming and leisure investment banking practice. Mr. Shea currently serves on the boards of Viskase Companies, Inc., and Kindred Group plc. Previously Mr. Shea served on the board of Equity Commonwealth, Hydra Industries, Perthera.ai, Sunlight Financial Holdings, Inc., and CVR Refining, LP. Mr. Shea received his B.A. in Economics, magna cum laude, from Boston College and an MBA from the University of Virginia.

G. Rodney Wolford became a Director of the Company in April 2016. Mr. Wolford, beginning his career as a CPA, has over 40 years of wide-ranging experience in the healthcare industry, having served in leadership roles with healthcare providers, suppliers, consulting firms, associations and insurers. Among his executive positions, Mr. Wolford served as chief executive officer of Alliant Healthcare (now Norton Healthcare, Inc.) in Louisville, Kentucky, Sterling Diagnostic, a worldwide manufacturer of x-ray film, Forhealth Technologies, the inventor of the first robot dedicated to hospital IV production, and a senior executive of Blue Cross Tennessee. Mr. Wolford currently serves on the boards of D4C Dental Brands, Liberate Medical, as Chairman of Parasight Systems and as a fund manager of Bluegrass Angel Venture Funds. Mr. Wolford also previously served on the boards of multiple healthcare related companies, including Image Guided Neurologics, Provation Medical, Haven Behavioral, Laboratory Supply Company and VetCor.

Code of Ethics

Our Board expects its members, as well as our officers and employees, to act ethically at all times and to acknowledge in writing their adherence to the policies comprising our Code of Conduct, which is known as "Common Ground," and, as applicable, our Code of Ethics for Senior Financial Officers and Chief Executive Officer.

The Board consists of 12 directors. The Board has the following standing committees: Audit; Compensation; Nominating and Governance; Compliance and Enterprise Risk; Quality; and Executive. In addition, the board of directors of the Parent also has a compensation committee that administers equity-based compensation plans in which our managers, officers, employees, consultants and directors participate. Apollo has the authority to designate a majority of the members of our Board and appoint of management.

Committees of our Board of Directors

The Board has adopted written charters for each of the following standing committees:

Audit Committee

The current members of the Audit Committee are Messrs. Shea, Wolford and Pritchett and Ms. Buhlman. Mr. Shea is the chair of the Audit Committee. The principal duties and responsibilities of the Audit Committee are to assist the Board in overseeing:

- the integrity of our financial statements;
- the independent auditor's qualifications, independence and performance;
- the performance of our internal audit function; and
- our compliance with certain legal, ethical and regulatory requirements.

The Audit Committee is also responsible for: (i) overseeing and periodically reviewing management's processes and procedures for assessing, identifying and managing material risks to us from cybersecurity threats and the effectiveness of our information security processes and procedures; (ii) periodically evaluating the knowledge, experience and capabilities of the members of the Audit Committee and management with respect to cybersecurity risk and information security processes and procedures; and (iii) evaluating the nature, scope, timing and impact to us of any material cybersecurity incidents.

The Audit Committee has the authority to conduct or authorize investigations into or studies of matters within its scope of responsibilities. It also has the authority to retain and determine funding for independent legal, accounting or other advisors (without seeking Board approval) as it determines necessary or appropriate to carry out its duties and responsibilities.

Our Board has determined that each of Messrs. Shea and Wolford is an "audit committee financial expert" within the meaning of applicable SEC regulations.

Compensation Committee

The current members of the Compensation Committee are Messrs. Nord and David. Mr. Nord is the chair of the Compensation Committee. The principal duties and responsibilities of the Compensation Committee are as follows:

- approving the non-equity-based compensation of our officers, directors and key employees;
- administering our non-equity-based compensation plans; and
- making recommendations to the Parent for the equity-based compensation of the Parent and its subsidiaries' officers, directors, employees and other service providers.

Nominating and Governance Committee

The current members of our Nominating and Governance Committee are Ms. Cahill and Mr. David. Mr. David is the chair of the Nominating and Governance Committee. The principal duties and responsibilities of the Nominating and Governance Committee are as follows:

- to assist the Board in identifying individuals qualified to serve as members of the Board and/or its committees; and
- other duties and responsibilities that our Board may delegate to the Nominating and Governance Committee.

Compliance and Enterprise Risk Committee

The current members of the Compliance and Enterprise Risk Committee are Messrs. Bayh, Pritchett, Shea and Wolford. Mr. Wolford is the chair of the Compliance and Enterprise Risk Committee. The Compliance and Enterprise Risk Committee is responsible for overseeing our legal and regulatory compliance program, including our enterprise risk management program, and certain healthcare and regulatory compliance matters that affect us and our business operations.

Quality Committee

The current members of the Quality Committee are Ms. Buhlman and Messrs. Brownstein and David. Ms. Buhlman is the chair of the Quality Committee. The Quality Committee is responsible for monitoring and evaluating the adequacy and effectiveness of our quality of care and patient safety programs and initiatives.

Executive Committee

The current members of the Executive Committee are Ms. Cahill and Messrs. David and Nord. Mr. Nord is the chair of the Executive Committee. The principal duties and responsibilities of the Executive Committee are as follows:

- to advise and counsel our Chief Executive Officer regarding company matters; and
- to take such actions as are necessary due to their urgent or highly confidential nature, or where convening the Board is impracticable, subject to certain limitations.

Item 11. ***Executive Compensation.***

The information that would be required to be disclosed under Part III, Item 11 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

The information that would be required to be disclosed under Part III, Item 12 of an annual report on Form 10-K filed with the SEC has been omitted as permitted pursuant to Section 4.02(a) of each of the Indentures.

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

Executive Compensation

Employment Agreements

From time to time, we are party to employment and employment related agreements with our officers, employees, contractors and consultants that are entered into in the ordinary course of business.

Nonqualified Deferred Compensation

We established a nonqualified deferred compensation plan effective January 1, 2021 in which certain Company executives and employees participate. Certain former Kindred executives and employees, including Mr. Zachariah, who are now Company executives and employees, participate in a separate nonqualified deferred compensation plan that replicates the former Kindred deferred compensation plan. Plan participants may defer a portion of their salary and bonuses. Currently, the Company does not make any matching or other contributions to the nonqualified deferred compensation plans. The timing and form of payments are based on the terms of the applicable plan and deferral elections made by participants.

Parent Capital Units and Profits Units

Certain of our and our affiliates' executives, employees, consultants, directors and other service providers have been granted profits units and/or purchased or otherwise acquired capital units in the Parent.

The profits units provide the recipients with the opportunity to share in our future appreciation, subject to vesting. In general, for grants to non-directors, one-third of the profits units vest in substantially equal installments on the last day of each of the first 20 calendar quarters commencing on or after the applicable grant date, and the remaining two-thirds of the profits units vest based on the achievement of certain investment returns to our Sponsor. The profits units we grant to certain members of our Board on an annual basis generally vest on the date that is six months and one day from the date of grant. The time-vested profits units and the director profits units will vest in full on a sale of the Company.

The capital units and profits units are generally subject to the terms and condition set forth in the applicable award agreements or subscription agreements, as applicable, and in the partnership agreement of the Parent, including, but not limited to, customary transfer restrictions, redemption rights, drag-along rights, tag-along rights, and preemptive rights.

Equity Repurchases

From time to time, the Parent repurchases previously issued profits units and capital units held by certain of our former and current service providers, including executive officers and directors. Refer to Note 12 to our accompanying consolidated financial statements included elsewhere in this Report for a discussion of profits units issued by the Parent to our service providers and additional information regarding our accounting for stock-based compensation.

Director Retainers and Fees

Certain members of our Board are entitled to receive annual retainers and fees for their service in accordance with our director compensation policy.

Management Agreement

We are party to a management consulting agreement dated June 25, 2021 (the "***Management Agreement***") with an affiliate of our Sponsor relating to the provision of certain management consulting and advisory services. In exchange for the provision of such services, we currently pay a non-refundable quarterly management fee of approximately $2.3 million. The Management Agreement will terminate on the earlier of (i) the eighth anniversary of July 25, 2021, (ii) the consummation of any transaction or series of transactions, whether or not related, as a result of which New Holders (as defined in the Management Agreement) become the beneficial owner, directly or indirectly, of more than 90% of our equity and voting securities and (iii) such earlier date as is mutually agreed upon. Our payment obligations under the Management Agreement may be subject to deferral to the extent such obligations would otherwise violate any prohibitions or limitations under our then existing indebtedness. We may be required to reimburse such affiliate of our Sponsor for all out-of-pocket expenses incurred by such affiliate and its affiliates and each of their representatives in the connection with the performance of its obligations under the Management Agreement or the Transaction Fee Agreement (as defined in this Report), including expenses incurred in connection with any Underwritten Offering or Change of Control (as defined in the Transaction Fee Agreement).

Transaction Fee Agreement

We are party to a transaction fee agreement dated June 25, 2021 (the "***Transaction Fee Agreement***") with an affiliate of our Sponsor, which will terminate automatically upon the termination of the Management Agreement. Under the Transaction Fee Agreement, if we, or certain of our parent entities or controlled affiliates, consummate an acquisition (including of assets or equity interests) of any business or entity, we are required to pay to an affiliate of our Sponsor a success fee equal to 1% of the aggregate enterprise value (i) paid or provided by or to the Company Group (as defined in the Transaction Fee Agreement) or us or (ii) otherwise indicated by such acquisition. We may be required to reimburse such affiliate of our Sponsor for all out-of-pocket expenses incurred by such affiliate and its affiliates and each of their representatives in the connection with the performance of its obligations under the Transaction Fee Agreement.

Participation of Apollo Global Securities, LLC

Apollo Global Securities, LLC, an affiliate of our Sponsor, acted as an initial purchaser in the sale of the Unsecured Notes and the Secured Notes, including our offerings of the 9.875% Secured Notes and the 11.00% Secured Notes completed during the year ended December 31, 2023, and received a portion of the initial purchasers' discount and commissions for each offering. Apollo Global Securities, LLC or one of its affiliates also participated as an arranger and received customary fees in respect of the Term Loan Facility and the ABL Facility, including such fees in respect of the amendment to the Term Loan Facility completed during the year ended December 31, 2023.

Transition Services Agreements and Other Agreements with ScionHealth

In connection with the Kindred Transaction, we have entered into a number of TSAs and other ancillary agreements with ScionHealth and its subsidiaries. For the year ended December 31, 2023, in connection with the TSAs, we were reimbursed by ScionHealth for certain costs incurred on its behalf of $47 million, and we paid ScionHealth $2 million for certain costs incurred on our behalf. For the year ended December 31, 2022, in connection with the TSAs, we were reimbursed by ScionHealth for certain costs incurred on its behalf of $61 million, and we paid ScionHealth $3 million for certain costs incurred on our behalf. We had a net receivable of $124 million and $84 million, respectively, recorded under the caption "Other current assets" in our consolidated balance sheets as of December 31, 2023 and December 31, 2022, respectively. In connection with the Kindred Transaction, we acquired the Class B Units with an aggregate initial value of $350 million, which are perpetual non-convertible, non-voting units that accrue cumulative dividends at the rate of 10.00% per annum and, upon liquidation, are entitled to a return of their nominal value issue price of $350 million plus accrued, unpaid dividends. Additionally, we own an aggregate $50 million principal amount of ScionHealth's senior secured term loan, which we acquired for approximately $47 million during the twelve months ended December 31, 2022. For more information regarding such term loan receivable, refer to Note 8 to our accompanying consolidated financial statements included elsewhere in this Report.

In addition, we and ScionHealth are party to a number of commercial services agreements pursuant to which we provide ScionHealth with therapy services, rehabilitation unit and behavioral health unit management, consulting and development services, among other commercial services. For the twelve months ended December 31, 2023 and December 31, 2022, we recorded revenues related to these commercial services agreements of $63 million and $55 million, respectively.

On January 20, 2023, ScionHealth acquired Cornerstone Healthcare Group Holding, Inc., a Delaware corporation ("***Cornerstone***"), which operated 15 specialty hospitals, eight senior living locations, and El Dorado (the "***Cornerstone Transaction***"). Immediately following ScionHealth's acquisition of Cornerstone on January 20, 2023, we paid $35 million in cash to acquire El Dorado from ScionHealth. In connection with the Cornerstone Transaction and the El Dorado Transaction, we entered into a number of TSAs other ancillary agreements with ScionHealth and its subsidiaries pursuant to which (i) we provide certain transition services to ScionHealth to support the businesses acquired by ScionHealth in connection with the Cornerstone Transaction and (ii) ScionHealth provides certain transition services to us to support El Dorado.

Investments Related to Lifepoint Forward Innovation Strategy

In connection with our Lifepoint Forward innovation strategy, we have made investments of cash and contributions of existing investments and securities into certain unconsolidated but affiliated entities owned by us, Parent, ScionHealth and other affiliated entities (collectively, "***Forward Health Ventures***"). Forward Health Ventures, in turn makes targeted and strategic investments in new and existing early-stage enterprises primarily focused on developing meaningful solutions to enhance quality, increase access to care, and improve value across our enterprise, including a significant focus on digital health capabilities that span the healthcare continuum. In exchange for our investments of cash and contributions of existing investments and securities, Forward Health Ventures has issued to us noncontrolling equity interests and perpetual cumulative preferred instruments.

As of December 31, 2023, in the aggregate, our cost method investment in Forward Health Ventures totaled $54 million. In addition to our cost method investment in Forward Health Ventures, we also have entered into management and administrative services arrangements with Forward Health Ventures and commercial arrangements with certain underlying early-stage enterprises, including pilot and services agreements and a revolving credit facility that we provide to one of these enterprises. The revolving credit facility provides for loans up to approximately $15 million, has a 5-year maturity (or earlier upon our demand) and bears interest at 9.00%. As of December 31, 2023, $14 million was drawn and outstanding on such facility.

Non-Core Real Estate Financing Transaction

In September 2023, the Company and the Lifepoint OpCos entered into, and consummated the transactions contemplated by, a Master Transaction Agreement with DSB Holdings, Realpoint and the Realpoint PropCos. Refer to Note 7 to our accompanying consolidated financial statements included elsewhere in this Report for additional information regarding the transactions.

Item 14. *Principal Accountant Fees and Services.*

The Audit Committee has appointed Ernst & Young LLP as our independent registered public accounting firm. Services provided to us by Ernst & Young LLP in fiscal 2023 are described below.

Audit Fees. The aggregate audit fees billed by Ernst & Young LLP for professional services rendered for the audit of our annual consolidated financial statements and services that are normally provided by the independent registered public accounting firm in connection with statutory and regulatory filings totaled approximately $5 million for 2023 and approximately $4 million for 2022.

Audit-Related Fees. The aggregate fees billed by Ernst & Young LLP for assurance and related services other than those described under "Audit Fees" were nominal for each of the years 2023 and 2022.

Tax Fees. The aggregate fees billed by Ernst & Young LLP for professional services rendered for tax compliance, tax advice and tax planning were approximately $1 million for each of the years 2023 and 2022.

All Other Fees. There were no fees billed by Ernst & Young LLP for products or services other than those described above in 2023 or 2022.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules.***

(a) The following documents are filed as part of this Report:

1. *Consolidated Financial Statements*:

2. *Financial Statement Schedule*: All schedules for which provision is made in the applicable accounting regulations of the SEC are omitted because they either are not required under the related instructions, are inapplicable, or the required information is shown in the consolidated financial statements or notes thereto.

3. *Exhibits*: The exhibits required by Item 601 of Regulation S-K that would be disclosed under Part IV, Item 15 of an annual report on Form 10-K filed with the SEC have been omitted as permitted pursuant to Section 4.02(a) of the Indentures.

Ernst & Young LLP
222 2nd Avenue South
Suite 2100
Nashville, TN 37201

Tel: (615) 252 2000
Fax: (615) 242 9128
ey.com

Report of Independent Auditors

Board of Directors and Shareholders of
Lifepoint Health, Inc.

Opinion

We have audited the consolidated financial statements of Lifepoint Health, Inc. (the Company), which comprise the consolidated balance sheets as of December 31, 2023 and 2022, and the related consolidated statements of operations, comprehensive (loss) income, equity and cash flows for each of the three years in the period ended December 31, 2023, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2023 and 2022, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2023, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements. In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

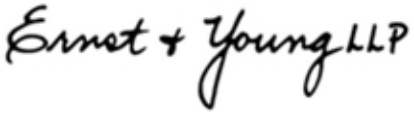
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Other Information

Management is responsible for the other information. The other information comprises the financial and nonfinancial information included in the annual report but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.



February 29, 2024

Lifepoint Health, Inc.

Consolidated Statements of Operations
For the Years Ended December 31, 2023, 2022 and 2021
(In millions)

	2023	2022	2021
Revenues	$ 9,111	$ 8,020	$ 8,937
Salaries and benefits	4,466	4,016	4,176
Supplies	1,306	1,243	1,505
Other operating expenses, net	2,456	2,025	2,228
Depreciation and amortization	330	323	345
Interest expense, net	679	480	466
Debt refinancing costs	52	-	-
Other transaction-related costs	28	46	86
Other non-operating losses (gains), net	12	(8)	19
	9,329	8,125	8,825
(Loss) income before income taxes	(218)	(105)	112
Provision for (benefit from) income taxes	52	100	(27)
Net (loss) income	(270)	(205)	139
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(66)	(66)	(9)
Net (loss) income attributable to Lifepoint Health, Inc.	$ (336)	$ (271)	$ 130

Lifepoint Health, Inc.

Consolidated Statements of Comprehensive (Loss) Income
For the Years Ended December 31, 2023, 2022 and 2021
(In millions)

	2023	2022	2021
Net (loss) income	$ (270)	$ (205)	$ 139
Other comprehensive (loss) gain:			
Unrealized gains on changes in funded status of pension benefit obligations	-	4	6
Net change in other comprehensive income attributable to equity method investment	(5)	-	-
Other comprehensive (loss) gain	(5)	4	6
Comprehensive (loss) income	(275)	(201)	145
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(66)	(66)	(9)
Comprehensive (loss) income attributable to Lifepoint Health, Inc.	$ (341)	$ (267)	$ 136

Lifepoint Health, Inc.
Consolidated Balance Sheets
As of December 31, 2023 and 2022
(In millions)

	2023	2022
ASSETS		
Current assets:		
Cash and cash equivalents	$ 90	$ 395
Accounts receivable	1,223	1,042
Inventories	189	195
Prepaid expenses	125	128
Other current assets	542	323
	2,169	2,083
Property and equipment, at cost	4,988	4,455
Accumulated depreciation	(1,602)	(1,339)
Property and equipment, net	3,386	3,116
Investments	857	684
Right-of-use operating lease assets	1,023	638
Other long-term assets	164	157
Goodwill and intangible assets	4,250	3,894
Total assets	$ 11,849	$ 10,572
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 606	$ 405
Accrued salaries	293	225
Other current liabilities	681	545
Current maturities of long-term debt	56	29
	1,636	1,204
Long-term debt, net	7,447	6,865
Long-term portion of right-of-use operating lease obligations	952	572
Other long-term liabilities	349	368
Total liabilities	10,384	9,009
Redeemable noncontrolling interests	143	143
Equity:		
Lifepoint Health, Inc. stockholders' equity	953	1,095
Noncontrolling interests	369	325
Total equity	1,322	1,420
Total liabilities and equity	$ 11,849	$ 10,572

Lifepoint Health, Inc.

Consolidated Statements of Cash Flows
For the Years Ended December 31, 2023, 2022 and 2021
(In millions)

	2023	2022	2021
Cash flows from operating activities:			
Net (loss) income	$ (270)	$ (205)	$ 139
Adjustments to reconcile net (loss) income to net cash provided by (used in) operating activities:			
Depreciation and amortization	330	323	345
Other non-cash amortization	28	33	33
Non-cash interest expense (income), net	8	(4)	(24)
Debt refinancing costs	52	-	-
Stock-based compensation	5	5	117
Other non-operating losses (gains), net	12	(8)	19
Reserve for self-insurance claims, net of payments	(26)	(6)	6
Changes in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:			
Accounts receivable	(116)	(7)	(112)
Inventories, prepaid expenses and other current assets	(196)	(105)	(83)
Accounts payable, accrued salaries and other current liabilities	315	(20)	131
Medicare advance payments and deferred payroll taxes	-	-	(1,075)
Income taxes payable/receivable and deferred income taxes	15	72	(71)
Other	(16)	4	(15)
Net cash provided by (used in) operating activities	141	82	(590)
Cash flows from investing activities:			
Purchases of property and equipment	(229)	(227)	(274)
Acquisitions, net of cash acquired	(313)	-	-
Net cash impact related to common control transaction	-	-	(875)
Proceeds from sales of hospitals and equity method investment	37	135	119
Investment in ScionHealth term loan	-	(47)	-
Other	11	1	(4)
Net cash used in investing activities	(494)	(138)	(1,034)
Cash flows from financing activities:			
Net change in ABL Facility	35	-	-
Proceeds from borrowings	3,830	-	-
Payments of borrowings	(3,818)	(144)	-
Proceeds from non-core real estate transaction	225	-	-
Payments of debt financing costs	(108)	-	-
Distributions to Parent	(12)	(10)	(93)
Distributions and other cash transactions associated with noncontrolling interests and redeemable noncontrolling interests	(72)	(84)	(26)
Termination of finance lease obligations	-	(130)	(28)
Amortization of finance lease obligations	(32)	(34)	(29)
Net cash provided by (used in) financing activities	48	(402)	(176)
Change in cash and cash equivalents	(305)	(458)	(1,800)
Cash and cash equivalents at beginning of period	395	853	2,653
Cash and cash equivalents at end of period	$ 90	$ 395	$ 853
Supplemental disclosure of cash flow information:			
Interest payments	$ 496	$ 373	$ 379
Capitalized interest	$ 9	$ 5	$ 3
Property and equipment acquired under finance leases	$ 61	$ 44	$ 50
Income tax payments, net	$ 37	$ 28	$ 44

Lifepoint Health, Inc.

Consolidated Statements of Equity
For the Years Ended December 31, 2023, 2022 and 2021
(Dollars in millions)

	Common Stock		Capital in Excess of	Accumulated Other Comprehensive	Accumulated (Deficit)	Noncontrolling	
	Shares	Amount	Par Value	(Loss) Income	Income	Interests	Total
Balance at December 31, 2020	100	$ -	$ 1,267	$ (9)	$ (103)	$ 32	$ 1,187
Comprehensive income	-	-	-	6	130	5	141
Stock-based compensation	-	-	117	-	-	-	117
Net equity adjustments related to common control transactions	-	-	48	-	-	-	48
Distributions to Parent	-	-	(85)	-	-	-	(85)
Noncontrolling interests recognized in common control transactions	-	-	-	-	-	317	317
Cash distributions to joint venture partners	-	-	-	-	-	(3)	(3)
Balance at December 31, 2021	100	-	1,347	(3)	27	351	1,722
Comprehensive income (loss)	-	-	-	4	(271)	65	(202)
Stock-based compensation	-	-	5	-	-	-	5
Distributions to Parent	-	-	(10)	-	-	-	(10)
Cash distributions to joint venture partners, net of contributions	-	-	-	-	-	(84)	(84)
Non-cash contributions from joint venture partners	-	-	-	-	-	17	17
Non-cash adjustments related to noncontrolling interests and redeemable noncontrolling interests and other	-	-	(4)	-	-	(24)	(28)
Balance at December 31, 2022	100	-	1,338	1	(244)	325	1,420
Comprehensive (loss) income	-	-	-	(5)	(336)	67	(274)
Stock-based compensation	-	-	5	-	-	-	5
Distributions to Parent	-	-	(12)	-	-	-	(12)
Cash distributions to joint venture partners, net of contributions	-	-	-	-	-	(57)	(57)
Non-cash contributions from joint venture partners	-	-	-	-	-	34	34
Net equity adjustments related to common control transactions	-	-	232	-	-	-	232
Reclassification of equity to noncontrolling interests related to joint venture activity	-	-	(14)	-	-	14	-
Net impact to noncontrolling interests related to acquisitions and divestitures	-	-	-	-	-	(14)	(14)
Non-cash adjustments related to redeemable noncontrolling interests	-	-	(12)	-	-	-	(12)
Balance at December 31, 2023	100	$ -	$ 1,537	$ (4)	$ (580)	$ 369	$ 1,322

Note 1. Organization and Summary of Significant Accounting Policies

Organization

Lifepoint Health, Inc., a Delaware corporation ("Lifepoint" or the "Company"), acting through its subsidiaries, is a leading provider of healthcare serving patients, clinicians, communities and partner organizations across the healthcare continuum. The Company generates revenues by providing a broad range of general and specialized healthcare services to patients through a growing diversified healthcare delivery network, which at December 31, 2023 was comprised of 60 community hospital campuses, 39 inpatient rehabilitation facilities ("IRFs"), 23 behavioral health facilities ("BHFs") and additional sites of care that include acute rehabilitation units ("ARUs"), outpatient centers and post-acute care facilities. At December 31, 2023, on a consolidated basis, the Company operated 122 healthcare facilities in 31 states throughout the United States ("U.S.") with approximately 12,000 licensed beds and approximately 50,000 dedicated employees.

Unless otherwise indicated or the context otherwise requires, references throughout these notes to the consolidated financial statements to the "Company" or "Lifepoint" refer to Lifepoint Health, Inc., and each of its consolidated subsidiaries. References in this Annual Report for the fiscal year ended December 31, 2023 to the "Sponsor" refer to certain funds that are affiliates of the Company (the "Apollo Funds") that are ultimately controlled and/or managed by certain affiliates of Apollo Management Holdings, L.P. ("Apollo Management" and, when acting on behalf of the Apollo Funds, "Apollo"), which is an affiliate of Apollo Global Management, Inc.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through majority voting control and variable interest entities of which the Company is the primary beneficiary. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation. Noncontrolling interests in non-wholly-owned consolidated subsidiaries of the Company are presented as noncontrolling interests and redeemable noncontrolling interests and distinguish between the interests of the Company and the interests of the noncontrolling owners. Net income attributable to noncontrolling interests and redeemable noncontrolling interests represents the amounts attributable to the noncontrolling interests for each of the applicable periods presented. Investments in entities the Company does not control but in which it does have a substantial ownership interest and over which it can exercise significant influence are accounted for using the equity method.

The Company's financial statements have been presented on the basis of push down accounting in accordance with Financial Accounting Standards Board Accounting Standards Codification ("ASC") No. 805-50-S99. Under the push down basis of accounting, certain transactions incurred by the parent company which would otherwise be accounted for in the accounts of the parent are "pushed down" and recorded on the financial statements of the subsidiary. Accordingly, certain items resulting from the acquisition by Apollo have been recorded on the financial statements of the Company.

Use of Estimates

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

Reclassifications

Certain reclassifications have been made to the prior years to conform to current year presentation. These reclassifications had no effect on results of operations, financial position or cash flows as previously reported.

Revenue Recognition and Accounts Receivable

Overview

The Company recognizes revenues in the period in which performance obligations are satisfied. Generally, the Company bills patients and third-party payers several days after the services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payers and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. Amounts the Company receives for treatment of patients covered by governmental programs and third-party payers such as Medicare, Medicaid, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and private insurers as well as directly from patients are subject to contractual adjustments, discounts and implicit price concessions. Accordingly, the revenue and accounts receivable reported in the Company's financial statements are recorded at the net consideration to which the Company expects to be entitled to receive in exchange for providing patient care.

The majority of the Company's performance obligations are satisfied over time for the delivery of patient care in both outpatient and inpatient settings. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected charges for services anticipated to be provided. The Company believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the remaining services needed to satisfy the obligation. Generally, unsatisfied or partially unsatisfied performance obligations at the end of the reporting period are related to patients admitted to the Company's hospitals that have not yet been discharged. The performance obligations for these patients are typically satisfied when the patients are discharged, which generally occurs within a matter of days of admission. Patients are generally billed when discharged, though they may be billed on an interim basis for longer stays. Accordingly, because all of the Company's performance obligations are part of a contract that is expected to have a duration of one year or less, the Company has elected to apply the exemption provided by ASC 606, "Revenue from Contracts with Customers" ("ASC 606") to not disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied as of period end.

Subsequent adjustments that are determined to be the result of an adverse change in the patient's or the payer's ability to pay are recognized as bad debt expense. With the adoption of ASC 606, bad debt expense is included under the caption "Other operating expenses, net" in the accompanying consolidated statements of operations, instead of separately as a deduction to arrive at revenue. Bad debt expense for the years ended December 31, 2023, 2022 and 2021 was not material for the Company.

Contractual Discounts

The Company derives a significant portion of its revenues from Medicare, Medicaid and other payers that receive discounts from the Company's established billing rates. The Company must estimate the total amount of these discounts to prepare its financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Company estimates contractual discounts on a payer-specific basis given its interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Subsequent changes in estimates for contractual discounts are reflected as an adjustment to revenues in the period of the change. Medicare, Medicaid and other discounted payer accounts receivables are written off after they have been final settled with the payer.

Medicaid Supplemental Payments

Medicaid supplemental payments ("MSPs") are payments made to providers separate from, and in addition to, those made at a state's standard Medicaid payment rate. MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare-related taxes imposed by states in the form of a mandatory provider payment related to healthcare items or services. The two most prevalent forms of MSPs are Medicaid Disproportionate Share Hospital ("DSH") and Upper Payment Limit ("UPL") payments. The Company had total receivables related to Medicaid DSH and UPL programs of $239 million and $106 million at December 31, 2023 and 2022, respectively, which are included under the caption "Other current assets" in the Company's accompanying consolidated balance sheets.

North Carolina Healthcare Access and Stabilization Program and Medicaid Expansion

On March 27, 2023, the governor of North Carolina signed into law a bill to expand Medicaid coverage in North Carolina, which expanded health coverage to an estimated 600,000 people across North Carolina on December 1, 2023. The legislation also enacted the Healthcare Access and Stabilization Program ("HASP") aimed at increasing Medicaid reimbursement rates to hospitals providing safety-net services for low-income patients. The Centers for Medicare and Medicaid Services ("CMS") approved initial HASP payments for the North Carolina fiscal year July 1, 2022 to June 30, 2023. HASP payments for future fiscal years will require annual approval by CMS. Increased reimbursement rates under the initial HASP preprint were applied retrospectively to the beginning of the North Carolina fiscal year, which commenced on July 1, 2022. As a result of the increased reimbursement rates, the Company recognized additional revenues of $121 million in its consolidated statements of operations for the year ended December 31, 2023, of which $35 million is related to the period from July 1, 2022 to December 31, 2022. The Company recognized additional provider taxes of $28 million for the year ended December 31, 2023, included under the caption "Other operating expenses, net" in its accompanying consolidated statements of operations, of which $9 million is related to the period from July 1, 2022 to December 31, 2022.

Kentucky Hospital Rate Improvement Program

The Commonwealth of Kentucky has implemented a Medicaid Hospital Rate Improvement Program ("KY HRIP"), which provides supplemental Medicaid payments to all Kentucky hospitals, other than university hospitals and state mental hospitals, and is intended to reduce the gap between the Kentucky Medicaid program's regular inpatient Medicaid payments and each hospital's Medicare allowable costs. During the first quarter of 2021, CMS and the Commonwealth of Kentucky approved a modification to the KY HRIP, which increased the inpatient hospital reimbursement rate from a contracted managed care rate up to a percentage of the average commercial rate. This modification was applied retrospectively to the beginning of the KY HRIP fiscal year, which commenced on July 1, 2020. As a result of this modification, the Company recognized additional revenues of $113 million in its consolidated statement of operations for the year ended December 31, 2021, of which $33 million is related to the period from July 1, 2020 to December 31, 2020. Additionally, the Company recognized additional provider taxes of $15 million for the year ended December 31, 2021, included under the caption "Other operating expenses, net" in the accompanying consolidated statement of operations, of which $5 million is related to the period from July 1, 2020 to December 31, 2020.

Cost Report Settlements

Cost report settlements under reimbursement agreements with Medicare, Medicaid and certain other payers for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the payment terms of the reimbursement agreement with the payer, correspondence from the payer, and the Company's historical experience. Estimated settlements are adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near-term.

The net cost report settlements due to the Company were $4 million and $3 million at December 31, 2023 and 2022, respectively, and are included under the caption "Accounts receivable" on the accompanying consolidated balance sheets. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs consistent with the constraints that are required by ASC 606.

For the years ended December 31, 2023, 2022 and 2021, the net retroactive adjustments to revenue related to prior periods for changes in MSP programs, estimated cost report settlements and other reimbursement adjustments resulted in an increase to revenues of $47 million, $32 million and $62 million, respectively.

Self-Pay Revenues

Self-pay revenues are derived from patients who do not have any form of healthcare coverage as well as from patients with third-party healthcare coverage related to the patient responsibility portion, including deductibles and co-payments. The Company evaluates these patients, after such patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs. The Company estimates the transaction price for self-pay patients and the patient responsibility portion using a number of analytical tools, benchmarks and market conditions. No single statistic or measurement determines the transaction price for these patients. Some of the analytical tools that the Company utilizes include, but are not limited to, historical cash collection experience, revenue trends by payer classification and revenue days in accounts receivable.

The revenues associated with self-pay patients are reported at the net amount that the Company expects to collect. Because the Company provides care to patients regardless of their ability to pay, the Company has determined that the differences between the amounts it bills based on gross or discounted charges and the amounts the Company expects to collect represent implicit price concessions. The final amount that will be received from the patient is not known at the date of service, and the Company accounts for this variable consideration in accordance with the provisions of ASC 606. Self-pay accounts receivable are written off after collection efforts have been followed in accordance with the Company's policies.

Charity Care

The Company provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the years ended December 31, 2023, 2022 and 2021, the Company estimates that its costs of care provided under its charity care programs approximated $28 million, $18 million and $23 million, respectively. The Company does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Company's policy not to pursue collection of amounts related to these patients, and therefore contracts with these patients do not exist.

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

Financing Component

The Company has elected to apply the practical expedient permitted under ASC 606 and does not adjust the estimated amount of consideration from patients and third-party payers for the effects of a significant financing component due to the Company's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payer pays for that service will be one year or less.

Rental Income

The Company leases certain real estate assets it owns to unrelated third parties, primarily medical office buildings to non-employed physicians. The Company recognizes rental income for these operating lease arrangements in which the Company is the lessor on a straight-line basis over the lease term in accordance with ASC 842, "Leases" ("ASC 842").

Concentration of Revenues

The Company's revenues by payer and approximate percentages of revenues were as follows for the years ended December 31, 2023, 2022 and 2021:

	2023	2022	2021
	% of Revenues	% of Revenues	% of Revenues
Medicare	37.4 %	40.1 %	37.7 %
Medicaid	19.1	16.8	18.4
HMOs, PPOs and other private insurers	37.9	37.1	41.3
Self-pay	0.7	0.7	0.6
Other (a)	4.7	5.1	1.8
Revenue from contracts with customers	99.8	99.8	99.8
Rental income	0.2	0.2	0.2
Revenues	100.0 %	100.0 %	100.0 %

(a) Includes revenues from managed ARUs and ancillary goods and services.

During the years ended December 31, 2023, 2022 and 2021, approximately 56.5%, 56.9% and 56.1%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs, collectively. The Company's management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies.

Any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs could have an adverse effect on the Company's revenues or results of operations. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payer or geographic area that would subject the Company to any significant credit risks in the collection of its accounts receivable.

The Company's revenues by primary service type and approximate percentages of revenues were as follows for the years ended December 31, 2023, 2022 and 2021:

	2023		2022		2021	
	% of Revenues		% of Revenues		% of Revenues	
Inpatient services	44.4	%	43.5	%	39.4	%
Outpatient services	50.7		51.2		58.6	
Non-patient (a)	4.9		5.3		2.0	
Revenues	100.0	%	100.0	%	100.0	%

(a) Includes revenues from managed ARUs and ancillary goods and services.

General and Administrative Costs

The majority of the Company's operating expenses are "cost of revenue" items. Operating expenses that could be classified as "general and administrative" by the Company would include its corporate overhead costs, which were $237 million, $207 million and $195 million for the years ended December 31, 2023, 2022 and 2021, respectively, excluding depreciation and amortization, net income and losses associated with non-consolidated equity investments, and certain costs the Company considers non-recurring in nature, including but not limited to, severance and restructuring charges, and transaction and advisory costs recognized in connection with the Company's various business development activities. Lastly, the Company recognized accelerated stock-based compensation expense during the year ended December 31, 2021 in connection with a transaction involving the Company's indirect parent, DSB Parent, L.P., a Delaware limited partnership (the "Parent"), which is also excluded from its aforementioned general and administrative costs. Refer to Note 12 for further discussion of the Company's accounting for the stock-based compensation.

Legislative and Regulatory Response to COVID-19

Numerous legislative and regulatory actions, including enacting the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") and related stimulus legislation, were taken in an attempt to provide businesses, including healthcare providers, with relief from, and to combat the negative effects of, the COVID-19 pandemic.

Medicare Accelerated and Advance Payment Program

Using existing authority and certain expanded authority under the CARES Act, the U.S. Department of Health and Human Services temporarily expanded the CMS Accelerated and Advance Payment Program to a broad group of Medicare Part A and Part B providers. Under the expanded CMS Accelerated and Advance Payment Program, inpatient acute care hospitals could request up to 100% of their Medicare payment amount for a six-month period (critical access hospitals could request up to 125% of their payment amount for such period), and other providers and suppliers could request up to 100% of their Medicare payment amount for a three-month period.

The Company received a total of $991 million of Medicare advance payments under the CMS Accelerated and Advance Payment Program during the year ended December 31, 2020. During the year ended December 31, 2021, the Company fully repaid all Medicare advance payments.

CARES Act Tax Provisions

The CARES Act also provided for certain federal income tax changes, including an increase in the interest expense tax deduction limitation, the deferral of the employer portion of Social Security payroll taxes, refundable payroll tax credits, employee retention tax credits, net operating loss carryback periods, alternative minimum tax credit refunds and bonus depreciation of qualified improvement property. During the year ended December 31, 2020, the Company deferred cash payments of approximately $84 million related to Social Security payroll tax payments. During the year ended December 31, 2021, the Company fully repaid all previously deferred Social Security payroll taxes.

Cash and Cash Equivalents

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

Inventories

Inventories of supplies are stated at the lower of cost (first-in, first-out) or market and consist of purchased items. Inventories acquired in connection with business combinations are recorded at fair value which approximates replacement cost. Inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

Investments and Notes Receivable

The Company accounts for its investments in entities in which the Company does not control under either the cost method or the equity method of accounting in accordance with ASC 321 “Investments – Equity Securities” (“ASC 321”) or ASC 323, “Investments – Equity Method and Joint Ventures” (“ASC 323”), respectively. The Company does not consolidate its cost and equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses or evaluates them for impairment and observable price changes. Refer to Note 8 for further discussion of the Company’s investments.

In June 2016, the Financial Accounting Standards Board issued Accounting Standards Update No. (this “ASU”) 2016-13, Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments. This ASU requires entities to report “expected” credit losses on financial instruments and other commitments to extend credit rather than the current “incurred loss” model. These expected credit losses for financial assets held at the reporting date are to be based on historical experience, current conditions, and reasonable and supportable forecasts. This ASU will also require enhanced disclosures relating to significant estimates and judgments used in estimating credit losses, as well as the credit quality. This ASU was effective for the Company beginning January 1, 2023. The Company has adopted this ASU with no material impact to its consolidated financial statements.

Property and Equipment

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

The following table provides information regarding the Company’s property and equipment included in the accompanying consolidated balance sheets as of December 31, 2023 and 2022 (in millions):

	2023	2022
Land	$ 212	$ 180
Buildings and improvements	2,638	2,376
Equipment	1,926	1,751
Construction in progress	212	148
Property and equipment, at cost	4,988	4,455
Accumulated depreciation	(1,602)	(1,339)
Property and equipment, net of accumulated depreciation	$ 3,386	$ 3,116

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

	Years		
Buildings and improvements (including those under finance leases)	3	-	40
Equipment	2	-	15
Equipment under finance leases	3	-	6

Depreciation expense (including amortization of finance lease obligations) totaled $330 million, $323 million and $344 million for the years ended December 31, 2023, 2022 and 2021, respectively.

Whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances. There were no long-lived asset impairments recorded for the years ended December 31, 2023, 2022 and 2021.

Goodwill and Intangible Assets

The Company accounts for its acquisitions in accordance with ASC 805 using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350, Intangibles – Goodwill and Other ("ASC 350"), goodwill and intangible assets with indefinite lives are reviewed by the Company annually for impairment on October 1. In 2022, the Company was comprised of two distinct reporting units (i) acute hospital operations and (ii) rehabilitation hospital operations. Due to the significance of the Springstone Transaction (as defined under Note 2) and the impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280, "Segment Reporting" ("ASC 280") and ASC 350 during 2023 and determined that the Company is now comprised of three distinct reporting units: (i) acute hospital operations, (ii) rehabilitation hospital operations and (iii) behavioral health operations.

For the annual impairment evaluation, the Company estimates fair values of its reporting units utilizing both a discounted cash flow ("DCF") analysis and a guideline public company ("GPC") analysis considering observable market data of the Company's industry peers. Determining fair value requires the exercise of significant judgment, including judgments about appropriate discount rates, perpetual growth rates, profitability and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing the Company's assumptions. The cash flows employed in the DCF analysis are based on the Company's most recent financial budgets and business plans and, when applicable, various growth rates and profitability for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risks inherent in the future cash flows of the reporting unit.

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

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the income tax provision in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is not likely, a valuation allowance is established. The establishment or increase in a valuation allowance is included as an expense within the provision for income taxes in the consolidated statements of operations. The Company classifies interest and penalties related to its tax positions as a component of income tax expense. Refer to Note 5 for further discussion of the Company's accounting for income taxes.

Reserves for Self-Insurance Claims

Given the nature of the Company's operating environment, the Company is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("SIR") and deductible levels**.** At December 31, 2023, the Company's SIR for professional liability claims is $15 million per claim at the majority of its acute care hospitals. Additionally, the Company participates in state-specific professional liability programs in New Mexico and Pennsylvania. The Company has a $25,000 deductible for professional liability at each of its IRFs and a $100,000 deductible at each of its BHFs. At December 31, 2023, the Company's deductible for workers' compensation claims at each of its acute care and BHFs was $1 million per claim in all states in which it operates except for Montana, Ohio and Washington. The Company participates in state-specific programs for its workers' compensation claims arising in these states. There is no deductible for workers' compensation claims at IRFs. The Company's SIR and deductible levels are evaluated annually as a part of the Company's insurance program's renewal process.

The Company's reserves for self-insurance and deductible claims reflect the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The Company's expense for self-insurance and deductible claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's SIR and deductible levels; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance and deductible claims was approximately $48 million, $69 million and $86 million for the years ended December 31, 2023, 2022 and 2021, respectively.

The Company's reserves for professional liability claims are based upon quarterly and/or semi-annual actuarial calculations. These reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. The Company's reserves for self-insured claims have been discounted to their present value using a discount rate of 2.0% at December 31, 2023 and 1.8% at December 31, 2022. The Company's management selects a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

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

The following table provides information regarding the classification of the Company's reserves for self-insured claims at December 31, 2023 and 2022 (in millions):

	2023	2022
Current portion	$ 70	$ 74
Long-term portion	195	219
	$ 265	$ 293

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2023 and 2022 (in millions):

	2023	2022
Reserve at the beginning of the period	$ 293	$ 295
Increase for the provision of current year claims	55	65
(Decrease)/Increase for the provision of prior year claims	(5)	5
Payments related to current year claims	(3)	(3)
Payments related to prior year claims	(71)	(72)
Provision for the change in discount rate	(2)	(1)
Non-cash change in reserve for claims in excess of SIR levels	(6)	2
Liabilities assumed in connection with acquisitions	4	2
Reserve at the end of the period	$ 265	$ 293

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of the Company's quarterly and semi-annual actuarial calculations resulted in changes to its reserves for self-insured claims for prior years. As a result, the Company's related self-insured claims expense decreased by $5 million and increased by $5 million for the years ended December 31, 2023 and 2022, respectively.

Point of Life Indemnity, Ltd.

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

Self-Insured Medical Benefits

The Company is self-insured for substantially all of the eligible medical plan claims of its employees. The reserve for medical benefits primarily reflects the current estimate of incurred but not reported losses based upon an annual actuarial calculation as of the balance sheet date. The undiscounted reserve for self-insured medical benefits was $72 million and $50 million at December 31, 2023 and 2022, respectively, and is included in the Company's accompanying consolidated balance sheets under the caption "Other current liabilities".

Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to the Company. The Company's accompanying consolidated financial statements include all assets, liabilities, revenues, and expenses at their consolidated amounts, which include the amounts attributable to the Company and the noncontrolling interest. The Company recognizes as a separate component of earnings that portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company. Refer to Note 9 for further discussion of the Company's noncontrolling interests and redeemable noncontrolling interests.

Variable Interest Entities

The Company follows the provisions of ASC 810, "Consolidation" for determining whether an entity is a variable interest entity ("VIE"). In order to determine if the Company is a primary beneficiary of a VIE for financial reporting purposes, it must consider whether it has the power to direct activities of the VIE that most significantly impact the performance of the VIE and whether the Company has the obligation to absorb losses or the right to receive returns that are significant to the VIE. The Company consolidates a VIE when it is the primary beneficiary.

As of December 31, 2023, the Company consolidated 23 acute care hospitals, 36 IRFs, and 19 BHFs that are subject to joint venture agreements. Under GAAP, the Company determined that 9 of its acute care hospitals, 32 of its IRFs and 19 of its BHFs qualify as VIEs, and furthermore, the Company concluded that it is the primary beneficiary in all of the VIEs. The Company holds an ownership interest and acts as manager in each of the partnerships. Through the management services agreement, the Company is delegated necessary responsibilities to provide management services, administrative services and direction of the day-to-day operations. Based upon the Company's assessment of the most significant activities of its acute care hospitals and IRFs, the Company, as manager, has the ability to direct the majority of those activities in all such joint ventures which qualify as VIEs.

The analysis upon which the consolidation determination rests can be complex, can involve uncertainties, and requires judgment on various matters, some of which could be subject to different interpretations.

The Company's consolidated VIEs comprised approximately $2,303 million, or 19.4%, of the Company's total assets and $1,366 million, or 13.2%, of the Company's total liabilities as of December 31, 2023.

Stock-Based Compensation

The Parent has issued profits units (the "Units") to certain employees, directors, consultants and other service providers under the terms and conditions of the Third Amended and Restated Limited Partnership Agreement of the Parent dated May 27, 2022 (as amended, the "Parent Partnership Agreement") and forms of award agreements. The Company accounted for these stock-based awards in accordance with the provisions of ASC 718, "Compensation – Stock Compensation" ("ASC 718"). In accordance with ASC 718, the Company recognized compensation expense based on the estimated grant date fair value of each stock-based award. The Company recognizes forfeitures of Units as they occur. Refer to Note 12 for further discussion of the Company's accounting for the Units.

Defined Benefit Pension Plans

The Company maintains certain assets and assumed certain liabilities associated with two separate defined benefit pension plans covering certain employees at two of its facilities. The Company accounts for its defined benefit pension plans in accordance with ASC 715, "Compensation – Defined Benefit Plans" ("ASC 715"). In accordance with ASC 715, the Company recognizes the unfunded liability of its defined benefit pension plans in the Company's consolidated balance sheets and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the defined benefit pension plans' assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligations are measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality. Refer to Note 11 for further discussion of the Company's defined benefit pension plans.

Defined Contribution Plans

During the year ended December 31, 2023, the Company maintained a defined contribution retirement plan covering a majority of its employees. This defined contribution retirement plan contains discretionary matching contribution formulas, as well as definite contribution formulas for employees at certain facilities. Refer to Note 11 for further discussion of the Company's defined contribution plan.

Note 2. Business Development Update

Rehabilitation Expansion

The Company has continued to expand its rehabilitation business since closing the Kindred Transaction (as defined below). Following the transactions described below, as of December 31, 2023, the Company's consolidated inpatient rehabilitation operations include 39 IRFs with approximately 1,900 beds across 19 states.

Everest Operational IRFs Acquisition

On January 24, 2023, a wholly-owned, indirect subsidiary of the Company entered into a definitive agreement with entities affiliated with Everest Rehabilitation Hospitals, LLC ("Everest"), to acquire four IRFs (the "Everest Operational IRFs") located in Arkansas, Texas, and Ohio (the "Everest Operational IRF Transaction") for an aggregate purchase price of approximately $38 million. The closing of the Everest Operational IRF Transaction was consummated on March 1, 2023. Effective September 28, 2023, the Company contributed the Operational IRF located in Rogers, Arkansas to a new joint venture between the Company and Mercy Hospital Northwest Arkansas ("Mercy"). Upon formation of the joint venture, the Company reclassified $11 million of its equity in the facility to noncontrolling interests in the accompanying consolidated statements of equity representing the estimated fair value of Mercy's intangible assets contributed to the joint venture. The Company maintains a controlling interest in the joint venture and has continued to consolidate the facility in the Company's consolidated financial statements.

Everest Developing IRFs Acquisitions

In connection with the closing of the Everest Operational IRF Transaction, certain of the Company's affiliated entities entered into a definitive agreement with entities affiliated with Everest to acquire six IRFs that Everest is currently developing in Texas and Florida (the "Everest Developing IRFs") for an aggregate purchase price of approximately $60 million. The acquisition of the first of the Everest Developing IRFs, located in El Paso, Texas ("El Paso"), was consummated on August 1, 2023. The Company accounted for the acquisition of El Paso in accordance with ASC 805, under the acquisition method of accounting. The fair values of assets acquired and liabilities assumed are on a preliminary basis at December 31, 2023. The Company anticipates closing the acquisition of the remaining five Everest Developing IRFs on a rolling basis beginning in the second quarter of 2024.

De Novo IRFs Openings

During the two years ended December 31, 2023, the Company's consolidated joint ventures have opened six de novo IRFs with approximately 300 beds (which does not include Saint Thomas Rehabilitation Hospital listed below), as summarized below.

Facility Name	Location	Opening Date	Beds
Frazier Rehabilitation Hospital - Brownsboro	Louisville, KY	July 18, 2023	40
UC Davis Rehabilitation Hospital	Sacramento, CA	May 18, 2023	52
Community Rehabilitation Hospital West	Indianapolis, IN	May 16, 2023	40
Dignity Health East Valley Rehabilitation Hospital - Gilbert	Gilbert, AZ	December 21, 2022	40
Mercy Rehabilitation Hospital South	St. Louis, MO	December 6, 2022	50
Saint Thomas Rehabilitation Hospital (a)	Nashville, TN	June 14, 2022	40
Tampa Rehabilitation Hospital	Tampa, FL	May 17, 2022	80

(a) We hold a noncontrolling ownership interest in Saint Thomas Rehabilitation Hospital and have accounted for it as an equity investment in accordance with ASC 323

Behavioral Health Expansion

During the year ended December 31, 2023, the Company significantly expanded its behavioral health presence through the transactions described below. Following such transactions, as of December 31, 2023, the Company's consolidated behavioral health operations include 23 BHFs with approximately 1,700 beds across ten states.

Springstone Transaction

On August 26, 2022, the Company entered into a definitive agreement with (i) entities affiliated with Medical Properties Trust, Inc. ("MPT") and (ii) BH EIK Management, LP, a management company owned by certain members of the executive leadership team ("Springstone Management") of Springstone Health Opco, LLC ("Springstone"), for an affiliate of the Company (the "Lifepoint Member") to acquire a majority ownership interest in Springstone from Springstone Management and to acquire a promissory note issued by Springstone to an affiliate of MPT (the "Springstone Transaction"). Springstone was a national behavioral health provider with 18 BHFs and 37 outpatient locations across nine states. Pursuant to the Springstone Transaction, MPT continued to own the majority of Springstone's real estate locations, subject to an amended and restated master lease between affiliates of MPT and Springstone (the "Springstone Master Lease"), and an affiliate of MPT ("MPT DS") retained a noncontrolling interest in Springstone, subject to a put/call agreement (the "Put/Call Agreement").

The Springstone Transaction was consummated on February 7, 2023, upon which certain of the Company's subsidiaries entered into the Springstone Master Lease, and the Company funded $229 million in cash to complete the transaction. Refer to Note 7 for further discussion of the Springstone Master Lease.

On January 25, 2024, MPT DS delivered to the Lifepoint Member a put option notice pursuant to the Put/Call Agreement, notifying the Lifepoint Member of its exercise of the put right under the Put/Call Agreement. In accordance with the Put/Call Agreement, the Lifepoint Member is obligated to acquire all of the equity interests of Springstone owned by MPT DS. The Company expects to close on the purchase of MPT DS's equity interest in Springstone during the three months ended March 31, 2024 for a purchase price of approximately $12 million, following which the Company will own all of the outstanding equity interests of Springstone.

The Company accounted for the Springstone Transaction in accordance with ASC 805 under the acquisition method of accounting. The following table summarizes the fair values of assets acquired and liabilities assumed on a preliminary basis in connection with the Springstone Transaction (in millions):

Current assets	$	82
Property and equipment, net		481
Right-of-use operating lease assets		13
Goodwill and intangible assets		286
Current liabilities		(53)
Finance lease obligations		(541)
Other long-term debt, net		(23)
Long-term portion of right-of-use operating lease obligations		(11)
Noncontrolling interests and redeemable noncontrolling interests		(5)
Net assets acquired	$	229

Cornerstone El Dorado Transaction

On January 20, 2023, a subsidiary of Knight Health Holdings LLC (d/b/a ScionHealth), a Delaware limited liability company ("ScionHealth"), acquired Cornerstone Healthcare Group Holding, Inc., a Delaware corporation ("Cornerstone"), which operates 15 specialty hospitals, eight senior living locations, and Cornerstone Behavioral Health El Dorado ("El Dorado") (the "Cornerstone Transaction"). Immediately following ScionHealth's acquisition of Cornerstone on January 20, 2023, the Company paid $35 million in cash to acquire El Dorado, a 54-bed BHF located in Tucson, Arizona, from ScionHealth (the "El Dorado Transaction"). The Company accounted for the acquisition of El Dorado in accordance with ASC Subtopic 805-50 "Related Issues" ("ASC 805-50") as a transaction between entities under common control.

In connection with the Cornerstone Transaction and the El Dorado Transaction, the Company entered into a number of transition services agreements ("TSAs") and other ancillary agreements with ScionHealth and its subsidiaries pursuant to which (i) the Company provides certain transition services to ScionHealth to support the businesses acquired by ScionHealth in connection with the Cornerstone Transaction and (ii) ScionHealth provides certain transition services to the Company to support El Dorado.

De Novo BHF Opening

During the year ended December 31, 2023, the Company's consolidated joint venture opened one de novo BHF, as summarized below.

Facility Name	Location	Opening Date	Beds
Valley Springs Behavioral Health Hospital	Holyoke, MA	August 14, 2023	150

Joint Venture for Highpoint Health System

Effective December 1, 2023, the Company formed a new joint venture with an affiliate of Ascension Saint Thomas to expand access to high quality care and services in Northern Middle Tennessee (the "Highpoint Joint Venture"). Pursuant to a contribution agreement between the parties, at the closing the Company contributed its ownership interest in the Highpoint Health System in exchange for a controlling interest in the Highpoint Joint Venture. The Highpoint Health System is a regional health system comprised of Sumner Regional Medical Center, a 167-bed acute care hospital located in Gallatin, Tennessee; Sumner Station Emergency Room and Outpatient Services, a free standing emergency department and outpatient services center located in Gallatin, Tennessee; Trousdale Medical Center, a 25-bed critical access hospital located in Carthage, Tennessee; and Riverview Regional Medical Center, a 25-bed critical access hospital located in Carthage, Tennessee; and more than 15 affiliated clinics and sites of care. Upon formation of the Highpoint Joint Venture, the Company reclassified $22 million of its equity in Highpoint Health System to noncontrolling interests representing the estimated fair value of Ascension Saint Thomas' ownership interest in Highpoint. The Company maintains a controlling interest in Highpoint Health System and has continued to consolidate the facility in the Company's consolidated financial statements.

Kindred Transaction

On June 18, 2021, the Company entered into a securities purchase agreement (the "Kindred Purchase Agreement") for us and/or one or more affiliated assignees to acquire, directly or indirectly, Kindred Healthcare, LLC ("Kindred"), a leading specialty hospital company that operated facilities providing post-acute care, rehabilitation services and behavioral health services throughout the U.S. Upon the closing of the Kindred Transaction on December 23, 2021, a new healthcare company was established operating under the name ScionHealth, which is separate from Lifepoint. The Company acquired the IRF, behavioral health, contract rehabilitation service and certain support center businesses of Kindred, separated and transferred the equity and assets comprising 18 select acute care hospitals to ScionHealth and acquired Class B Units of ScionHealth, with an aggregate value of $350 million, which are perpetual non-convertible, non-voting units that accrue cumulative dividends at the rate of 10.00% per annum and, upon liquidation, are entitled to a return of their nominal value issue price of $350 million plus accrued, unpaid dividends. The Company refers to the foregoing transactions as the "Kindred Transaction." The Company's acquisition of Kindred's inpatient rehabilitation and contract rehabilitation service business (including 28 IRFs with 1,447 beds), behavioral health business (including two BHFs with 96 beds), and certain support center businesses transformed the Company into a more diversified healthcare platform, well-positioned to advance healthcare delivery in communities across the country.

Transition Services Agreements

The Company entered into a number of TSAs and other ancillary agreements with ScionHealth and its subsidiaries. For the years ended December 31, 2023 and 2022, in connection with the TSAs, the Company was reimbursed by ScionHealth for certain costs incurred on its behalf of $47 million and $61 million, respectively, and paid ScionHealth $2 million and $3 million for each period, respectively, for certain costs incurred on the Company's behalf.

Additionally, the Company and ScionHealth are party to a number of commercial services agreements, pursuant to which the Company provides ScionHealth with therapy services, rehabilitation unit and behavioral health unit management, consulting and development services, among other commercial services. For the years ended December 31, 2023 and 2022, the Company recorded revenues related to these commercial services agreements of $63 million and $55 million, respectively.

Lastly, the Company had a net receivable of $124 million and $84 million, respectively, recorded under the caption "Other current assets" in its accompanying consolidated balance sheets at December 31, 2023 and December 31, 2022.

Accounting for the Kindred Transaction

The Company accounted for the Kindred Transaction in accordance with ASC 805-50 as a transaction between entities under common control. In accordance with ASC 805-50, the Company recognized the assets and liabilities transferred in connection with the Kindred Transaction at the common parent's historical cost basis as of December 23, 2021. In accordance with ASC 805-50, combinations of entities under common control requires retrospective adjustment of comparative period financial information for the periods in which the entities were under common control. The Company and the Knight Transferred Business were under common control beginning December 23, 2021, and therefore, the Company has not retrospectively adjusted its previously issued financial statements.

The following tables summarize the impact of the net asset transfers in connection with ScionHealth and the finalized purchase price allocation (in millions):

Net assets transferred from ScionHealth to Lifepoint	$	1,031
Net assets transferred from Lifepoint to ScionHealth		(404)
Cash transferred to ScionHealth from Lifepoint		(929)
Class B Units of ScionHealth transferred to Lifepoint		350
Net equity adjustments related to common control transactions	$	48

	From ScionHealth To Lifepoint	From Lifepoint To ScionHealth
Current assets	$ 198	$ (271)
Property and equipment, net	153	(501)
Other long-term assets	475	(30)
Goodwill and intangible assets	1,095	(121)
Current liabilities	(123)	118
Long-term liabilities	(473)	378
Noncontrolling interests and redeemable noncontrolling interests	(294)	23
Net assets transferred to (from) Lifepoint	$ 1,031	$ (404)

Transaction-Related Costs

During the years ended December 31, 2023, 2022 and 2021, the Company recognized transaction-related costs of $28 million, $46 million and $86 million, respectively. The transaction-related costs recognized during the year ended December 31, 2023, were primarily related to the Springstone Transaction, the Non-Core Real Estate Financing Transaction (as defined under Note 7) and other business development activities. The transaction-related costs recognized during the years ended December 31, 2022 and 2021 were primarily related to the Kindred Transaction, Springstone Transaction and other business development activities. For more information related to the Non-Core Real Estate Financing Transaction, refer to Note 7.

Additional Divestitures

Clark Memorial Hospital and Scott Memorial Hospital

Effective September 29, 2023, the Company sold its 75% equity interest in the joint venture that owned Clark Memorial Hospital (“Clark Memorial”), a 236-bed acute care facility located in Jeffersonville, Indiana, and Scott Memorial Hospital (“Scott Memorial”), a 25-bed acute care facility located in Scottsburg, Indiana, to Norton Healthcare, Inc., the minority owner of such joint venture. The Company received net cash proceeds from the transaction of $37 million, including certain net working capital accounts.

In connection with the divestitures of Clark Memorial and Scott Memorial, the Company recognized a net loss of approximately $10 million, which is included under the caption “Other non-operating losses (gains), net” in the accompanying consolidated statements of operations for the year ended December 31, 2023. The net loss on sale is primarily attributable to the excess of the carrying values of the net assets associated with Clark Memorial and Scott Memorial, including allocated goodwill, over the net proceeds received in the transaction.

Colorado Plains Medical Center and Western Plains Medical Complex

Effective May 1, 2022, the Company sold Colorado Plains Medical Center (“Colorado Plains”), a 50-bed acute care facility located in Fort Morgan, Colorado, and Western Plains Medical Complex (“Western Plains”), a 99-bed acute care facility located in Dodge City, Kansas, to an unrelated third party. The Company received cash proceeds from the Colorado Plains and Western Plains transaction of $135 million, including net working capital, of which $63 million was utilized to settle a finance lease obligation related to Western Plains.

In connection with the sale of Colorado Plains and Western Plains, the Company recognized a net gain of $12 million, which is included under the caption "Other non-operating (gains) losses, net" in the accompanying consolidated statements of operations for the year ended December 31, 2022. The net gain on sale is primarily attributable to transaction proceeds in excess of the book values of the net assets associated with Colorado Plains and Western Plains, partially offset by losses associated with the write-off of allocated goodwill and the termination of a finance lease obligation related to Western Plains.

Providence Health and KershawHealth

Effective August 1, 2021, the Company sold Providence Health, comprised of two hospital campuses located in Columbia, South Carolina, and KershawHealth, located in Camden, South Carolina, to an unrelated third party. The Company received cash proceeds from the transaction of $86 million, including net working capital, a portion of which was utilized to settle a $28 million finance lease obligation related to KershawHealth. Refer to Note 7 for additional information regarding the Company's accounting for leases.

In connection with the divestiture of Providence Health and KershawHealth, the Company recognized a net impairment loss of $42 million during the year ended December 31, 2021, which is included under the caption "Other non-operating (gains) losses, net" in the accompanying consolidated statement of operations for the year ended December 31, 2021. The net impairment loss is primarily attributable to the write-down of property and equipment and allocated goodwill to their estimated fair values, as well as the termination of a finance lease obligation related to KershawHealth.

Capital Medical Center

On December 23, 2020, the Company entered into a definitive agreement with an unrelated third party to sell its majority ownership interest in Capital Medical Center, located in Olympia, Washington. Effective April 1, 2021, the Company sold its ownership interest in Capital Medical Center for cash proceeds of $38 million, including net working capital, in addition to the purchaser's assumption of certain finance lease obligations.

In connection with the Company's divestiture of Capital Medical Center, the Company recognized a net gain on sale of $24 million during the year ended December 31, 2021, which is included under the caption "Other non-operating (gains) losses, net" in the accompanying consolidated statement of operations for the year ended December 31, 2021. The net gain on sale is primarily attributable to the purchaser's assumption of certain finance lease obligations and liabilities, partially offset by the write-off of property and equipment, allocated goodwill, and certain other assets.

Note 3. Long-Term Debt & Lease Obligations

The Company's long-term debt, including current portions and finance lease obligations, consisted of the following at December 31, 2023 and 2022 (in millions):

	2023	2022
ABL Facility	$ 35	$ -
ABL Last-Out Revolving Credit Facility	80	-
Term Loan Facility	1,850	3,215
6.75% Secured Notes	-	600
4.375% Secured Notes	600	600
9.875% Secured Notes	800	-
11.0% Secured Notes	1,100	-
9.75% Unsecured Notes	1,270	1,270
5.375% Unsecured Notes	500	500
Other Secured Debt	20	-
Unamortized debt issuance costs	(132)	(100)
Finance lease obligations	1,380	809
Total debt	$ 7,503	$ 6,894

Maturities of the Company's long-term debt outstanding at December 31, 2023, excluding finance lease obligations and unamortized debt issuance costs, are as follows for the years indicated (in millions):

2024	$	19
2025		18
2026		1,309
2027		618
2028		1,891
Thereafter		2,400
	$	6,255

As described below, effective October 10, 2023, the Company used the net proceeds of the amendment and restatement of the Term Loan Facility in an outstanding principal amount of $1,850 million and the offering of $1,100 million aggregate principal amount of the 11.0% Secured Notes, together with cash on hand, to prepay all $3,015 million of existing term loans then-outstanding under the Term Loan Facility.

ABL Facility

General

As of December 31, 2023, the Company had $35 million in borrowings outstanding under the ABL Facility (as defined below) and approximately $63 million in letters of credit outstanding primarily related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims and as security for certain lease agreements. Amounts available for borrowing under the ABL Facility were approximately $682 million as of December 31, 2023.

Effective November 16, 2018, the Company entered into a senior secured asset-based revolving credit facility (as amended from time to time the "ABL Facility") in an aggregate principal amount of $800 million with a maturity of five years. The ABL Facility also includes both a letter of credit sub-facility and a swingline loan sub-facility. In addition, the Company may request one or more incremental revolving commitments in an aggregate principal amount up to the greater of (x) the greater of (i) $255 million and (ii) 0.23 times pro forma Adjusted EBITDA (as defined in this Report) for the most recently available four fiscal quarter periods, and (y) the amount by which the borrowing base exceeds the aggregate commitments under the ABL Facility, subject to certain conditions and receipt of commitments by existing or additional lenders.

On January 27, 2023, the Company entered into an Incremental Assumption and Amendment Agreement No. 2 with certain of the Company's subsidiaries, DSB Acquisition LLC ("Holdings"), the lenders party thereto and Citibank, N.A., as administrative agent, which amended and restated the ABL Facility. The ABL Facility matures on January 27, 2028; provided, that if more than $200 million aggregate principal amount of the Notes or the Term Loan Facility (as defined below) remain outstanding 91 days before the stated maturity thereof, then the ABL Facility will mature and the commitments under the facility will terminate on such date. The ABL Facility continues to provide revolving availability of $800 million, with a $150 million letter of credit sub-facility and a $40 million swingline sub-facility, and under the ABL Facility, the Company continues to have the right to request one or more incremental revolving commitments. Availability under the ABL Facility continues to be subject to a borrowing base that is based on a specified percentage of eligible accounts receivable. Borrowings under the ABL Facility continue to be subject to the satisfaction of customary conditions, including the absence of a default and the accuracy of representations and warranties.

Collateral and Guarantors

The obligations under the ABL Facility are guaranteed by Holdings, on a limited recourse basis and each of the direct and indirect material, wholly-owned domestic subsidiaries of the Company that guaranteed the obligations under the ABL Facility. The obligations are secured by a pledge of the capital stock of the Company and substantially all of their assets and those of each subsidiary guarantor subject to certain exceptions. Such security interests consist of a first-priority lien with respect to "ABL Priority Collateral" (which generally includes most accounts receivable and certain related assets of the Company and the subsidiary guarantors) and a second-priority lien with respect to the "Non-ABL Priority Collateral" (which generally includes most inventory and fixed assets, equity interests and intellectual property of the Company and the subsidiary guarantors). Additionally, certain of the Company's restricted subsidiaries that are not guarantors will pledge certain of their assets (the "Credit Support Party Collateral") on a first-priority basis, as further security of the obligations under the ABL Facility. The Credit Support Party Collateral will secure only the obligations under

the ABL Facility.

Interest Rates and Fees

Prior to the amendment and restatement effective January 27, 2023, as discussed below, borrowings under the ABL Facility bore interest at a rate equal to, at the Company's option, either (a) a London Interbank Offered Rate ("LIBOR") rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an initial applicable margin of 1.75% for LIBOR loans and 0.75% for base rate loans. The applicable margin for borrowings was subject to step-downs based on average availability thresholds.

Effective January 27, 2023, borrowings under the ABL Facility will bear interest at a rate equal to, at the Company's option, either (a) an adjusted term Secured Overnight Financing Rate ("SOFR") for the interest period in effect, subject to a floor of 0.00%, or (b) a base rate determined by the highest of (i) the prime rate in effect, (ii) the federal funds effective rate plus 0.50% and (iii) an adjusted term SOFR with an interest period of one month plus 1.00%, subject to a floor of 1.00%, in each case plus an applicable margin of 1.75% for adjusted term SOFR loans and 0.75% for base rate loans. The applicable margin for borrowings will be subject to step-downs based on average availability thresholds.

The Company is required to pay a commitment fee under the ABL Facility in respect of the unutilized commitments at an initial rate equal to 0.375% per annum. The commitment fee may be subject to one step-down based on the average daily utilization under the ABL Facility. The Company will also be required to pay customary agency fees as well as letter of credit participation fees.

Restrictive Covenants and Other Matters

The ABL Facility contains certain customary affirmative covenants and events of default. The negative covenants in the ABL Facility include, among other things, limitations (none of which are absolute) on the Company and its subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates, enter into sale-leaseback transactions, change their lines of business, restrict dividends from their subsidiaries or restrict liens, change their fiscal year, and modify the terms of certain debt.

The ABL Facility requires that the Company and its restricted subsidiaries maintain a minimum fixed charge coverage ratio of not less than 1.00 to 1.00 at any time when availability is less than an agreed amount.

The ABL Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the ABL Facility are entitled to take various actions, including the acceleration of amounts due under the ABL Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the ABL Facility.

ABL Last-Out Revolving Credit Facility

On September 28, 2023, the Company executed an amendment to the ABL Facility that provided for $80 million in last-out revolving credit commitments (collectively, the "ABL Last-Out Revolving Credit Facility") with a maturity date of January 27, 2028, which were incremental to the $800 million revolving commitments under the ABL Facility. The ABL Last-Out Revolving Credit Facility is required to be drawn before the revolving commitments under the ABL Facility but cannot be repaid if any amount of the revolving commitment under the ABL Facility remains outstanding unless the applicable ABL Last-Out Revolving Credit Facility is permanently reduced and certain other conditions are met. As of December 31, 2023, there was $80 million outstanding under the ABL Last-Out Revolving Credit Facility.

The ABL Last-Out Revolving Credit Facility bears interest at a rate per annum equal to the SOFR rate, adjusted for statutory reserves, plus a margin of 3.75%. Relative to the 4.375% Secured Notes, the 9.875% Secured Notes and the Company's Term Loan Facility, the ABL Last-Out Revolving Credit Facility shares in the guarantee and security interests in respect of the ABL Facility with the same lien priority as any other loans or obligations under the ABL Facility but is junior in right of payment as compared to such other loans and certain obligations under the ABL Facility.

Term Loan Facility

General

Effective November 16, 2018, the Company entered into a senior secured term loan credit facility initially scheduled to mature on November 16, 2025 (the "Term Loan Facility"). The Term Loan Facility had an initial aggregate principal amount of $3,550 million. The aggregate principal amount outstanding as of January 1, 2022 and June 30, 2023 was $3,215 million. On August 14, 2023, the Company made an optional prepayment of $200 million of outstanding borrowings under the Term Loan Facility with a portion of the net proceeds from the offering of $800 million in aggregate principal amount of the 9.875% Secured Notes described below, together with cash on hand. On October 10, 2023, the Company made an optional prepayment of the remaining $3,015 million of outstanding borrowings under the Term Loan Facility with the net proceeds of a $1,850 million new term loan (as described below) and the net proceeds from the offering of $1,100 million in aggregate principal amount of the 11.0% Secured Notes (the "11.0% Secured Notes") together with cash on hand.

Effective October 10, 2023, the Company entered into an Incremental Assumption and Amendment Agreement No. 4, which amended and restated the Term Loan Facility in its entirety to provide for a new senior secured term loan credit facility in an aggregate principal amount of $1,850 million, maturing on November 16, 2028. In addition, the Company may request one or more incremental term commitments in an aggregate principal amount up to the greater of (i) $800 million and (ii) 0.75 times pro forma Adjusted EBITDA for the most recently available four fiscal quarter periods, plus additional amounts subject to certain agreed leverage requirements, certain other conditions and receipt of commitments by existing or additional lenders. The Term Loan Facility has a springing 91-day maturity if more than $150 million aggregate principal amount of the Company's 9.75% Unsecured Notes remain outstanding 91 days before the stated maturity thereof.

Collateral and Guarantors

All obligations under the Term Loan Facility are unconditionally guaranteed by Holdings on a limited recourse basis and each of the existing and future direct and indirect material, wholly-owned domestic subsidiaries of the co-borrowers, subject to certain exceptions. The obligations under the Term Loan Facility are secured by a pledge of the capital stock of the Company and substantially all of its assets and those of each subsidiary guarantor, including a pledge of the capital stock of all entities directly held by the Company and each subsidiary guarantor (which pledge is limited to 65% of the voting capital stock of first-tier foreign subsidiaries), in each case subject to certain exceptions. Such security interests consist of a first-priority lien with respect to the Non-ABL Priority Collateral and a second-priority lien with respect to the ABL Priority Collateral.

Interest Rates and Principal Payments

Prior to the amendment effective June 30, 2023, as discussed below, borrowings under the Term Loan Facility bore interest at a rate equal to, at the Company's option, either (a) a LIBOR rate determined by reference to the costs of funds for Eurodollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs or (b) a base rate determined by reference to the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate of Citibank, N.A. and (iii) the one-month adjusted LIBOR plus 1.00%, in each case plus an applicable margin of 3.75% for LIBOR loans and 2.75% for base rate loans.

Effective June 30, 2023, borrowings under the Term Loan Facility bore interest at a rate equal to, at the Company's option, either (a) adjusted SOFR for the interest period in effect, subject to a floor of 0.00%, or (b) a base rate determined by the highest of (i) prime rate in effect, (ii) federal funds effective rate plus 0.50% and (iii) adjusted SOFR for a one-month interest period plus 1.00%, in each case, plus an applicable margin of 3.75% for SOFR loans and 2.75% for base rate loans.

Effective October 10, 2023, borrowings under the Term Loan Facility bore interest at a rate equal to, at the Company's option, either (a) adjusted SOFR for the interest period in effect, subject to a floor of 0.00%, plus an applicable margin of 5.50% or (b) a base rate determined by the highest of (i) prime rate in effect, (ii) federal funds effective rate plus 0.50% and (iii) adjusted SOFR for a one-month interest period plus 1.00%, in each case, plus an applicable margin of 4.50%. Effective October 10, 2023, the Term Loan Facility requires scheduled quarterly amortization payments in an annual amount equal to 1.0% of the original principal amount of the term loans borrowed on such date, with the balance to be paid at maturity. The Term Loan Facility requires the Company to make certain mandatory prepayments, including using (i) a portion of annual excess cash flow, as defined in the Term Loan Facility, (ii) net cash proceeds of certain non-ordinary assets sales or dispositions of property and (iii) net cash proceeds of any issuance or incurrence of debt not permitted under the Term Loan Facility.

Restrictive Covenants and Other Matters

The Term Loan Facility contains certain customary affirmative covenants and events of default. The negative covenants in the Term Loan Facility include, among other things, limitations (none of which are absolute) on the Company and its subsidiaries' ability to incur additional debt or issue certain preferred shares, create liens on certain assets, make certain loans or investments (including acquisitions), pay dividends on or make distributions in respect of their capital stock or make other restricted payments, consolidate, merge, sell or otherwise dispose of all or substantially all of theirs and their restricted subsidiaries' assets, sell certain assets, enter into certain transactions with their affiliates enter into sale-leaseback transactions, change their lines of business, restrict dividends from subsidiaries or restrict liens, change their fiscal year and modify the terms of certain debt or organizational agreements.

The Term Loan Facility contains certain customary events of default, including relating to a change of control. If an event of default occurs, the lenders under the Term Loan Facility are entitled to take various actions, including the acceleration of amounts due under the Term Loan Facility and all actions permitted to be taken by a secured creditor in respect of the collateral securing the Term Loan Facility.

4.375% Secured Notes

On February 13, 2020, the Company completed the offering of $600 million in aggregate principal amount of its 4.375% Secured Notes (the "4.375% Secured Notes"). The 4.375% Secured Notes will mature on February 15, 2027. Interest on the 4.375% Secured Notes will accrue at 4.375% per annum and will be paid semi-annually, in arrears, on February 15 and August 15 of each year, beginning August 15, 2020. The net proceeds from the offering, together with the net proceeds from the Incremental Term Loan and cash on hand, were used to fund the settlement of the tender offer, which satisfied and discharged the Company's obligations as it relates to the 8.25% secured notes due 2023 and the 11.5% secured notes due 2024 and to pay certain fees in connection with the refinancing transactions described herein.

The Company's obligations under the 4.375% Secured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Term Loan Facility. The 4.375% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 4.375% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority Collateral.

The Company may redeem the 4.375% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in such indenture (as amended or supplemented from time to time, the "4.375% Secured Notes Indenture").

The 4.375% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions as described in the 4.375% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 4.375% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 4.375% Secured Notes Indenture also provides for customary events of default.

9.875% Secured Notes

On August 14, 2023, the Company completed the offering of $800 million in aggregate principal amount of its 9.875% Secured Notes (the "9.875% Secured Notes"). The 9.875% Secured Notes will mature on August 15, 2030. Interest on the 9.875% Secured Notes accrues at 9.875% per annum and is paid semi-annually, in arrears, on February 15 and August 15 of each year, beginning February 15, 2024. The net proceeds from the offering of the 9.875% Secured Notes, together with cash on hand, were used to purchase or redeem all $600 million aggregate principal amount of the Company's outstanding 6.75% Secured Notes (the "6.75% Secured Notes"), repay $200 million of outstanding borrowings under the Company's Term Loan Facility and pay related fees and expenses in connection with the 9.875% Secured Notes offering.

The Company's obligations under the 9.875% Secured Notes are fully and unconditionally guaranteed, jointly and severally, by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Term Loan Facility and the other Notes. The 9.875% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 9.875% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority Collateral.

Prior to August 15, 2026, the Company may redeem the 9.875% Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 9.875% Secured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to August 15, 2026, the Company may also redeem up to 40% of the original aggregate principal amount of the 9.875% Secured Notes (calculated after giving effect to any issuance of additional 9.875% Secured Notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 109.875%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 9.875% Secured Notes (calculated after giving effect to any issuance of additional 9.875% Secured Notes) must remain outstanding after each such redemption. On or after August 15, 2026, the Company may redeem the 9.875% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in such indenture (as amended or supplemented from time to time, the "9.875% Secured Notes Indenture").

The 9.875% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions as described in the 9.875% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 9.875% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 9.875% Secured Notes Indenture also provides for customary events of default.

11.0% Secured Notes

On October 10, 2023, the Company completed the offering of $1,100 million in aggregate principal amount of its 11.0% Secured Notes. The 11.0% Secured Notes will mature on October 15, 2030. Interest on the 11.0% Secured Notes accrues at 11.0% per annum and is paid semi-annually, in arrears, on April 15 and October 15 of each year, beginning April 15, 2024. The net proceeds from the offering of the 11.0% Secured Notes, together with the net proceeds of the amendment and restatement of the Term Loan Facility and cash on hand, were used to repay in full all $3,015 million of outstanding borrowings under the Term Loan Facility and to pay related fees and expenses in connection with the 11.0% Secured Notes offering.

The Company's obligations under the 11.0% Secured Notes are fully and unconditionally guaranteed, jointly and severally, by each of the Company's wholly-owned domestic restricted subsidiaries that guarantee the Term Loan Facility and the other Notes. The 11.0% Secured Notes and the related guarantees are secured obligations of the Company and each subsidiary guarantor. The 11.0% Secured Notes and related guarantees are secured by, subject to permitted liens, (i) first-priority security interests in the Company's Non-ABL Priority Collateral and (ii) second-priority security interests in the Company's ABL Priority Collateral.

Prior to October 15, 2026, the Company may redeem the 11.0% Secured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 11.0% Secured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to October 15, 2026, the Company may also redeem up to 40% of the original aggregate principal amount of the 11.0% Secured Notes (calculated after giving effect to any issuance of additional 11.0% Secured Notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 111.0%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 11.0% Secured Notes (calculated after giving effect to any issuance of additional 11.0% Secured Notes) must remain outstanding after each such redemption. On or after October 15, 2026, the Company may redeem the 11.0% Secured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in such indenture (as amended or supplemented from time to time, the "11.0% Secured Notes Indenture").

The 11.0% Secured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions as described in the 11.0% Secured Notes Indenture. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 11.0% Secured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 11.0% Secured Notes Indenture also provides for customary events of default.

Tender Offer and Redemption of 6.75% Secured Notes

On August 14, 2023, the Company repurchased and cancelled approximately $569 million (or 95%) of the 6.75% Secured Notes pursuant to the Company's previously announced tender offer and consent solicitation. The Company used part of the net proceeds from the 9.875% Secured Notes offering and cash on hand to repurchase such notes. In connection with the tender offer and consent solicitation for the 6.75% Secured Notes, the Company and the trustee for the 6.75% Secured Notes entered into a supplemental indenture to the indenture governing the 6.75% Secured Notes to eliminate substantially all of the restrictive covenants and certain events of default in the indenture governing the 6.75% Secured Notes, release the collateral securing the 6.75% Secured Notes and shorten the required notice period for redemptions of the 6.75% Secured Notes from 30 days to 2 business days.

Shortly following the repurchases of the 6.75% Secured Notes described above, the Company delivered a notice of redemption to redeem the 6.75% Secured Notes not purchased by the Company on the early settlement date for the tender offer. Such 6.75% Secured Notes were redeemed on August 16, 2023 at a redemption price of 101.688% of the principal amount thereof, plus accrued and unpaid interest to the redemption date.

Debt Refinancing Costs

In connection with the offering of the 9.875% Secured Notes, the 11.0% Secured Notes and the Term Loan Facility, the Company capitalized approximately $12 million, $10 million, and $67 million, respectively, of new debt issuance costs, which are included as a reduction to "Long-term debt, net" in the Company's accompanying consolidated balance sheet.

Additionally, during the year ended December 31, 2023, the Company recognized approximately $52 million of debt refinancing costs associated with the various debt refinancing transactions completed during 2023, which are included under the caption "Debt refinancing costs" in the accompanying consolidated statements of operations for the year ended December 31, 2023. These debt refinancing costs were comprised of $11 million of early termination premiums associated with the tender offer and redemption of 6.75% Secured Notes, the write-off of $36 million of previously capitalized debt issuance costs, and $5 million of other miscellaneous costs.

9.75% Unsecured Notes

On November 16, 2018, the Company completed the offering of $1,425 million in aggregate principal amount of 9.75% Unsecured Notes (the "9.75% Unsecured Notes," and together with the 5.375% Unsecured Notes (the "5.375% Unsecured Notes"), 6.75% Secured Notes and the 4.375% Secured Notes, the "Notes"). The 9.75% Unsecured Notes will mature on December 1, 2026. Interest on the 9.75% Unsecured Notes accrues at 9.750% per annum and is paid semi-annually, in arrears, on June 1 and December 1 of each year, beginning June 1, 2019.

The Company's obligations under the 9.75% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 9.75% Unsecured Notes and the related guarantees are unsecured obligations of the Company and the subsidiary guarantors.

The Company may redeem the 9.75% Unsecured Notes at its option, in whole at any time or in part from time to time, at the redemption prices set forth in such indenture (as amended or supplemented from time to time, the "9.75% Unsecured Notes Indenture").

The 9.75% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. These covenants are subject to a number of important qualifications and exceptions. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 9.75% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 9.75% Unsecured Notes Indenture also provides for customary events of default.

5.375% Unsecured Notes

On December 4, 2020, the Company completed the offering of the 5.375% Unsecured Notes. The 5.375% Unsecured Notes will mature on January 15, 2029. Interest on the 5.375% Unsecured Notes accrues at 5.375% per annum and is paid semi-annually, in arrears, on January 15 and July 15 of each year, beginning July 15, 2021. The net proceeds of the offering, together with cash on hand, were used to prepay $500 million of the total aggregate principal amount outstanding under the Term Loan Facility and to pay related fees and expenses in connection with the offering.

The Company's obligations under the 5.375% Unsecured Notes are fully and unconditionally guaranteed by each of the Company's wholly-owned domestic restricted subsidiaries that guarantees the Term Loan Facility. The 5.375% Unsecured Notes and the related guarantees are unsecured obligations of the Company and the subsidiary guarantors.

Prior to January 15, 2024, the Company may redeem the 5.375% Unsecured Notes at its option, in whole at any time or in part from time to time, at a redemption price equal to 100% of the principal amount of the 5.375% Unsecured Notes redeemed, plus a "make-whole" premium and accrued and unpaid interest, if any. In addition, prior to December 4, 2023, the Company may also redeem up to 40% of the original aggregate principal amount of the 5.375% Unsecured Notes (calculated after giving effect to any issuance of additional notes) in an aggregate amount not to exceed the amount of net cash proceeds of one or more equity offerings at a redemption price equal to 105.375%, plus accrued and unpaid interest, if any, so long as at least 50% of the original aggregate principal amount of the 5.375% Unsecured Notes (calculated after giving effect to any issuance of additional notes) must remain outstanding after each such redemption. On or after January 15, 2024, the Company may redeem the 5.375% Unsecured Notes at the redemption prices set forth in such indenture (as amended or supplemented from time to time, the "5.375% Unsecured Notes Indenture").

The 5.375% Unsecured Notes Indenture, among other things, limits the Company's ability and the ability of its restricted subsidiaries to, among other things: (i) incur or guarantee additional indebtedness; (ii) pay dividends or distributions on, or redeem or repurchase, capital stock and make other restricted payments; (iii) make certain investments; (iv) consummate certain asset sales; (v) engage in certain transactions with affiliates; (vi) grant or assume certain liens; and (vii) consolidate, merge or transfer all or substantially all of their assets. Additionally, upon the occurrence of specified change of control events, the Company must offer to repurchase the 5.375% Unsecured Notes at 101% of the principal amount, plus accrued and unpaid interest, if any, to, but not including, the purchase date. The 5.375% Unsecured Notes Indenture also provides for customary events of default.

Other Secured Debt

On February 7, 2023, concurrently with the consummation of the Springstone Transaction, certain of the Company's subsidiaries entered into an amended and restated credit agreement with Capital One, N.A. as administrative agent and lender, which provides for a $35 million senior secured asset-based revolving credit facility ("Other Secured Debt") and matures on December 17, 2026. At December 31, 2023, $20 million of Other Secured Debt was outstanding.

Notes Repurchase Program

On June 3, 2022, the Executive Committee of the Board of Directors of the Company authorized the repurchase of up to $200 million aggregate principal amount of the Notes (the "Notes Repurchase Program"). During the year ended December 31, 2022, the Company repurchased $155 million aggregate principal amount of its 9.75% Unsecured Notes for an aggregate repurchase price of $144 million in connection with the Notes Repurchase Program. As of December 31, 2023, the Company had remaining authority to repurchase up to an additional $45 million aggregate principal amount of the Notes in accordance with the Notes Repurchase Program. Future repurchases, if any, under the Notes Repurchase Program will depend on a number of factors, including but not limited to market conditions.

Finance Lease Obligations

Refer to Note 7 for discussion of the Company's finance lease obligations.

Interest Rate Swap Agreement

On December 21, 2018, the Company entered into an interest rate swap agreement with Citibank, N.A. as counterparty (the "Interest Rate Swap") whereby the Company paid a fixed rate of 2.63% on a notional amount of $1,100 million and received one-month LIBOR. The Interest Rate Swap became effective on February 19, 2019 and terminated on February 19, 2022. Refer to Note 10 for additional information regarding the Company's accounting for its Interest Rate Swap.

Note 4. Goodwill and Intangible Assets

Goodwill

The following table presents the changes in the carrying amount of goodwill for the years ended December 31, 2023 and 2022 (in millions):

Balance at January 1, 2022	$	3,914
Additions related to acquisitions		16
Finalization of the purchase price allocation for the Kindred Transaction		(74)
Write-off allocation related to 2022 divestitures		(45)
Balance at December 31, 2022		3,811
Additions related to acquisitions		375
Write-off allocation related to 2023 divestitures		(19)
Balance at December 31, 2023	$	4,167

In 2022, the Company was comprised of two distinct reporting units (i) acute hospital operations and (ii) rehabilitation hospital operations. Due to the significance of the Springstone Transaction and the impact on the Company's management team and business operations, the Company re-evaluated its reporting units in accordance with ASC 280 and ASC 350 during 2023 and determined that the Company is now comprised of three distinct reporting units: (i) acute hospital operations, (ii) rehabilitation hospital operations and (iii) behavioral health operations. For the annual impairment evaluation, the Company estimates fair values of its reporting units utilizing both a DCF analysis and a GPC analysis. The Company did not recognize any goodwill impairment charges during the years ended December 31, 2023, 2022 and 2021.

Intangible Assets

The following table provides information regarding the Company's intangible assets included in the accompanying consolidated balance sheets as of December 31, 2023 and 2022 (in millions):

	2023	2022
Amortizable intangible assets:		
Physician minimum revenue guarantees		
Gross carrying amount	$ 17	$ 21
Accumulated amortization	(9)	(12)
Net total	8	9
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	27	26
Licenses, provider numbers, and accreditations	48	48
Net total	75	74
Total intangible assets:		
Gross carrying amount	92	95
Accumulated amortization	(9)	(12)
Net total	$ 83	$ 83

Physician Minimum Revenue Guarantees

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or "physician minimum revenue guarantees," with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460, "Guarantees" ("ASC 460"). In accordance with ASC 460, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized as a component of other operating expenses, in the accompanying consolidated statements of operations, over the period of the physician contract, which typically ranges from four to five years.

Certificates of Need and Certificates of Need Exemptions

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and certain equipment at the Company's facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. The Company has acquired facilities in certain states that have adopted certificate of need laws. The Company has determined that these intangible assets have an indefinite useful life.

Licenses, Provider Numbers and Accreditations

To operate hospitals, the Company must obtain certain licenses, provider numbers and accreditations from federal, state and other accrediting agencies. The Company has acquired facilities in certain jurisdictions that require licenses, provider numbers and accreditations.

Amortization Expense

Amortization expense for the Company's intangible assets during the years ended December 31, 2023, 2022 and 2021 was $4 million, $5 million and $8 million, respectively.

Total estimated amortization expense for the Company's intangible assets during the next five years are as follows (in millions):

2024	$ 4
2025	2
2026	1
2027	1
	$ 8

Note 5. Income Taxes

The Company recognized a provision for income taxes of $52 million and $100 million for the years ended December 31, 2023 and 2022, respectively, and a benefit from income taxes of $27 million for the year ended December 31, 2021. The provision for income taxes recognized for the years ended December 31, 2023 and 2022 is primarily a result of an increase in the valuation allowance for certain deferred tax assets due to the limitation on the deductibility of interest expense under Section 163(j) of the Code (and the regulations thereunder) and write-offs of goodwill associated with divestitures. The benefit from income taxes recognized for the year ended December 31, 2021 is primarily a result of a reduction in the valuation allowance for certain deferred tax assets, partially offset by limitations on the tax deductibility of interest expense (back to its previous limitation of 30% of adjusted taxable income), stock-based compensation expense, write-offs of goodwill associated with divestitures, and certain transaction and advisory costs recognized during the year ended December 31, 2021.

The provision for (benefit from) income taxes for the years ended December 31, 2023, 2022 and 2021 consisted of the following (in millions):

	2023	2022	2021
Current:			
Federal	$ 46	$ 56	$ 46
State	16	5	5
	62	61	51
Deferred:			
Federal	(115)	(70)	23
State	(31)	1	(7)
	(146)	(69)	16
Change in valuation allowance	136	108	(94)
Total	$ 52	$ 100	$ (27)

The following table reconciles the differences between the statutory federal income tax rate to the Company's effective tax rate on net (loss) income before income taxes and including net income attributable to noncontrolling interests and redeemable noncontrolling interests for the years ended December 31, 2023, 2022 and 2021:

	2023	2022	2021
Federal statutory rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal income tax benefits	5.9	5.6	(2.6)
Change in valuation allowance	(62.5)	(102.6)	(83.3)
Tax effect of goodwill write-offs and impairments	(1.7)	(8.7)	9.9
Noncontrolling interests and redeemable noncontrolling interests	6.9	12.8	-
State net operating loss carryforward expirations, refunds and rate and state apportionment changes	2.4	(11.2)	-
Taxes payable and deferred tax liability adjustments	5.0	(10.7)	-
Nondeductible acquisition and merger-related costs	-	-	30.2
Other nondeductible expenses and other items	(1.2)	(1.3)	1.1
Effective income tax rate	(24.2) %	(95.1) %	(23.7) %

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects were as follows as of December 31, 2023 and 2022 (in millions):

	2023	2022
Deferred income tax liabilities:		
Depreciation and amortization	$ (92)	$ (98)
Right-of-use operating lease assets	(68)	(24)
Tax deductible goodwill	(30)	(28)
Investments in partnerships	(85)	(46)
Other	(2)	(6)
Total deferred income tax liabilities	(277)	(202)
Deferred income tax assets:		
Provision for doubtful accounts	56	43
Employee compensation	47	40
Net operating loss carryforwards	109	115
Insurance reserves	78	76
Section 163(j) interest expense carryforward	216	118
Investments in partnerships	59	1
Right-of-use operating lease obligations	68	24
Deferred loss on sale of facilities	21	21
Other	43	50
Total deferred income tax assets	697	488
Valuation allowance	(441)	(305)
Net deferred income tax assets	256	183
Deferred income taxes	$ (21)	$ (19)

Noncurrent deferred income tax liabilities totaled $21 million and $19 million at December 31, 2023 and 2022, respectively, and are included under the caption "Other long-term liabilities" on the accompanying consolidated balance sheets.

As of December 31, 2023, the Company had federal net operating loss carryforwards ("NOLs") of approximately $47 million with an indefinite carryforward period and subject to annual usage limitations under Section 382 of the Internal Revenue Code 1986, as amended (the "Code"). In addition, the Company had state and local NOLs of approximately $2 billion that expire at various dates between 2024 and 2042 or have an indefinite carryforward period.

The Company has established a valuation allowance for deferred tax assets at December 31, 2023 and 2022, due to the uncertainty of realizing these assets in the future. During the years ended December 31, 2023 and 2022, the Company increased its valuation allowance by $136 million and $108 million, respectively, primarily because of the limitation on the deductibility of interest expense under Section 163(j) of the Code.

The Company made federal income tax payments of $25 million, $20 million, and $50 million for the years ended December 31, 2023, 2022 and 2021, respectively. A net refund of federal income taxes previously paid by Legacy Lifepoint Health, Inc. ("Legacy Lifepoint") for the tax year ended December 31, 2013, in the amount of $23 million was received during the year ended December 31, 2021 related to the carryback of the final Legacy Lifepoint federal NOL generated for the year ended November 16. 2018, to the tax year ended December 31, 2013. The Company made net state and local income tax payments in the amount of $12 million, $8 million, and $17 million for the years ended December 31, 2023, 2022 and 2021, respectively.

The Company's policy is to accrue interest and penalties related to potential underpayment of income taxes within the provision for income taxes. Interest is computed on the difference between the Company's uncertain tax benefit positions and the amount deducted or expected to be deducted in our income tax returns. The Company does not expect to incur interest or penalties related to income taxes for the year ended December 31, 2023, and therefore made no increase to its accrual for uncertain tax benefit positions associated with prior years during the year ended December 31, 2023.

The Company files a consolidated U.S. federal income tax return, as well as income tax returns in various state jurisdictions. All of the Company's tax years are subject to examination by the Internal Revenue Service and various state taxing authorities.

Note 6. Other Current Liabilities

The following table provides information regarding the Company's other current liabilities, which are included in the accompanying consolidated balance sheets at December 31, 2023 and 2022 (in millions):

	2023	2022
Accrued interest	$ 138	$ 86
Current portion of right-of-use operating lease obligations	82	71
Current portion of self-insurance reserves	70	74
Self-insured medical benefits liabilities	72	50
Medicaid supplemental payment program provider taxes	53	25
Income taxes payable	33	10
Accrued property taxes	20	24
Accrued expenses and other	213	205
	$ 681	$ 545

Note 7. Leases

Summary

The Company leases real property and equipment under finance and operating leases. The leases expire at various times and have various renewal options. For leases with terms greater than twelve months, the Company records the related assets and obligations at the present value of lease payments over the term. Interest rates used in computing the present value of the lease payments are based on the Company's incremental borrowing rate at the inception of the lease. The Company's lease agreements generally require the Company to pay maintenance, repairs, taxes and insurance costs.

The following table presents certain information related to the Company's lease assets and liabilities at December 31, 2023 and 2022 (dollars in millions):

	Balance Sheet Classification	2023	2022
Assets:			
Finance leases	Property and equipment, net	$ 963	$ 514
Operating leases	Other long-term assets	1,023	638
Total lease assets		$ 1,986	$ 1,152
Liabilities:			
Current:			
Finance leases	Current maturities of long-term debt	$ 37	$ 29
Operating leases	Other current liabilities	82	71
Long-term:			
Finance leases	Long-term debt, net	1,343	780
Operating leases	Other long-term liabilities	952	572
Total lease liabilities		$ 2,414	$ 1,452
Weighted-average remaining term (in years):			
Finance leases		16.2	17.0
Operating leases		11.1	9.7
Weighted-average discount rate:			
Finance leases		10.2 %	9.6 %
Operating leases		9.4 %	7.6 %

The following table presents certain information related to finance and operating lease expense for the years ended December 31, 2023, 2022 and 2021 (in millions):

	Statement of Operations	2023	2022	2021
Finance lease expense:				
Amortization related to lease assets	Depreciation and amortization	$ 64	$ 44	$ 44
Interest related to lease liabilities	Interest expense, net	123	49	82
Operating lease expense	Other operating expenses, net	152	114	76
Short-term, variable and other lease expense	Other operating expenses, net	48	42	45
Total lease expense		$ 387	$ 249	$ 247

The following table presents supplemental cash flow information related to finance and operating leases for the years ended December 31, 2023, 2022 and 2021 (in millions):

	2023	2022	2021
Operating cash flows related to operating leases	$ 190	$ 149	$ 118
Operating cash flows related to finance leases	$ 113	$ 53	$ 79
Financing cash flows related to finance leases	$ 32	$ 34	$ 29

The following table reconciles the undiscounted cash flows to the finance and operating lease obligations included in the consolidated balance sheet at December 31, 2023 (in millions):

	Finance Leases	Operating Leases
2024	$ 158	175
2025	159	164
2026	154	155
2027	145	146
2028	138	137
Thereafter	1,855	988
Total minimum lease payments	2,609	1,765
Less: Amounts attributable to interest	(1,980)	(731)
Present value of minimum lease payments	629	1,034
Non-cash portions of finance lease obligations	751	-
Less: Current portions of lease obligations	(37)	(82)
Long-term portion of lease obligations	$ 1,343	$ 952

Springstone

Effective February 7, 2023, concurrently with the consummation of the Springstone Transaction, certain of the Company's subsidiaries entered into the Springstone Master Lease with certain affiliates of MPT, with respect to the 18 BHFs acquired. The Springstone Master Lease provides a 20-year term with two optional five-year renewal periods. The Company accounted for the Springstone Master Lease as a finance lease in accordance with ASC 842 and established an initial finance lease obligation of $545 million. Refer to Note 2 for further discussion of the Springstone Transaction.

MPT Lease Modifications

On August 1, 2021, the Company sold KershawHealth, which was subject to the Amended and Restated Master Lease Agreement with certain affiliates of MPT, dated March 21, 2016 (the "Capella Master Lease") and paid $28 million to MPT to terminate its lease obligation associated with KershawHealth. The removal of KershawHealth from the Capella Master Lease triggered a lease modification for accounting purposes in accordance with ASC 842, which resulted in the reclassification of right-of-use operating lease assets and obligations of $98 million and $106 million, respectively, related to certain other properties subject to the Capella Master Lease, to property and equipment and finance lease obligations of $129 million and $137 million, respectively.

Effective December 23, 2021, the Company terminated the Capella Master Lease, the Amended and Restated Hot Springs Master Lease Agreement with certain affiliates of MPT dated March 21, 2016 and the Master Lease Agreement with certain affiliates of MPT dated December 17, 2019, and certain subsidiaries of the Company entered into a new master lease agreement with certain affiliates of MPT, dated December 23, 2021, with respect to ten of the Company's facilities (the "2021 Master Lease"). The entry into the 2021 Master Lease triggered a lease modification for accounting purposes in accordance with ASC 842, which resulted in the reclassification of right-of-use operating lease assets and obligations of $61 million and $66 million, respectively, to property and equipment and finance lease obligations of $41 million and $46 million, respectively. All of the facilities subject to the 2021 Master Lease are accounted for as finance leases as of December 31, 2023.

Effective May 1, 2022, the Company sold Western Plains, which was subject to the 2021 Master Lease. In connection therewith, the 2021 Master Lease was amended. The purchase of Western Plains from MPT triggered a lease modification for accounting purposes in accordance with ASC 842, which resulted in the derecognition of a $33 million finance lease obligation related to Western Plains, and the recognition of additional property assets and finance lease obligations of $6 million related to certain other properties subject to the 2021 Master Lease.

Effective December 13, 2022, the 2021 Master Lease was amended to, among other things, provide for a five-year extension and amendment of certain financial covenants. Additionally, as a result of increases in the discount rates associated with the 2021 Master Lease, the Company's finance lease obligations include a non-cash end-of-term deferred gain of $462 million.

Non-Core Real Estate Financing Transaction

Effective September 19, 2023, the Company and certain of its subsidiaries (such subsidiaries, the "Lifepoint OpCos") entered into a Master Transaction Agreement (the "Master Transaction Agreement") with DSB Holdings, Inc., an indirect parent company of Lifepoint ("DSB Holdings"), Realpoint Properties, LLC, a subsidiary of DSB Holdings ("Realpoint"), and certain of Realpoint's subsidiaries (such subsidiaries, the "Realpoint PropCos"). Under the terms of the Master Transaction Agreement, the Lifepoint OpCos contributed to the Realpoint PropCos, by deed or 99-year ground lease as applicable, 36 medical office buildings, one skilled nursing facility and one assisted living facility. In connection with the foregoing transactions contemplated by the Master Transaction Agreement, the applicable Lifepoint OpCos entered into separate triple-net leases for the contributed properties, which have a 15-year term and aggregate initial base rent of approximately $25 million per year, subject to a 3% annual escalator. In addition, in connection with the foregoing transactions, under the Master Transaction Agreement, Realpoint distributed approximately $225 million in cash to the Company, and the Company retained approximately $169 million of Class B preferred interests in Realpoint, having a liquidation preference of approximately $169 million with a 9.5% annual preferred return, and approximately 2% of the outstanding Class A common interests in Realpoint. In addition, the Company entered into asset management agreements with Realpoint or the Realpoint PropCos, as applicable, under which Lifepoint will provide certain administrative and management services to them in exchange for management fees of approximately $0.3 million per year, in the aggregate, subject to a 3% annual escalator. DSB Holdings, the Company and one of its subsidiaries serve as guarantor for each of the triple-net leases, and DSB Holdings and the Company have provided an environmental indemnity and a non-recourse carveout guaranty on Realpoint's financing of the acquisition of the real estate from the Lifepoint OpCos. These transactions are referred to, collectively, as the "Non-Core Real Estate Financing Transaction."

The Company accounted for the Lifepoint OpCos' contributions of $149 million net book value of real property assets to the Realpoint PropCos in accordance with ASC 805-50, as a transaction between entities under common control and accounted for the leases of the properties transferred to the Realpoint PropCos as operating leases under ASC 842. The Company recognized $219 million of right-of-use operating lease assets and right-of-use operating lease obligations under the captions "Right-of-use operating lease assets" and "Long-term portion of right-of-use operating lease obligations", respectively, in its accompanying consolidated balance sheet as of December 31, 2023. The Company accounts for the equity investment in Realpoint under ASC 323 and the carrying value of the Company's investment in Realpoint was $166 million and is included under the caption "Investments" in its accompanying consolidated balance as of December 31, 2023. The Lifepoint OpCos' contributions of real property assets to the Realpoint PropCos and the initial equity investment in Realpoint resulted in a net equity adjustment of $245 million recorded under the caption "Net equity adjustments related to common control transactions" in the Company's accompanying consolidated statements of equity for the year ended December 31, 2023.

Lease Covenants

Certain of the Company's lease agreements, including the 2021 Master Lease and the Springstone Master Lease, contain financial covenants, including required minimum lease coverage and fixed charge coverage ratios. The Company's lease agreements generally include non-financial covenants, which may include those requiring the Company to maintain licenses necessary for operation of a facility or required for certification under Medicare or Medicaid. The failure to comply with or obtain a waiver of such covenants or otherwise cure such non-compliance could result in an event of default under the applicable lease. Certain of the Company's lease agreements, including the 2021 Master Lease and the Springstone Master Lease, are structured as master leases under which certain defaults related to one facility may result in a default on the entire portfolio subject to the applicable master lease agreement.

Note 8. Investments and Notes Receivable

Investments

The Company accounts for its investments in entities in which the Company does not control under either the cost method or the equity method of accounting in accordance with ASC 321 or ASC 323, respectively. The Company does not consolidate its cost and equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period or evaluates them for impairment and observable price changes. Investment income is included under the caption "Other operating expenses, net" in the accompanying consolidated statements of operations.

The following table presents the changes in the Company's investments during the years ended December 31, 2023 and 2022 (in millions):

Balance at January 1, 2022	$	655
Income [(a)]		102
Contributions		26
Distributions and other [(a)]		(99)
Balance at December 31, 2022		684
Income		57
Contributions [(b)]		397
Net change in other comprehensive income attributable to equity method investment		(7)
Distributions and other [(b)]		(274)
Balance at December 31, 2023	$	857

_____

(a) Includes a gain of approximately $60 million recognized in connection with the receipt of a dividend associated with a cost method investment.

(b) Includes real property contributions of $394 million and cash distributions of $225 million, respectively, related to the Non-Core Real Estate Financing Transaction. The Company retained approximately $169 million of Class B preferred interests in Realpoint.

ScionHealth Class B Units

In connection with the Kindred Transaction during the year ended December 31, 2021, Lifepoint acquired the Class B Units with an aggregate initial value of $350 million. The Class B Units in ScionHealth, a privately held company, do not have a readily determinable fair value, and therefore, the Company has accounted for the Class B Units using the measurement alternative in accordance with ASC 321. The Company's investment in the Class B Units was recorded at $350 million and is included under the caption "Investments" in the accompanying consolidated balance sheets at December 31, 2023 and 2022. The Company noted no observable price changes or transactions between the date of acquisition and December 31, 2023 and did not recognize any impairment charges related to the Class B Units during the years ended December 31, 2023, 2022 and 2021. The Class B Units are perpetual non-convertible, non-voting units that accrue cumulative dividends at the rate of 10.00% per annum and, upon liquidation, are entitled to a return of their nominal value issue price of $350 million plus accrued, unpaid dividends.

Realpoint Investments

In connection with the Non-Core Real Estate Financing Transaction, Lifepoint retained approximately $169 million of Class B preferred interests in Realpoint, having a liquidation preference of approximately $169 million with a 9.5% annual preferred return, and approximately 2% of the outstanding Class A common interests in Realpoint. The Company accounts for its equity investment in Realpoint in accordance with ASC 323. Under ASC 323, the Company recognizes its proportionate share of Realpoint income and loss in its accompanying consolidated statement of operations. The Company recognizes its proportionate share of Realpoint other comprehensive income and loss as an increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). In applying the equity method of accounting, the Company allocates its share of earnings and losses, including other comprehensive income using a hypothetical liquidation at book value method. The Company's investment is reported at cost and adjusted each period for the Company's share of Realpoint income or loss, including other comprehensive income, and dividends paid, if any. For the year ended December 31, 2023, the Company recognized investment income of $4 million included under the caption "Other operating expenses, net" in the accompanying consolidated statement of operations and other comprehensive loss of $7 million included under the caption "Net change in other comprehensive income attributable to equity method investment" in the accompanying consolidated statements of equity. The carrying value of the Company's investment in Realpoint was $166 million and is included under the caption "Investments" in its accompanying consolidated balance sheet as of December 31, 2023. The Company assesses its investment for impairment whenever events or changes in circumstances indicate that the carrying value of an investment may not be recoverable.

Investments Related to Lifepoint Forward Innovation Strategy

In connection with the Lifepoint Forward innovation strategy, the Company made investments of cash and contributions of existing investments and securities into certain unconsolidated but affiliated entities owned by the Company, Parent, ScionHealth and other affiliated entities (collectively, "Forward Health Ventures"). Forward Health Ventures, in turn, makes targeted and strategic investments in new and existing early-stage enterprises primarily focused on developing meaningful solutions to enhance quality, increase access to care, and improve value across our enterprise, including a significant focus on digital health capabilities that span the healthcare continuum. In exchange for the Company's investments of cash and contributions of existing investments and securities, Forward Health Ventures has issued to Lifepoint noncontrolling equity interests and perpetual cumulative preferred instruments. The equity interests in Forward Health Ventures, a privately held company, do not have a readily determinable fair value, and therefore, the Company has accounted for the equity interests using the measurement alternative in accordance with ASC 321. At December 31, 2023 and 2022, in the aggregate, the Company's cost method investment in Forward Health Ventures totaled $54 million and $53 million, respectively. The Company noted no observable price changes or transactions between the date of initial investment and December 31, 2023 and did not recognize any impairment charges related to the investment in Forward Health Ventures during the years ended December 31, 2023, 2022 and 2021. In addition to the cost method investment in Forward Health Ventures, the Company also entered into management and administrative services arrangements with Forward Health Ventures and commercial arrangements with certain underlying early-stage enterprises, including pilot and services agreements and a revolving credit facility that the Company provides to one of these enterprises. The revolving credit facility provides for loans up to approximately $15 million, has a 5-year maturity (or earlier upon our demand) and bears interest at 9.00%. At December 31, 2023, $14 million was drawn and outstanding.

Notes Receivable

On March 10, 2022, certain of the Company's subsidiaries invested approximately $47 million for an aggregate $50 million principal amount of ScionHealth's senior secured term loan (the "Term Loan Note Receivable"). The Term Loan Note Receivable matures on December 23, 2028 and bears interest at a rate equal to, at ScionHealth's option, (a) a eurocurrency rate plus an applicable margin of 5.25% or (b) a base rate plus an applicable margin of 4.25%. The Company has accounted for the Term Loan Note Receivable in accordance with ASC 310, "Receivables". As of December 31, 2023, the Term Loan Note Receivable had a carrying value of approximately $46 million and is included under the caption "Other long-term assets" on the Company's accompanying consolidated balance sheet.

Note 9. Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling Interests

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

The following table presents the changes in the Company's noncontrolling interests during the years ended December 31, 2023 and 2022 (in millions):

Balance at January 1, 2022	$	351
Net income attributable to noncontrolling interests		65
Cash distributions, net of contributions		(84)
Finalization of the purchase price allocations for the Kindred Transaction		(24)
Non-cash contributions from joint venture partners		17
Balance at December 31, 2022		325
Net income attributable to noncontrolling interests		67
Cash distributions, net of contributions		(57)
Non-cash contributions from joint venture partners		34
Reclassification of equity to noncontrolling interests related to joint venture activity		14
Net impact to noncontrolling interests related to acquisitions and divestitures		(14)
Balance at December 31, 2023	$	369

Redeemable Noncontrolling Interests

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

The following table presents the changes in the Company's redeemable noncontrolling interests during the years ended December 31, 2023 and 2022 (in millions):

Balance at January 1, 2022	$	139
Net income attributable to redeemable noncontrolling interests		1
Sale of redeemable noncontrolling interest units		5
Distributions and repurchases		(5)
Fair value adjustments		3
Balance at December 31, 2022		143
Net income attributable to redeemable noncontrolling interests		(1)
Redeemable noncontrolling interests recognized in connection with the Springstone Transaction		4
Distributions and repurchases		(15)
Fair value adjustments		12
Balance at December 31, 2023	$	143

Note 10. Fair Value of Financial Instruments

Fair Value Hierarchy

Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the fair value hierarchy pursuant to ASC 820, "Fair Value Measurements and Disclosures" ("ASC 820") that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

Level 1: Quoted market prices in active markets for identical assets or liabilities.
Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.
Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability.

Cash and Cash Equivalents, Accounts Receivable, Accounts Payable and Other Current Liabilities

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

Long-Term Debt

The carrying amounts and fair values of the Company's long-term debt instruments, excluding unamortized debt issuance costs, as of December 31, 2023 and December 31, 2022 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2023	December 31, 2022	December 31, 2023	December 31, 2022
ABL Facility	$ 35	$ -	$ 35	$ -
ABL Last-Out Revolving Credit Facility	$ 80	$ -	$ 80	$ -
Term Loan Facility	$ 1,850	$ 3,215	$ 1,843	$ 3,014
6.75% Secured Notes	$ -	$ 600	$ -	$ 563
4.375% Secured Notes	$ 600	$ 600	$ 554	$ 506
9.875% Secured Notes	$ 800	$ -	$ 808	$ -
11.0% Secured Notes	$ 1,100	$ -	$ 1,159	$ -
9.75% Unsecured Notes	$ 1,270	$ 1,270	$ 1,257	$ 1,024
5.375% Unsecured Notes	$ 500	$ 500	$ 368	$ 281
Other Secured Debt	$ 20	$ -	$ 20	$ -

The fair values of the Company's long-term debt instruments were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820.

Interest Rate Swap

The Company measured its Interest Rate Swap at fair value on a recurring basis. The fair value of the Company's Interest Rate Swap was based on quotes from its counterparty. The Company considers those inputs to be Level 2 in the fair value hierarchy.

The Company did not designate its Interest Rate Swap as a cash flow hedge in accordance with ASC 815, "Derivatives and Hedging." Accordingly, all changes in the fair value of the Company's Interest Rate Swap were recognized through interest expense in its statements of operations. The Company recognized non-cash interest income of $4 million and $27 million during the years ended December 31, 2022 and 2021, respectively, related to changes in the fair value of its Interest Rate Swap. The Interest Rate Swap terminated on February 19, 2022.

Financial Liabilities

The Company has a contingent consideration liability payable to the former owners of Canyon Vista Medical Center ("Canyon Vista") that represents the Level 3 estimated fair value of the contingent consideration using unobservable inputs and assumptions available to the Company. The key assumptions used in estimating the fair value of the Canyon Vista contingent consideration liability are the range of probabilities that the payments will be earned by the seller and a discount rate adjusted for the Company's credit risk.

At December 31, 2023 and 2022, the Canyon Vista contingent consideration liability was recorded at an estimated fair value of $11 million and $12 million, respectively, of which $1 million is included under the caption "Other current liabilities" at December 31, 2023 and 2022, and $10 million and $11 million, respectively, is included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheets. For the year ended December 31, 2022, the Company recognized a non-cash gain of $4 million, related to the change in the estimated fair value of the Canyon Vista contingent consideration liability, which is included under the caption "Other non-operating losses, net" on the accompanying consolidated statement of operations.

Note 11. Employee Benefit Plans

Defined Benefit Pension Plans

The Company maintains certain assets and assumed certain liabilities associated with two separate defined benefit pension plans (i) associated with certain employees of Marquette General Hospital covered by a collective bargaining agreement (the "Marquette Pension Plan") and (ii) associated with certain non-union employees of Bell Hospital (the "Bell Pension Plan" and, collectively with the Marquette Pension Plan, the "Pension Plans"). Both Pension Plans are closed to new participants. Participants in the Marquette Pension Plan are required to make annual contributions totaling 6% of annual compensation to the Marquette Pension Plan to continue accruing benefits. Participants in the Bell Pension Plan no longer accrue benefits. The Company makes contributions to the Pension Plans sufficient to meet its minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended.

Status and Expense

The following table presents the changes in the benefit obligations and plan assets of the Pension Plans during the years ended December 31, 2023 and 2022 and the unfunded liability of the Pension Plans at December 31, 2023 and 2022 (in millions):

	2023	2022
Change in benefit obligations:		
Benefit obligations at beginning of year	$ 55	$ 73
Service costs	-	1
Interest costs	3	2
Actuarial loss (gain)	3	(19)
Benefits paid	(3)	(2)
Benefit obligations at end of year	58	55
Change in plan assets:		
Fair value of plan assets at beginning of year	47	59
Actual return on plan assets	7	(11)
Employer contributions	-	1
Benefits and expenses paid	(3)	(2)
Fair value of plan assets at end of year	51	47
Unfunded pension benefit obligations	$ 7	$ 8

The Company recognizes changes in the funded status of the Pension Plans as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). For the years ended December 31, 2023 and 2022, the Company recognized comprehensive gains that were nominal and $4 million, respectively, as an increase in equity. These adjustments were primarily related to changes in the Company's unfunded pension liability due to changes in the discount rates and mortality assumptions used to measure the projected benefit obligation.

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligations as of December 31, 2023 and 2022 (in millions):

	2023	2022
Discount rate	4.9 %	5.1 %
Rate of compensation increases, when applicable	3.0 %	3.0 %

Plan Assets

At December 31, 2023, the Pension Plans' investments include a balance of mutual funds and money market funds in order to achieve an overall rate of return that minimizes the need for additional employer contributions. The Company measures the fair value of its Pension Plans' assets in accordance with ASC 820. The Pension Plans' investments in mutual funds are valued at the net asset value ("NAV") of shares reported in the active market in which the funds are traded. Because quoted prices are available for mutual funds and the markets in which they are traded are generally considered active, the Company has classified each of them as a Level 1 investment. The Pension Plans' investments in money market funds are valued at quoted prices in markets that are not active by a combination of inputs, including but not limited to dealer quotes who are market makers in the underlying funds and other directly and indirectly observable inputs. Because the inputs used to value money market funds are either directly or indirectly observable, but are not quoted prices in active markets, the Company has classified these assets as Level 2 investments. The Pension Plans' investments in pooled, common and collective funds are valued at the NAV of shares owned based on the readily determinable quoted market price that each fund publishes at the end of each day. While the underlying assets are actively traded on an exchange, the pooled, common and collective funds are not and, therefore, the Company has not classified these assets in the fair value hierarchy. No investment is classified as Level 3 as of December 31, 2023 and 2022.

The following table summarizes the assets of the Pension Plans, measured at fair value as of December 31, 2023 and 2022, by major asset category and aggregated by level within the fair value hierarchy (in millions):

	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	NAV
December 31, 2023:				
Mutual funds	$ 35	$ 35	$ -	$ -
Money market funds	1	-	1	-
Pooled, Common and Collective Funds	15	-	-	15
Total	$ 51	$ 35	$ 1	$ 15
December 31, 2022:				
Mutual funds	$ 32	$ 32	$ -	$ -
Money market funds	1	-	1	-
Pooled, Common and Collective Funds	14	-	-	14
Total	$ 47	$ 32	$ 1	$ -

The Company expects to make nominal contributions to the Pension Plans during the year ended December 31, 2024. Additionally, the Company expects to make future benefit payments from the Pension Plans as follows for the years indicated (in millions):

2024	$ 3
2025	3
2026	3
2027	4
2028	4
Five years thereafter	19
	$ 36

Multiemployer Pension Plan

The Company has the obligation to contribute to a multiemployer pension plan on behalf of certain employees covered by collective bargaining agreements, in accordance with the terms of such collective bargaining agreements. The Company's contributions to the multiemployer pension plan are determined based on the terms of the applicable collective bargaining agreements. Multiemployer plans are different from single-employer plans because assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers. Also, if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers. If the Company stops participating in the multiemployer plan, the Company may be required to pay a withdrawal liability based on its portion of the unfunded status of the plan. Currently, the Company does not anticipate ending its participation in this plan.

Defined Contribution Plans

During the year ended December 31, 2023, the Company maintained a defined contribution retirement plan covering a majority of its employees. This defined contribution plans contains discretionary matching contribution formulas and definite non-elective contribution formulas for employees at certain facilities. The Company's expense related to its defined contribution plans was $31 million, $28 million and $30 million for the years ended December 31, 2023, 2022 and 2021, respectively.

Deferred Compensation Plans

The Company maintains supplemental deferred compensation plans with respect to certain of its employees and affiliated physicians. As of December 31, 2023 and 2022, the assets associated with these deferred compensation plans were $51 million and $45 million, respectively, and the liabilities were $64 million and $56 million, respectively. These amounts are included under the captions "Other long-term assets" and "Other long-term liabilities", respectively, on the accompanying consolidated balance sheets at December 31, 2023 and 2022.

Note 12. Stock-Based Compensation

The Parent is authorized to issue Units to employees, executives, directors, and other service providers of the Company, under the terms and conditions of the Parent Partnership Agreement. The Company has determined that the Units are a substantive class of members' equity for accounting purposes because the Units are legal equity of the Parent, they have participation features, including distribution and liquidation rights, which allow them to participate in the residual returns of the Parent, and vested interests are retained upon termination, subject to certain repurchase rights. As a result, these awards are accounted for under ASC 718.

In June 2021, certain affiliates of the Parent completed the sale of the Parent, including the Company and its subsidiaries, to other affiliates of the Parent (the "Parent Transaction"). Following the Parent Transaction, the Company continues to be owned by affiliates of the Parent and the transaction had no business or operational impact on the Company. However, in connection with the Parent Transaction, all unvested and outstanding Units held by certain current employees, executives, and directors of the Company became vested. The Company has accounted for this event as a modification in accordance with ASC 718 and recognized additional stock-based compensation expense of $112 million during the nine months ended September 30, 2021 related to the modification and accelerated vesting of such Units. Additionally, for the nine months ended September 30, 2021, the Company made cash distributions to the Parent of $93 million to partially fund the Parent's repurchase of certain previously issued Units and capital units, primarily held by certain former employees, as well as certain current employees, executives, and directors of the Company.

Following the Parent Transaction, on June 25, 2021, an aggregate of 20,775,000 Units were granted to certain executives and employees of the Company under the Parent Partnership Agreement and a newly adopted equity incentive plan and an additional 1,000,000 Units were granted on September 28, 2021. Approximately 2,800,000 Units were granted in 2022 to certain executives, directors, and certain of our employees and our affiliates' employees.

Service Units

Service Units of Parent ("Service Units") have been granted to certain members of the Company's Board of Directors (the "Board"), and Tranche A Units of Parent ("Tranche A Units") have been granted to certain of our employees and executives and certain of our affiliates' employees. Service Units vest on a time-basis only, on the date that is the earliest of (i) six months and one day following grant date or (ii) the date of the applicable director's termination of service due to death, disability or as a result of the director's removal from the Board other than for cause. Tranche A Units vest in equal installments on the last day of each of the first twenty calendar quarters that commence on or after the grant date, subject to continued service. Service Units and Tranche A Units will automatically vest upon the sale of the Company. In the event of an initial public offering, all unvested Service Units and Tranche A Units will remain outstanding and continue to vest based on the stated vesting pattern. Unvested Service Units and Tranche A Units are forfeited upon a holder's termination of service. As of December 31, 2023, there were approximately 7.9 million outstanding Service Units, approximately 4.7 million of which are unvested.

Service Units and Tranche A Units are accounted for as equity awards and related compensation expense is recognized ratably over the vesting period. As of December 31, 2023, Service Units and Tranche A Units had unrecognized compensation expense of $15 million. The expense is expected to be recognized over a weighted-average period of 1.8 years from December 31, 2023.

Performance Units

Performance Units of Parent ("Performance Units") which have been granted as Tranche B Units and Tranche C Units of Parent, will vest based upon equity holders of the Parent realizing certain targeted multiples of invested capital ("MOIC thresholds"). Performance Units are accounted for as equity awards with expense recognition occurring upon the realization of the stated MOIC thresholds due to a liquidity event. Unvested Units that do not vest on termination are forfeited upon such termination, subject to certain conditions. As of December 31, 2023, there were approximately 15.3 million outstanding Performance Units, all of which are unvested.

The following table summarizes the Company's total stock-based compensation expense for the years ended December 31, 2023, 2022 and 2021 (in millions):

	2023	2022	2021
Service Units	$ 5	$ 5	$ 30
Performance Units	-	-	87
Total stock-based compensation expense	$ 5	$ 5	$ 117

Valuation Assumptions

The fair value of all Units was determined using a Monte Carlo simulation framework. The following table shows the weighted average assumptions used by the Company to develop the fair value estimates and the resulting estimates of weighted-average fair value per Unit granted during the years ended December 31, 2023, 2022 and 2021:

Common equity value of the Company (in millions)	$ 3,600
Expected volatility	63.1 %
Risk-free interest rate	0.92 %
Expected dividends	-
Average expected term (years)	5.0

Note 13. Commitments and Contingencies

Capital Expenditure Commitments

The Company is reconfiguring some of its facilities to more effectively accommodate patient services and to provide for a greater variety of services. The Company has incurred approximately $212 million in costs related to uncompleted projects as of December 31, 2023, which is included under the caption "Property and equipment, at cost" in the Company's accompanying consolidated balance sheet. At December 31, 2023, these uncompleted projects had an estimated cost to complete of approximately $138 million. The estimated timeframe for completion of these projects generally ranges from less than one year up to two years. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities. At December 31, 2023, the Company estimated its total remaining capital expenditure commitments to be approximately $540 million. The majority of this amount represents long-term commitments that are computed as a percentage of revenues at the applicable facility.

Legal Proceedings and General Liability Claims

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

In addition, the Company is subject to the regulation and oversight of various state and federal governmental agencies. Further, under the False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against healthcare facilities that submit false claims for payments to, or improperly retain identified overpayments from, governmental payers. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without the Company's knowledge. If a provider is found to be liable under the False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus substantial civil monetary penalties that are subject to annual adjustment for inflation for each separate false claim.

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

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

The Company accrues an estimate for a contingent liability when losses are both probable and reasonably estimable. The Company reviews its accruals each quarter and adjusts them to reflect the impact of developments, advice of legal counsel and other information pertaining to a particular matter.

Note 14. Subsequent Events

In accordance with the provisions of ASC 855, "Subsequent Events," the Company evaluated all material events subsequent to the balance sheet date through February 29, 2024, the date of issuance, for events requiring disclosure or recognition in the Company's consolidated financial statements. There were no subsequent events requiring disclosure or recognition in the Company's consolidated financial statements other than those included below or elsewhere in the notes to these consolidated financial statements.

Change Healthcare Systems Incident

The Company uses, directly or indirectly through its third-party vendors, information technology systems provided by Change Healthcare ("Change Systems") for various business and administrative support functions, including revenue cycle management. On February 21, 2024, the Company was notified by Change Healthcare of a cyber security incident impacting the Change Systems (the "Change Systems Incident"), and the Company's access to such systems was disabled. As of the date of this Report, Change Healthcare has not provided an estimated timeframe for resuming functionality of the Change Systems. The Company's management continues to work directly with Change Healthcare, its third-party vendors, and other parties to identify and implement solutions intended to minimize the operational and financial impact to the Company caused by the Change Systems Incident. The Company has implemented, and plans to continue to implement, alternative systems where available to help mitigate the potential impact of delays in the timing of remittances from payors. While the Change Systems Incident has yet to be resolved, to date, it has not adversely impacted patient care at the Company's facilities, and the Company does not expect it will have a material impact on its business, financial condition or results of operations. However, the Company cannot predict the ultimate outcome of the Change Systems Incident and whether its efforts to minimize its impact will be successful.

Item 16. ***Form 10-K Summary*****.**

None.

SIGNATURE

Lifepoint Health, Inc. has caused this Report to be signed on its behalf by the undersigned thereunto duly authorized.

LIFEPOINT HEALTH, INC.

Date: February 29, 2024

By: /s/ Michael S. Coggin
Michael S. Coggin
Executive Vice President and Chief Financial Officer

3-year Recruitment Plan - Growth

Start Year	Specialty	FTE Needs	Commentary/Notes
2024	OB/GYN	1	• ORHC has no full-time OB/GYNs, we currently utilize 1099 contracted providers
2025	Internal Medicine	2	• PSA shows a need of 11.4 FTE's • ORHC has 4 Family medicine providers and currently no Internal Medicine providers
2025	Orthopedic APP	1	• Second Ortho begins late fall of 2024 • As ramp up continues, APP will be needed
2025	General Surgeon	1	• Continuing growth of service line.
2025	OB/GYN	1	• ORHC will have 1 full time OB/GYN by 2025 • Need 2 full-time physicians to maintain service line
2026	Internal Medicine	1	• Continuing growth of IM service line • Demand will continue to outpace access

3-year Recruitment Plan - Backfill

Provider Name	Specialty	FTE	Employed or Affiliate	Expected Departure Date / Year	Reason for Departure	Near-term Mitigation Plan (including other physicians)
[redacted]	Gen.Surg.	1	Employed	9/19/2024	Resignation	• Utilizing Locums while recruiting • Negotiating with Gen. Surg. regional practice for contract

Lifepoint Health

Med Staff Development

Primary Care & Medicine Provider Employment

Adjustment Reasons:
- Demand too low, area can support additional physicians
- Demand too high, area has sufficient physicians
- Service patients outside of area
- Other (please provide notes)

Specialty	PSA Physician Supply	PSA Physician Demand	Demand Adjustment FTE	PSA Net Need	Adjustment Reason	Adjustment Notes
Family/General Practice	14.4	13.9		(0.5)		
Internal Medicine	4.6	15.9	2.0	11.2	Area can support additional physicians	
Pediatrics	4.9	6.8		2.0	Area needs mostly covered by local FQHC and independent providers	
Primary Care	**23.9**	**36.6**	**0.0**	**12.7**		
Allergy/Immunology	1.1	0.4		(0.6)		
Cardiology	5.2	2.3		(2.9)	Need additional cardiologists to meet area demand, [redacted]	
Dermatology	1.0	1.5		0.6		
Endocrinology	0.1	0.4		0.4		
Hematology/Oncology	1.5	1.3		(0.2)		
Infectious Disease	0.2	0.5		0.3		
Nephrology	1.5	0.6		(0.9)		
Neurology	1.8	1.8		0.0		
OB-GYN	4.4	5.5	2	1.0	Area can support additional physician	
Pulmonology	0.2	0.8		0.5		
Radiation Oncology	0.0	0.7		0.7		
Rheumatology	1.0	0.4		(0.6)		
Medicine	**17.9**	**16.3**	**0.0**	**(1.6)**		
Psychiatry	**3.5**	**3.1**	**0.0**	**(0.4)**	Utilizing contract service to fill needs	

Note that the Physician Supply and the Demand do not include APP's

Med Staff Development

Surgery

Provider Employment

Adjustment Reasons:
- Demand too low, area can support additional physicians
- Demand too high, area has sufficient physicians
- Service patients outside of area
- Other (please provide notes)

Specialty	PSA Physician Supply	PSA Physician Demand	Demand Adjustment FTE	PSA Net Need	Adjustment Reason	Adjustment Notes
ENT	0.3	1.8		1.5		
Gastroenterology	1.0	1.9		1.0		
General Surgery	3.0	4.1	1	1.0	Area can support additional physician	Needed support for increased ER Call support
Neurosurgery	0.0	0.6		0.6		
Ophthalmology	2.9	2.5		(0.4)		
Orthopedics	2.3	3.3		1.0	1 FT Ortho signed and will start 11/24	
Plastic Surgery	0.1	0.6		0.5		
Thoracic Surgery	0.4	0.4		0.0		
Urology	1.4	1.7		0.3	Demand met, new services being introduced to community and to state	
Vascular Surgery	0.6	0.7		0.1		
Surgical Total	**12.1**	**17.7**	**0.0**	**5.6**		

Note that the Physician Supply and the Demand do not include APP's

Lifepoint Health

OTTUMWA REGIONAL HEALTH CENTER
BALANCE SHEET
AS OF: 12/31/11

	THIS YEAR 12/31/11	LAST YEAR 12/31/10	LAST MONTH 11/30/11
ASSETS			
CASH AND SHORT TERM INVESTMENTS	147,069.85	1,841,645.83	909,142.69
PATIENT ACCOUNTS RECEIVABLE	20,329,642.31	27,916,153.40	20,743,916.60
RESERVES FOR CONTRACTUAL ALLOWANC	(7,823,632.41)	(11,415,792.98)	(7,489,529.49)
ALLOWANCE FOR UNCOLLECTIBLES	(4,830,945.10)	(5,272,825.48)	(4,982,333.39)
OTHER RECEIVABLES	262,453.12	861,046.25	259,894.50
INVENTORIES	2,140,366.80	2,061,589.22	2,124,931.24
PREPAID EXPENSES	538,932.56	343,839.88	452,808.72
DUE FROM AFFILIATES	664,832.29	405,339.86	651,910.36
INVESTMENTS IN JOINT VENTURES	245,867.42	2,641,132.85	245,867.42
GOODWILL & INTANGIBLES	16,619,571.33	12,225,420.38	16,690,526.00
PROPERTY, PLANT AND EQUIPMENT	60,261,478.99	51,630,039.39	59,134,657.03
CWIP	357,895.71	9,248.00	64,768.62
ACCUMULATED DEPRECIATION	(8,042,484.79)	(3,364,166.20)	(7,747,124.76)
TOTAL ASSETS	80,871,048.08	79,882,670.40	81,059,435.54
LIABILITIES			
ACCOUNTS PAYABLE	1,891,329.77	1,676,856.44	1,799,576.49
CURRENT PORTION OF LT DEBT	502,463.46	523,380.76	542,667.10
CURRENT PORTION OF LT DEBT	103,702.17	.00	99,683.13
CURRENT PORTION OF LT DEBT	161,129.41	.00	.00
SALARIES, BENEFITS & PAYROLL TAXE	1,230,770.51	2,043,809.43	994,965.76
VESTED EMPLOYEE BENEFITS PAYABLE	845,653.55	1,253,449.29	943,434.79
SETTLEMENTS PAYABLE	(273,641.25)	(250,506.68)	(792,425.86)
OTHER ACCRUED LIABILITIES	2,159,218.87	1,370,845.67	1,879,583.55
PHYSICIAN RECRUITMENT INTANGIBLES	148,295.21	.00	184,394.79
INTERCOMPANY ACCOUNTS	202,973.24	4,933,655.82	1,495,969.17
LONG TERM DEBT & CAPITAL LEASES	63,431,146.03	59,862,629.88	62,716,974.13
EQUITY	10,964,758.00	10,964,758.00	10,964,758.00
UNALLOCATED PURCHASE PRICE	(2,496,208.21)	(2,496,208.21)	(2,496,208.21)
YEAR TO DATE NET INCOME	1,999,457.32	.00	2,726,062.70
TOTAL LIABILITIES AND FUND BALANCE	80,871,048.08	79,882,670.40	81,059,435.54

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/12

	ACTUAL 12/31/12	YTD 12/31/12
ASSETS		
CURRENT ASSETS:		
CASH AND EQUIVALENTS	2,268,973.72	1,034,138.59
ACCOUNTS RECEIVABLE:		
ACCOUNTS RECEIVABLE	895,944.63	34,496,589.61
ALLOW FOR C/A	(552,958.10)	(12,398,814.76)
NET PATIENT RECEIVABLES	342,986.53	22,097,774.85
ALLOWANCE FOR BAD DEBTS	(595,173.23)	(12,197,035.24)
TOTAL RECEIVABLES, NET	(252,186.70)	9,900,739.61
OTHER CURRENT ASSETS	(198,776.32)	(1,439,753.01)
INVENTORY	(131,021.59)	2,564,229.38
PREPAIDS	79,781.45	1,250,779.82
TOTAL CURRENT ASSETS	1,766,770.56	13,310,134.39
PROPERTY, PLANTS, EQUIPMENT:		
LAND AND IMPROVEMENTS	0.00	3,662,665.84
BUILDINGS	4,615.45	45,387,885.88
EQUIPMENT	243,903.65	18,204,794.58
CIP	155,549.27	1,497,502.88
TOTAL PROPERTY, PLANTS AND EQUIPMENT	404,068.37	68,752,849.18
ACCUMULATED DEPRECIATION	(422,221.71)	(13,306,568.33)
PROPERTY, PLANT, EQUIPMENT	(18,153.34)	55,446,280.85
OTHER ASSETS:		
GOODWILL	0.00	16,428,255.49
INTANGIBLE ASSETS	(70,177.73)	59,202.40
OTHER LONG TERM ASSETS		
OTHER ASSETS	0.00	377,251.42
TOTAL OTHER ASSETS	(70,177.73)	16,864,709.31
TOTAL ASSETS	1,678,439.49	85,621,124.55

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/12

	ACTUAL 12/31/12	YTD 12/31/12
CURRENT LIABILITIES		
TOTAL ACCOUNTS PAYABLE	245,850.94	2,937,783.42
ACCRUED SALARIES AND BENEFITS	164,655.91	2,740,112.77
ACR EXP & OTH CUR LIA	25,112.57	2,236,877.43
CURRENT PORTION LT DEBT	0.00	100,000.00
CURRENT PORTION OF CAP LEASE	0.00	0.00
TOTAL CURRENT LIABILITES	435,619.42	8,014,773.62
INTERCOMPANY PAYABLES/RECEIVBL	1,425,635.77	62,807,845.51
NON CURRENT LIABILITIES		
OTHER NON CURRENT LIABILITIES	189,506.79	426,810.47
CAPITAL LEASE LONG TERM	(69,637.24)	4,027,094.80
OTHER LONG TERM LIABILTY	0.00	0.00
TOTAL NON-CURR LIABILITIES	119,869.55	4,453,905.27
TOTAL LIABILITIES	1,981,124.74	75,276,524.40
RETAINED EARNINGS	565,636.64	(2,096,680.16)
TOTAL RETAINED EARNINGS	565,636.64	(2,096,680.16)
CURRENT YEAR - NET INCOME	(868,321.89)	12,441,280.31
TOTAL STOCK HOLDER EQUITY	(302,685.25)	10,344,600.15
TOTAL LIABLITIES AND STOCKHOLDERS' EQUITY	1,678,439.49	85,621,124.55

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/13

	ACTUAL 12/31/13	YTD 12/31/13
ASSETS		
CURRENT ASSETS:		
CASH AND EQUIVALENTS	458,567.62	1,433,601.97
ACCOUNTS RECEIVABLE:		
ACCOUNTS RECEIVABLE	(4,024,658.35)	46,143,048.44
ALLOW FOR C/A	1,270,641.10	(17,582,132.20)
NET PATIENT RECEIVABLES	(2,754,017.25)	28,560,916.24
ALLOWANCE FOR BAD DEBTS	2,126,445.82	(16,513,329.58)
TOTAL RECEIVABLES, NET	(627,571.43)	12,047,586.66
OTHER CURRENT ASSETS	211,770.51	(744,116.43)
INVENTORY	(281,327.09)	2,526,678.50
PREPAIDS	27,518.09	1,020,276.32
TOTAL CURRENT ASSETS	(211,042.30)	16,284,027.02
PROPERTY, PLANTS, EQUIPMENT:		
LAND AND IMPROVEMENTS	253,651.78	3,916,317.62
BUILDINGS	239,987.00	45,732,956.75
EQUIPMENT	1,704,273.01	24,265,933.08
CIP	(1,884,072.45)	1,201,054.73
TOTAL PROPERTY, PLANTS AND EQUIPMENT	313,839.34	75,116,262.18
ACCUMULATED DEPRECIATION	(617,483.09)	(18,729,704.94)
PROPERTY, PLANT, EQUIPMENT	(303,643.75)	56,386,557.24
OTHER ASSETS:		
GOODWILL	0.00	16,428,255.49
INTANGIBLE ASSETS	(32,910.40)	0.00
OTHER LONG TERM ASSETS		
OTHER ASSETS	0.00	377,251.42
TOTAL OTHER ASSETS	(32,910.40)	16,805,506.91
TOTAL ASSETS	(547,596.45)	89,476,091.17

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/13

	ACTUAL 12/31/13	YTD 12/31/13
CURRENT LIABILITIES		
TOTAL ACCOUNTS PAYABLE	1,255,280.13	4,066,416.47
ACCRUED SALARIES AND BENEFITS	933,152.58	2,957,875.59
ACR EXP & OTH CUR LIA	419,864.09	2,115,043.28
CURRENT PORTION LT DEBT	0.00	62,500.00
CURRENT PORTION OF CAP LEASE	2,315.24	316,769.26
TOTAL CURRENT LIABILITES	2,610,612.04	9,518,604.60
INTERCOMPANY PAYABLES/RECEIVBL	(1,611,168.98)	74,626,641.29
NON CURRENT LIABILITIES		
OTHER NON CURRENT LIABILITIES	135,647.68	175,000.00
CAPITAL LEASE LONG TERM	(17,633.55)	3,420,445.96
OTHER LONG TERM LIABILTY	0.00	0.00
TOTAL NON-CURR LIABILITIES	118,014.13	3,595,445.96
TOTAL LIABILITIES	1,117,457.19	87,740,691.85
RETAINED EARNINGS	(8,609,190.88)	(10,845,844.21)
TOTAL RETAINED EARNINGS	(8,609,190.88)	(10,845,844.21)
CURRENT YEAR - NET INCOME	6,944,137.24	12,581,243.53
TOTAL STOCK HOLDER EQUITY	(1,665,053.64)	1,735,399.32
TOTAL LIABLITIES AND STOCKHOLDERS' EQUITY	(547,596.45)	89,476,091.17

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/14

	ACTUAL 12/31/14	YTD 12/31/14
ASSETS		
CURRENT ASSETS:		
CASH AND EQUIVALENTS	(240,131.81)	1,075,547.79
ACCOUNTS RECEIVABLE:		
ACCOUNTS RECEIVABLE	402,313.52	39,775,190.60
ALLOW FOR C/A	(368,867.35)	(17,367,018.65)
NET PATIENT RECEIVABLES	33,446.17	22,408,171.95
ALLOWANCE FOR BAD DEBTS	(296,519.94)	(12,201,578.83)
TOTAL RECEIVABLES, NET	(263,073.77)	10,206,593.12
OTHER CURRENT ASSETS	182,432.08	237,195.10
INVENTORY	(56,080.37)	2,448,624.76
PREPAIDS	(124,136.32)	702,873.84
TOTAL CURRENT ASSETS	(500,990.19)	14,670,834.61
PROPERTY, PLANTS, EQUIPMENT:		
LAND AND IMPROVEMENTS	0.00	3,928,667.62
BUILDINGS	24,858.30	49,642,317.90
EQUIPMENT	166,816.01	25,684,246.73
CIP	418,025.31	529,166.18
TOTAL PROPERTY, PLANTS AND EQUIPMENT	609,699.62	79,784,398.43
ACCUMULATED DEPRECIATION	(485,251.40)	(24,416,709.92)
PROPERTY, PLANT, EQUIPMENT	124,448.22	55,367,688.51
OTHER ASSETS:		
GOODWILL	0.00	16,420,975.49
INTANGIBLE ASSETS	0.00	0.00
OTHER LONG TERM ASSETS		
OTHER ASSETS	0.00	245,867.42
TOTAL OTHER ASSETS	0.00	16,666,842.91
TOTAL ASSETS	(376,541.97)	86,705,366.03

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/14

	ACTUAL 12/31/14	YTD 12/31/14
CURRENT LIABILITIES		
TOTAL ACCOUNTS PAYABLE	1,109,241.60	4,142,332.33
ACCRUED SALARIES AND BENEFITS	223,504.85	2,974,649.40
ACR EXP & OTH CUR LIA	156,603.78	2,012,401.07
CURRENT PORTION LT DEBT	168.95	97,563.16
CURRENT PORTION OF CAP LEASE	2,484.29	345,627.48
TOTAL CURRENT LIABILITES	1,492,003.47	9,572,573.44
INTERCOMPANY PAYABLES/RECEIVBL	(1,242,654.57)	82,506,562.71
NON CURRENT LIABILITIES		
OTHER NON CURRENT LIABILITIES	0.00	175,000.00
CAPITAL LEASE LONG TERM	(32,991.09)	3,214,920.51
OTHER LONG TERM LIABILTY	0.00	0.00
TOTAL NON-CURR LIABILITIES	(32,991.09)	3,389,920.51
TOTAL LIABILITIES	216,357.81	95,469,056.66
RETAINED EARNINGS	(8,272,499.31)	(21,590,801.58)
TOTAL RETAINED EARNINGS	(8,272,499.31)	(21,590,801.58)
CURRENT YEAR - NET INCOME	7,679,599.53	12,827,110.95
TOTAL STOCK HOLDER EQUITY	(592,899.78)	(8,763,690.63)
TOTAL LIABLITIES AND STOCKHOLDERS' EQUITY	(376,541.97)	86,705,366.03

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/15

	ACTUAL 12/31/15	YTD 12/31/15
ASSETS		
CURRENT ASSETS:		
CASH AND EQUIVALENTS	127,953.36	(494,493.10)
ACCOUNTS RECEIVABLE:		
ACCOUNTS RECEIVABLE	(712,388.42)	38,950,651.16
ALLOW FOR C/A	887,783.67	(15,654,670.48)
NET PATIENT RECEIVABLES	175,395.25	23,295,980.68
ALLOWANCE FOR BAD DEBTS	(176,683.04)	(13,832,753.89)
TOTAL RECEIVABLES, NET	(1,287.79)	9,463,226.79
OTHER CURRENT ASSETS	21,482.56	255,572.95
INVENTORY	(41,159.10)	2,444,521.90
PREPAIDS	(56,436.10)	481,630.08
TOTAL CURRENT ASSETS	50,552.93	12,150,458.62
PROPERTY, PLANTS, EQUIPMENT:		
LAND AND IMPROVEMENTS	5,039.88	4,051,125.14
BUILDINGS	559,827.69	50,493,460.07
EQUIPMENT	70,360.31	27,526,085.32
CIP	(564,567.69)	44,550.34
TOTAL PROPERTY, PLANTS AND EQUIPMENT	70,660.19	82,115,220.87
ACCUMULATED DEPRECIATION	(456,388.49)	(30,301,406.32)
PROPERTY, PLANT, EQUIPMENT	(385,728.30)	51,813,814.55
OTHER ASSETS:		
GOODWILL	0.00	16,420,975.49
INTANGIBLE ASSETS	0.00	0.00
OTHER LONG TERM ASSETS		
OTHER ASSETS	0.00	245,867.42
TOTAL OTHER ASSETS	0.00	16,666,842.91
TOTAL ASSETS	(335,175.37)	80,631,116.08

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/15

	ACTUAL 12/31/15	YTD 12/31/15
CURRENT LIABILITIES		
TOTAL ACCOUNTS PAYABLE	364,762.06	3,783,746.64
ACCRUED SALARIES AND BENEFITS	(554,556.82)	2,601,006.51
ACR EXP & OTH CUR LIA	110,939.60	2,159,477.64
CURRENT PORTION LT DEBT	114.80	99,598.11
CURRENT PORTION OF CAP LEASE	4,063.67	376,587.73
TOTAL CURRENT LIABILITES	(74,676.69)	9,020,416.63
INTERCOMPANY PAYABLES/RECEIVBL	148,233.19	81,210,854.74
NON CURRENT LIABILITIES		
OTHER NON CURRENT LIABILITIES	0.00	175,000.00
CAPITAL LEASE LONG TERM	(35,771.60)	2,801,234.70
OTHER LONG TERM LIABILTY	0.00	0.00
TOTAL NON-CURR LIABILITIES	(35,771.60)	2,976,234.70
TOTAL LIABILITIES	37,784.90	93,207,506.07
RETAINED EARNINGS	(3,812,699.36)	(25,403,500.94)
TOTAL RETAINED EARNINGS	(3,812,699.36)	(25,403,500.94)
CURRENT YEAR - NET INCOME	3,439,739.09	12,827,110.95
TOTAL STOCK HOLDER EQUITY	(372,960.27)	(12,576,389.99)
TOTAL LIABLITIES AND STOCKHOLDERS' EQUITY	(335,175.37)	80,631,116.08

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/16

	ACTUAL 12/31/16	YTD 12/31/16
ASSETS		
CURRENT ASSETS:		
CASH AND EQUIVALENTS	(586,799.96)	(975,399.61)
ACCOUNTS RECEIVABLE:		
ACCOUNTS RECEIVABLE	(2,025,282.17)	40,962,697.27
ALLOW FOR C/A	395,267.70	(18,562,444.74)
NET PATIENT RECEIVABLES	(1,630,014.47)	22,400,252.53
ALLOWANCE FOR BAD DEBTS	1,260,205.09	(11,146,974.83)
TOTAL RECEIVABLES, NET	(369,809.38)	11,253,277.70
OTHER CURRENT ASSETS	(9,955.19)	133,475.84
INVENTORY	116,218.98	2,327,708.96
PREPAIDS	39,479.08	712,474.13
TOTAL CURRENT ASSETS	(810,866.47)	13,451,537.02
PROPERTY, PLANTS, EQUIPMENT:		
LAND AND IMPROVEMENTS	0.00	2,204,042.25
BUILDINGS	15,864.25	45,464,676.41
EQUIPMENT	464,340.24	11,278,776.71
CIP	0.00	136,039.65
TOTAL PROPERTY, PLANTS AND EQUIPMENT	480,204.49	59,083,535.02
ACCUMULATED DEPRECIATION	(396,375.53)	(5,004,568.33)
PROPERTY, PLANT, EQUIPMENT	83,828.96	54,078,966.69
OTHER ASSETS:		
GOODWILL	0.00	0.00
INTANGIBLE ASSETS	0.00	0.00
OTHER LONG TERM ASSETS		
OTHER ASSETS	0.00	0.00
TOTAL OTHER ASSETS	0.00	0.00
TOTAL ASSETS	(727,037.51)	67,530,503.71

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/16

	ACTUAL 12/31/16	YTD 12/31/16
CURRENT LIABILITIES		
TOTAL ACCOUNTS PAYABLE	552,535.89	4,017,849.94
ACCRUED SALARIES AND BENEFITS	(668,842.86)	2,687,582.26
ACR EXP & OTH CUR LIA	194,187.71	2,016,895.13
CURRENT PORTION LT DEBT	190.45	39,388.57
CURRENT PORTION OF CAP LEASE	2,010.23	220,254.04
TOTAL CURRENT LIABILITES	80,081.42	8,981,969.94
INTERCOMPANY PAYABLES/RECEIVBL	(884,307.89)	58,855,724.32
NON CURRENT LIABILITIES		
OTHER NON CURRENT LIABILITIES	0.00	0.00
CAPITAL LEASE LONG TERM	(21,303.32)	2,558,261.05
OTHER LONG TERM LIABILTY	0.00	0.00
TOTAL NON-CURR LIABILITIES	(21,303.32)	2,558,261.05
TOTAL LIABILITIES	(825,529.79)	70,395,955.31
RETAINED EARNINGS	(2,672,356.01)	(2,865,451.60)
TOTAL RETAINED EARNINGS	(2,672,356.01)	(2,865,451.60)
CURRENT YEAR - NET INCOME	2,770,848.29	0.00
TOTAL STOCK HOLDER EQUITY	98,492.28	(2,865,451.60)
TOTAL LIABLITIES AND STOCKHOLDERS' EQUITY	(727,037.51)	67,530,503.71

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/17

	ACTUAL 12/31/17	YTD 12/31/17
ASSETS		
CURRENT ASSETS:		
CASH AND EQUIVALENTS	30,913.16	(1,307,915.26)
ACCOUNTS RECEIVABLE:		
ACCOUNTS RECEIVABLE	(915,230.95)	44,142,548.11
ALLOW FOR C/A	840,986.34	(20,396,617.55)
NET PATIENT RECEIVABLES	(74,244.61)	23,745,930.56
ALLOWANCE FOR BAD DEBTS	(863,107.25)	(12,377,005.29)
TOTAL RECEIVABLES, NET	(937,351.86)	11,368,925.27
OTHER CURRENT ASSETS	(23,095.75)	370,524.99
INVENTORY	131,627.55	2,527,848.96
PREPAIDS	(224.32)	894,896.79
TOTAL CURRENT ASSETS	(798,131.22)	13,854,280.75
PROPERTY, PLANTS, EQUIPMENT:		
LAND AND IMPROVEMENTS	0.00	2,217,522.25
BUILDINGS	9,955.55	45,562,027.17
EQUIPMENT	1,788,660.89	14,061,503.33
CIP	0.00	259,731.66
TOTAL PROPERTY, PLANTS AND EQUIPMENT	1,798,616.44	62,100,784.41
ACCUMULATED DEPRECIATION	(405,162.55)	(9,875,419.56)
PROPERTY, PLANT, EQUIPMENT	1,393,453.89	52,225,364.85
OTHER ASSETS:		
GOODWILL	0.00	0.00
INTANGIBLE ASSETS	0.00	0.00
OTHER LONG TERM ASSETS		
OTHER ASSETS	0.00	0.00
TOTAL OTHER ASSETS	0.00	0.00
TOTAL ASSETS	595,322.67	66,079,645.60

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/17

	ACTUAL 12/31/17	YTD 12/31/17
CURRENT LIABILITIES		
TOTAL ACCOUNTS PAYABLE	428,814.08	4,724,174.19
ACCRUED SALARIES AND BENEFITS	(291,816.36)	2,496,985.67
ACR EXP & OTH CUR LIA	108,383.87	1,984,719.93
CURRENT PORTION LT DEBT	201.85	41,747.44
CURRENT PORTION OF CAP LEASE	2,173.19	228,677.10
TOTAL CURRENT LIABILITES	247,756.63	9,476,304.33
INTERCOMPANY PAYABLES/RECEIVBL	1,313,744.07	60,972,328.82
NON CURRENT LIABILITIES		
OTHER NON CURRENT LIABILITIES	0.00	0.00
CAPITAL LEASE LONG TERM	(23,678.34)	2,287,836.51
OTHER LONG TERM LIABILTY	27,304.66	43,546.50
TOTAL NON-CURR LIABILITIES	3,626.32	2,331,383.01
TOTAL LIABILITIES	1,565,127.02	72,780,016.16
RETAINED EARNINGS	(3,834,918.96)	(6,700,370.56)
TOTAL RETAINED EARNINGS	(3,834,918.96)	(6,700,370.56)
CURRENT YEAR - NET INCOME	2,865,114.61	0.00
TOTAL STOCK HOLDER EQUITY	(969,804.35)	(6,700,370.56)
TOTAL LIABLITIES AND STOCKHOLDERS' EQUITY	595,322.67	66,079,645.60

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/18

	ACTUAL 12/31/18	YTD 12/31/18
ASSETS		
CURRENT ASSETS:		
CASH AND EQUIVALENTS	1,970,777.26	585,383.54
ACCOUNTS RECEIVABLE:		
ACCOUNTS RECEIVABLE	(972,307.67)	43,541,285.89
ALLOW FOR C/A	167,631.34	(20,732,040.44)
NET PATIENT RECEIVABLES	(804,676.33)	22,809,245.45
ALLOWANCE FOR BAD DEBTS	123,368.62	(11,448,847.34)
TOTAL RECEIVABLES, NET	(681,307.71)	11,360,398.11
OTHER CURRENT ASSETS	(125,954.86)	199,621.64
INVENTORY	126,622.83	2,741,035.79
PREPAIDS	(67,298.27)	875,460.43
TOTAL CURRENT ASSETS	1,222,839.25	15,761,899.51
PROPERTY, PLANTS, EQUIPMENT:		
LAND AND IMPROVEMENTS	0.00	2,127,522.25
BUILDINGS	80,412.89	45,634,197.51
EQUIPMENT	324,841.25	15,950,099.97
CIP	(108,971.16)	160,850.74
TOTAL PROPERTY, PLANTS AND EQUIPMENT	296,282.98	63,872,670.47
ACCUMULATED DEPRECIATION	(416,550.30)	(14,600,710.85)
PROPERTY, PLANT, EQUIPMENT	(120,267.32)	49,271,959.62
OTHER ASSETS:		
GOODWILL	0.00	0.00
INTANGIBLE ASSETS	0.00	0.00
OTHER LONG TERM ASSETS		
OTHER ASSETS	0.00	800,000.00
TOTAL OTHER ASSETS	0.00	800,000.00
TOTAL ASSETS	1,102,571.93	65,833,859.13

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/18

	ACTUAL 12/31/18	YTD 12/31/18
CURRENT LIABILITIES		
TOTAL ACCOUNTS PAYABLE	1,096,311.68	4,920,891.64
ACCRUED SALARIES AND BENEFITS	367,960.86	2,610,454.13
ACR EXP & OTH CUR LIA	176,555.58	1,726,786.61
CURRENT PORTION LT DEBT	(3,572.44)	21,803.05
CURRENT PORTION OF CAP LEASE	2,347.89	255,864.60
TOTAL CURRENT LIABILITES	1,639,603.57	9,535,800.03
INTERCOMPANY PAYABLES/RECEIVBL	(371,755.38)	61,093,464.61
NON CURRENT LIABILITIES		
OTHER NON CURRENT LIABILITIES	0.00	0.00
CAPITAL LEASE LONG TERM	(22,453.81)	2,010,168.86
OTHER LONG TERM LIABILTY	(967.70)	31,934.10
TOTAL NON-CURR LIABILITIES	(23,421.51)	2,042,102.96
TOTAL LIABILITIES	1,244,426.68	72,671,367.60
RETAINED EARNINGS	(137,137.91)	(6,837,508.47)
TOTAL RETAINED EARNINGS	(137,137.91)	(6,837,508.47)
CURRENT YEAR - NET INCOME	(4,716.84)	0.00
TOTAL STOCK HOLDER EQUITY	(141,854.75)	(6,837,508.47)
TOTAL LIABLITIES AND STOCKHOLDERS' EQUITY	1,102,571.93	65,833,859.13

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/19

	ACTUAL 12/31/19	YTD 12/31/19
ASSETS		
CURRENT ASSETS:		
CASH AND EQUIVALENTS	2,133,660.66	228,435.13
ACCOUNTS RECEIVABLE:		
ACCOUNTS RECEIVABLE	(2,239,769.69)	42,731,073.96
ALLOW FOR C/A	2,044,714.67	(19,510,622.41)
NET PATIENT RECEIVABLES	(195,055.02)	23,220,451.55
ALLOWANCE FOR BAD DEBTS	(429,741.17)	(10,223,983.66)
TOTAL RECEIVABLES, NET	(624,796.19)	12,996,467.89
OTHER CURRENT ASSETS	181,719.28	298,781.17
INVENTORY	309,378.49	3,158,973.90
PREPAIDS	142,374.69	873,108.72
TOTAL CURRENT ASSETS	2,142,336.93	17,555,766.81
PROPERTY, PLANTS, EQUIPMENT:		
LAND AND IMPROVEMENTS	0.00	2,239,935.45
BUILDINGS	150,185.01	46,259,995.52
EQUIPMENT	256,484.12	17,060,054.74
CIP	10,586.63	73,665.10
TOTAL PROPERTY, PLANTS AND EQUIPMENT	417,255.76	65,633,650.81
ACCUMULATED DEPRECIATION	(418,427.76)	(19,417,791.19)
PROPERTY, PLANT, EQUIPMENT	(1,172.00)	46,215,859.62
OTHER ASSETS:		
GOODWILL	0.00	0.00
INTANGIBLE ASSETS	0.00	0.00
OTHER LONG TERM ASSETS		
OTHER ASSETS	0.00	800,000.00
TOTAL OTHER ASSETS	0.00	800,000.00
TOTAL ASSETS	2,141,164.93	64,571,626.43

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/19

	ACTUAL 12/31/19	YTD 12/31/19
CURRENT LIABILITIES		
TOTAL ACCOUNTS PAYABLE	783,919.29	4,519,840.05
ACCRUED SALARIES AND BENEFITS	236,042.62	3,108,872.68
ACR EXP & OTH CUR LIA	46,790.54	1,595,624.65
CURRENT PORTION LT DEBT	0.00	0.00
CURRENT PORTION OF CAP LEASE	2,535.18	285,229.07
TOTAL CURRENT LIABILITES	1,069,287.63	9,509,566.45
INTERCOMPANY PAYABLES/RECEIVBL	969,170.91	58,651,617.63
NON CURRENT LIABILITIES		
OTHER NON CURRENT LIABILITIES	0.00	0.00
CAPITAL LEASE LONG TERM	(24,988.99)	1,724,939.79
OTHER LONG TERM LIABILTY	(967.70)	20,321.70
TOTAL NON-CURR LIABILITIES	(25,956.69)	1,745,261.49
TOTAL LIABILITIES	2,012,501.85	69,906,445.57
RETAINED EARNINGS	1,502,689.33	(5,334,819.14)
TOTAL RETAINED EARNINGS	1,502,689.33	(5,334,819.14)
CURRENT YEAR - NET INCOME	(1,374,026.25)	0.00
TOTAL STOCK HOLDER EQUITY	128,663.08	(5,334,819.14)
TOTAL LIABLITIES AND STOCKHOLDERS' EQUITY	2,141,164.93	64,571,626.43

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/20

	ACTUAL 12/31/20	YTD 12/31/20
ASSETS		
CURRENT ASSETS:		
CASH AND EQUIVALENTS	(135,921.39)	(900,417.07)
ACCOUNTS RECEIVABLE:		
ACCOUNTS RECEIVABLE	(363,358.39)	41,863,827.72
ALLOW FOR C/A	1,073,556.16	(19,126,690.96)
NET PATIENT RECEIVABLES	710,197.77	22,737,136.76
ALLOWANCE FOR BAD DEBTS	2,036,399.00	(8,719,656.04)
TOTAL RECEIVABLES, NET	2,746,596.77	14,017,480.72
OTHER CURRENT ASSETS	57,537.98	(49,229.31)
INVENTORY	120,195.05	3,417,207.76
PREPAIDS	267,485.06	872,287.67
TOTAL CURRENT ASSETS	3,055,893.47	17,357,329.77
PROPERTY, PLANTS, EQUIPMENT:		
LAND AND IMPROVEMENTS	0.00	1,469,790.45
BUILDINGS	35,402.78	50,939,543.23
EQUIPMENT	771,980.00	17,897,320.01
CIP	58,728.51	401,107.19
TOTAL PROPERTY, PLANTS AND EQUIPMENT	866,111.29	70,707,760.88
ACCUMULATED DEPRECIATION	(953,126.41)	(24,441,579.09)
PROPERTY, PLANT, EQUIPMENT	(87,015.12)	46,266,181.79
OTHER ASSETS:		
GOODWILL	0.00	0.00
INTANGIBLE ASSETS	0.00	0.00
OTHER LONG TERM ASSETS		
OTHER ASSETS	0.00	0.00
TOTAL OTHER ASSETS	0.00	0.00
TOTAL ASSETS	2,968,878.35	63,623,511.56

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/20

	ACTUAL 12/31/20	YTD 12/31/20
CURRENT LIABILITIES		
TOTAL ACCOUNTS PAYABLE	634,593.53	4,752,745.49
ACCRUED SALARIES AND BENEFITS	255,399.08	3,321,715.43
ACR EXP & OTH CUR LIA	(3,908,144.80)	12,768,345.15
CURRENT PORTION LT DEBT	0.00	0.00
CURRENT PORTION OF CAP LEASE	4,545.82	812,360.94
TOTAL CURRENT LIABILITES	(3,013,606.37)	21,655,167.01
INTERCOMPANY PAYABLES/RECEIVBL	2,549,008.56	40,410,788.51
NON CURRENT LIABILITIES		
OTHER NON CURRENT LIABILITIES	0.00	0.00
CAPITAL LEASE LONG TERM	(69,581.00)	4,047,150.85
OTHER LONG TERM LIABILTY	(967.70)	8,709.30
TOTAL NON-CURR LIABILITIES	(70,548.70)	4,055,860.15
TOTAL LIABILITIES	(535,146.51)	66,121,815.67
RETAINED EARNINGS	2,836,515.03	(2,498,304.11)
TOTAL RETAINED EARNINGS	2,836,515.03	(2,498,304.11)
CURRENT YEAR - NET INCOME	667,509.83	0.00
TOTAL STOCK HOLDER EQUITY	3,504,024.86	(2,498,304.11)
TOTAL LIABLITIES AND STOCKHOLDERS' EQUITY	2,968,878.35	63,623,511.56

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/21

	ACTUAL 12/31/21	YTD 12/31/21
ASSETS		
CURRENT ASSETS:		
CASH AND EQUIVALENTS	30,925.84	72,804.74
ACCOUNTS RECEIVABLE:		
ACCOUNTS RECEIVABLE	(5,353,048.80)	51,382,271.23
ALLOW FOR C/A	(5,516.71)	(2,005,724.80)
NET PATIENT RECEIVABLES	(5,358,565.51)	49,376,546.43
ALLOWANCE FOR BAD DEBTS	(43,464.00)	(1,063,900.97)
TOTAL RECEIVABLES, NET	(5,402,029.51)	48,312,645.46
OTHER CURRENT ASSETS	(87,601.94)	1,321,208.47
INVENTORY	(113,092.62)	3,257,982.76
PREPAIDS	(287,182.15)	527,646.14
TOTAL CURRENT ASSETS	(5,858,980.38)	53,492,287.57
PROPERTY, PLANTS, EQUIPMENT:		
LAND AND IMPROVEMENTS	0.00	1,469,790.45
BUILDINGS	316,698.32	51,972,449.10
EQUIPMENT	(376,063.09)	21,079,751.00
CIP	0.00	322,231.17
TOTAL PROPERTY, PLANTS AND EQUIPMENT	(59,364.77)	74,844,221.72
ACCUMULATED DEPRECIATION	(404,082.48)	(29,415,371.66)
PROPERTY, PLANT, EQUIPMENT	(463,447.25)	45,428,850.06
OTHER ASSETS:		
GOODWILL	0.00	0.00
INTANGIBLE ASSETS	0.00	0.00
OTHER LONG TERM ASSETS		
OTHER ASSETS	0.00	0.00
TOTAL OTHER ASSETS	0.00	0.00
TOTAL ASSETS	(6,322,427.63)	98,921,137.63

Ottumwa Regional
CONSOLIDATED BALANCE SHEET
12/31/21

	ACTUAL 12/31/21	YTD 12/31/21
CURRENT LIABILITIES		
TOTAL ACCOUNTS PAYABLE	(636,216.07)	2,734,939.31
ACCRUED SALARIES AND BENEFITS	322,321.79	2,996,655.63
ACR EXP & OTH CUR LIA	(52,009.59)	1,930,635.85
CURRENT PORTION LT DEBT	0.00	0.00
CURRENT PORTION OF CAP LEASE	(27,724.89)	835,142.28
TOTAL CURRENT LIABILITES	(393,628.76)	8,497,373.07
INTERCOMPANY PAYABLES/RECEIVBL	(5,160,301.98)	53,703,477.54
NON CURRENT LIABILITIES		
OTHER NON CURRENT LIABILITIES	0.00	0.00
CAPITAL LEASE LONG TERM	0.00	3,254,086.49
OTHER LONG TERM LIABILTY	967.70	0.00
TOTAL NON-CURR LIABILITIES	967.70	3,254,086.49
TOTAL LIABILITIES	(5,552,963.04)	65,454,937.10
RETAINED EARNINGS	35,864,504.64	33,466,200.53
TOTAL RETAINED EARNINGS	35,864,504.64	33,466,200.53
CURRENT YEAR - NET INCOME	(36,633,969.23)	0.00
TOTAL STOCK HOLDER EQUITY	(769,464.59)	33,466,200.53
TOTAL LIABLITIES AND STOCKHOLDERS' EQUITY	(6,322,427.63)	98,921,137.63

Ottumwa Regional Health Center
Balance Sheet by COID
Year Ending 12-31-2022
All Entities

	Ottumwa Regional Health Center Consolidated
ASSETS	
Current assets:	
Cash And Cash Equivalents	$ (1,992,448)
Patient Accounts Receivable:	
Patient Receivables	23,518,986
Allowance For Bad Debts	(9,783,778)
Net Patient Accounts Receivable:	13,735,208
Final Settlements:	
Due To Due Fr Govt Programs	(44,240)
Net Final Settlements:	(44,240)
Net Accounts Receivable:	13,690,968
Inventories	3,468,096
Prepaid Expense	798,652
Other Receivables	764,347
Total Current Assets	16,729,615
Property and equipment:	
Land & Improvements	1,473,198
Building & Improvements	50,315,156
Equipment Owned	21,890,002
Equipment Capital Leases	3,387,323
Construction In Progress	1,782,254
	78,847,933
Accumulated depreciation	(34,021,256)
	44,826,677
Other Assets	1,628,862
Total Assets	**$ 63,185,154**
LIABILITIES AND STOCKHOLDERS' EQUITY	
Current liabilities:	
Accounts Payable	$ 3,991,883
Accrued Salaries	1,507,047
Accrued Expenses	2,466,661
Current Portion Long Term Debt	574,370
Other Current Liabilities	575,244
Total Current Liabilities	9,115,205
Long Term Debt Capital Leases	87,431,439
Long Term Debt Intercompany	5,551,435
Total Long Term Debt	92,982,874
Long Term Obligations	1,142,455
Total Other Liabilities	1,142,455
Retained Earning Beg Of Yr	(20,525,221)
Current Year Net Income	(19,530,159)
Total Equity	(40,055,379)
Total Liabilities and Equity	**$ 63,185,154**

Ottumwa Regional Health Center
Balance Sheet by COID
Year Ending 12-31-2023
All Entities

	Ottumwa Regional Health Center Consolidated
ASSETS	
Current assets:	
Cash And Cash Equivalents	$ (779,267)
Patient Accounts Receivable:	
Patient Receivables	23,631,606
Allowance For Bad Debts	(10,438,429)
Net Patient Accounts Receivable:	13,193,176
Final Settlements:	
Due To Due Fr Govt Programs	(9,431)
Net Final Settlements:	(9,431)
Net Accounts Receivable:	13,183,745
Inventories	3,851,616
Prepaid Expense	1,248,451
Other Receivables	7,423,190
Total Current Assets	24,927,735
Property and equipment:	
Land & Improvements	1,473,198
Building & Improvements	53,064,703
Equipment Owned	22,971,264
Equipment Capital Leases	5,920,771
Construction In Progress	361,756
	83,791,692
Accumulated depreciation	(38,882,401)
	44,909,291
Intangible Assets Net	182,781
Other Assets	1,513,985
Total Assets	**$ 71,533,792**
LIABILITIES AND STOCKHOLDERS' EQUITY	
Current liabilities:	
Accounts Payable	$ 8,081,981
Accrued Salaries	1,414,295
Accrued Expenses	2,392,338
Current Portion Long Term Debt	1,412,137
Other Current Liabilities	2,532,195
Total Current Liabilities	15,832,946
Long Term Debt Capital Leases	88,321,172
Long Term Debt Intercompany	29,457,284
Total Long Term Debt	117,778,456
Long Term Obligations	584,562
Total Other Liabilities	584,562
Retained Earning Beg Of Yr	(39,566,209)
Current Year Net Income	(23,095,963)
Total Equity	(62,662,172)
Total Liabilities and Equity	**$ 71,533,792**

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/12

	12/31/12	12/31/12
REVENUES		
IP REVENUE	(6,036,777.35)	(67,685,759.90)
OP REVENUE	(12,649,842.93)	(138,962,047.77)
OTHER PAT REVENUE	(1,268,188.85)	(9,690,926.86)
TOTAL GROSS PATIENT REVENUE	(19,954,809.13)	(216,338,734.53)
REVENUE DEDUCTIONS		
MEDICARE	6,741,515.28	70,363,282.84
MEDICARE MANAGED	0.00	0.00
MEDICAID	2,598,632.78	24,135,100.91
MANAGED MEDICAID	0.00	0.00
BCBS	0.00	0.00
HMO	0.00	0.00
PPO	0.00	0.00
UHC	0.00	0.00
COMMERCIAL	3,134,670.24	33,112,118.66
HIX	0.00	0.00
MRA	0.00	0.00
SAI	0.00	0.00
AETNA	0.00	0.00
CHAMPUS	0.00	0.00
WCOMP	0.00	0.00
FED/ST OTHER	0.00	0.00
CHARITY	0.00	0.00
SELF PAY	113,306.04	1,467,522.08
MCD PENDING	0.00	0.00
SELF PAY AFTER INS	0.00	0.00
OTHER	384,280.89	5,355,295.05
TOTAL REVENUE DEDUCTIONS	12,972,405.23	134,433,319.54
NET PATIENT REVENUE BEFORE BAD DEBT PROVISION	(6,982,403.90)	(81,905,414.99)
BAD DEBT	779,492.17	8,189,440.66
NET PATIENT REVENUE	(6,202,911.73)	(73,715,974.33)
TOTAL OTHER REVENUE	(967,140.20)	(12,827,167.20)
NET REVENUE	(7,170,051.93)	(86,543,141.53)
OPERATING EXPENSES		
Salary & Wages	2,642,295.64	31,027,502.98

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/12

	12/31/12	12/31/12
Contract Labor	255,915.07	1,640,892.51
Benefits and Taxes	544,641.77	6,923,143.48
Supplies	1,313,178.90	11,421,726.85
Professional Fees	770,717.57	7,669,236.71
Contract Services	323,595.29	2,939,619.23
Repairs and Maintenance	270,099.20	2,974,524.77
Lease and Rentals	94,495.33	1,184,275.68
Utilities	113,387.72	1,498,508.85
Insurance	54,214.00	595,668.67
Taxes Non-Income	79,971.26	2,845,102.59
Other Operating Expenses	305,930.16	2,605,176.48
TOTAL OPERATING EXPENSES	6,768,441.91	73,325,378.80
EBITDA (INCOME) LOSS	(401,610.02)	(13,217,762.73)
Depreciation	458,822.96	5,435,166.00
Depreciation and Amortization	0.00	524.00
EBIT (INCOME) LOSS	57,212.94	(7,782,072.73)
Interest Expense / (Income)	480,844.72	5,697,670.95
NET OPERATING (INCOME) LOSS	538,057.66	(2,084,401.78)
Acqusition Costs	0.00	0.00
Other Non-Operating Expense	(16,134.80)	(63,399.51)
Management Fees & Allocations	(141,173.00)	2,347,045.00
TOTAL NON OPERATING EXPENSE(INCOME)	(157,307.80)	2,283,645.49
PRE-TAX (INCOME) LOSS	380,749.86	199,243.71
INCOME TAXES		
NET (INCOME) LOSS	380,749.86	199,243.71

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/13

	12/31/13	12/31/13
REVENUES		
IP REVENUE	(6,676,929.57)	(72,967,877.90)
OP REVENUE	(13,902,302.96)	(164,668,775.32)
OTHER PAT REVENUE	(1,501,578.61)	(14,047,854.71)
TOTAL GROSS PATIENT REVENUE	(22,080,811.14)	(251,684,507.93)
REVENUE DEDUCTIONS		
MEDICARE	6,128,099.44	82,069,726.19
MEDICARE MANAGED	824,638.45	7,248,755.20
MEDICAID	1,906,594.31	23,781,365.95
MANAGED MEDICAID	0.00	0.00
BCBS	2,435,116.35	22,121,737.22
HMO	0.00	0.00
PPO	0.00	0.00
UHC	737,300.03	7,785,959.59
COMMERCIAL	74,262.41	3,729,761.56
HIX	0.00	0.00
MRA	0.00	0.00
SAI	0.00	0.00
AETNA	9,492.66	77,831.71
CHAMPUS	112,958.95	1,571,550.54
WCOMP	66,606.42	615,542.24
FED/ST OTHER	0.00	0.00
CHARITY	13,281.54	188,283.22
SELF PAY	203,834.86	1,527,465.98
MCD PENDING	0.00	0.00
SELF PAY AFTER INS	0.00	0.00
OTHER	792,413.26	9,296,853.78
TOTAL REVENUE DEDUCTIONS	13,304,598.68	160,014,833.18
NET PATIENT REVENUE BEFORE BAD DEBT PROVISION	(8,776,212.46)	(91,669,674.75)
BAD DEBT	1,887,172.98	14,092,163.96
NET PATIENT REVENUE	(6,889,039.48)	(77,577,510.79)
TOTAL OTHER REVENUE	(610,720.60)	(6,666,987.01)
NET REVENUE	(7,499,760.08)	(84,244,497.80)
OPERATING EXPENSES		
Salary & Wages	3,619,781.28	35,148,863.15

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/13

	12/31/13	12/31/13
Contract Labor	148,852.91	2,711,820.81
Benefits and Taxes	513,546.20	6,111,116.79
Supplies	1,298,470.06	12,987,757.73
Professional Fees	597,528.03	5,848,691.11
Contract Services	473,731.01	4,181,763.01
Repairs and Maintenance	333,514.04	3,878,687.72
Lease and Rentals	103,234.08	1,123,686.81
Utilities	150,689.88	1,615,148.07
Insurance	44,559.79	555,517.29
Taxes Non-Income	191,200.69	2,395,725.40
Other Operating Expenses	958,551.02	3,092,686.35
TOTAL OPERATING EXPENSES	8,433,658.99	79,651,464.24
EBITDA (INCOME) LOSS	933,898.91	(4,593,033.56)
Depreciation	770,219.61	5,990,465.79
Depreciation and Amortization	0.00	0.00
EBIT (INCOME) LOSS	1,704,118.52	1,397,432.23
Interest Expense / (Income)	492,511.03	5,725,100.18
NET OPERATING (INCOME) LOSS	2,196,629.55	7,122,532.41
Acqusition Costs	0.00	0.00
Other Non-Operating Expense	0.00	0.00
Management Fees & Allocations	232,008.75	2,527,333.75
TOTAL NON OPERATING EXPENSE(INCOME)	232,008.75	2,527,333.75
PRE-TAX (INCOME) LOSS	2,428,638.30	9,649,866.16
INCOME TAXES		
NET (INCOME) LOSS	2,428,638.30	9,649,866.16

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/14

	12/31/14	12/31/14
REVENUES		
IP REVENUE	(7,393,375.90)	(78,888,657.45)
OP REVENUE	(13,268,347.02)	(158,858,659.87)
OTHER PAT REVENUE	(1,904,580.37)	(22,989,682.22)
TOTAL GROSS PATIENT REVENUE	(22,566,303.29)	(260,736,999.54)
REVENUE DEDUCTIONS		
MEDICARE	6,055,844.10	74,881,458.28
MEDICARE MANAGED	849,748.81	8,159,732.91
MEDICAID	3,306,135.81	37,882,199.25
MANAGED MEDICAID	0.00	7.60
BCBS	2,632,929.75	25,714,482.14
HMO	0.00	0.00
PPO	0.00	0.00
UHC	717,735.41	7,819,003.01
COMMERCIAL	211,678.50	2,049,796.42
HIX	0.00	0.00
MRA	0.00	0.00
SAI	0.00	0.00
AETNA	5,483.86	64,157.46
CHAMPUS	174,295.28	2,136,512.00
WCOMP	19,084.78	604,671.06
FED/ST OTHER	0.00	0.00
CHARITY	0.00	55,700.23
SELF PAY	47,343.72	701,580.35
MCD PENDING	0.00	0.00
SELF PAY AFTER INS	0.00	0.00
OTHER	1,204,685.89	14,148,164.52
TOTAL REVENUE DEDUCTIONS	15,224,965.91	174,217,465.23
NET PATIENT REVENUE BEFORE BAD DEBT PROVISION	(7,341,337.38)	(86,519,534.31)
BAD DEBT	533,305.85	6,396,155.22
NET PATIENT REVENUE	(6,808,031.53)	(80,123,379.09)
TOTAL OTHER REVENUE	(98,143.17)	(2,662,728.02)
NET REVENUE	(6,906,174.70)	(82,786,107.11)
OPERATING EXPENSES		
Salary & Wages	2,691,821.71	33,728,292.50

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/14

	12/31/14	12/31/14
Contract Labor	367,877.06	4,055,089.58
Benefits and Taxes	275,190.63	5,657,240.22
Supplies	933,392.39	11,625,965.02
Professional Fees	583,190.57	6,276,788.94
Contract Services	486,695.58	4,863,361.24
Repairs and Maintenance	355,708.85	3,452,345.51
Lease and Rentals	79,285.98	960,073.72
Utilities	111,456.12	1,490,986.68
Insurance	63,306.28	753,528.84
Taxes Non-Income	146,904.58	1,780,602.66
Other Operating Expenses	297,047.81	4,750,777.89
TOTAL OPERATING EXPENSES	6,391,877.56	79,395,052.80
EBITDA (INCOME) LOSS	(514,297.14)	(3,391,054.31)
Depreciation	485,751.40	5,755,971.91
Depreciation and Amortization	0.00	0.00
EBIT (INCOME) LOSS	(28,545.74)	2,364,917.60
Interest Expense / (Income)	442,000.77	5,398,800.28
NET OPERATING (INCOME) LOSS	413,455.03	7,763,717.88
Acqusition Costs	0.00	0.00
Other Non-Operating Expense	0.00	0.00
Management Fees & Allocations	179,618.00	2,449,611.25
TOTAL NON OPERATING EXPENSE(INCOME)	179,618.00	2,449,611.25
PRE-TAX (INCOME) LOSS	593,073.03	10,213,329.13
INCOME TAXES		
NET (INCOME) LOSS	593,073.03	10,213,329.13

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/15

	12/31/15	12/31/15
REVENUES		
IP REVENUE	(5,429,851.69)	(76,761,778.46)
OP REVENUE	(12,618,411.81)	(168,210,576.16)
OTHER PAT REVENUE	(1,728,759.27)	(23,735,865.58)
TOTAL GROSS PATIENT REVENUE	(19,777,022.77)	(268,708,220.20)
REVENUE DEDUCTIONS		
MEDICARE	5,082,672.13	77,952,531.12
MEDICARE MANAGED	539,005.18	7,596,021.01
MEDICAID	3,342,714.54	41,535,037.55
MANAGED MEDICAID	0.00	1,897.93
BCBS	2,201,446.65	27,557,846.10
HMO	0.00	0.00
PPO	0.00	0.00
UHC	640,083.83	7,713,307.38
COMMERCIAL	119,223.38	1,781,424.80
HIX	0.00	0.00
MRA	0.00	0.00
SAI	0.00	0.00
AETNA	1,373.58	52,609.02
CHAMPUS	31,525.74	1,945,065.73
WCOMP	33,967.40	402,019.56
FED/ST OTHER	0.00	0.00
CHARITY	(10,157.81)	(5,854.81)
SELF PAY	59,360.47	892,818.12
MCD PENDING	0.00	0.00
SELF PAY AFTER INS	0.00	0.00
OTHER	856,820.34	13,316,435.07
TOTAL REVENUE DEDUCTIONS	12,898,035.43	180,741,158.58
NET PATIENT REVENUE BEFORE BAD DEBT PROVISION	(6,878,987.34)	(87,967,061.62)
BAD DEBT	351,218.31	4,802,851.02
NET PATIENT REVENUE	(6,527,769.03)	(83,164,210.60)
TOTAL OTHER REVENUE	(41,568.36)	(977,127.24)
NET REVENUE	(6,569,337.39)	(84,141,337.84)
OPERATING EXPENSES		
Salary & Wages	2,583,310.97	33,787,217.99

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/15

	12/31/15	12/31/15
Contract Labor	438,584.36	3,886,317.14
Benefits and Taxes	391,152.07	6,225,419.86
Supplies	1,007,655.37	11,222,203.58
Professional Fees	276,860.90	4,929,221.75
Contract Services	353,823.63	4,798,772.68
Repairs and Maintenance	308,761.10	3,864,466.92
Lease and Rentals	64,385.02	942,320.30
Utilities	94,554.72	1,357,344.62
Insurance	34,606.37	537,213.20
Taxes Non-Income	160,927.27	1,686,640.27
Other Operating Expenses	113,016.08	1,167,987.18
TOTAL OPERATING EXPENSES	5,827,637.86	74,405,125.49
EBITDA (INCOME) LOSS	(741,699.53)	(9,736,212.35)
Depreciation	456,388.49	5,931,096.40
Depreciation and Amortization	0.00	0.00
EBIT (INCOME) LOSS	(285,311.04)	(3,805,115.95)
Interest Expense / (Income)	436,661.31	5,177,018.97
NET OPERATING (INCOME) LOSS	151,350.27	1,371,903.02
Acqusition Costs	0.00	0.00
Other Non-Operating Expense	0.00	0.00
Management Fees & Allocations	221,610.00	2,455,008.00
TOTAL NON OPERATING EXPENSE(INCOME)	221,610.00	2,455,008.00
PRE-TAX (INCOME) LOSS	372,960.27	3,826,911.02
INCOME TAXES		
NET (INCOME) LOSS	372,960.27	3,826,911.02

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/16

	12/31/16	12/31/16
REVENUES		
IP REVENUE	(6,316,608.82)	(77,644,834.15)
OP REVENUE	(15,800,442.96)	(177,630,152.26)
OTHER PAT REVENUE	(2,104,159.41)	(25,238,132.57)
TOTAL GROSS PATIENT REVENUE	(24,221,211.19)	(280,513,118.98)
REVENUE DEDUCTIONS		
MEDICARE	6,062,396.45	71,935,826.61
MEDICARE MANAGED	1,605,454.73	16,417,449.33
MEDICAID	413,315.05	14,644,507.73
MANAGED MEDICAID	3,265,385.33	28,354,845.30
BCBS	2,837,710.00	31,343,693.86
HMO	0.00	0.00
PPO	0.00	0.00
UHC	638,112.98	6,871,588.19
COMMERCIAL	290,259.49	2,157,081.17
HIX	0.00	0.00
MRA	0.00	0.00
SAI	0.00	0.00
AETNA	2,676.13	65,861.04
CHAMPUS	216,862.18	1,775,780.11
WCOMP	27,591.46	440,181.89
FED/ST OTHER	0.00	0.00
CHARITY	0.00	0.00
SELF PAY	66,357.94	1,253,043.01
MCD PENDING	0.00	0.00
SELF PAY AFTER INS	0.00	0.00
OTHER	1,215,879.91	14,794,213.96
TOTAL REVENUE DEDUCTIONS	16,642,001.65	190,054,072.20
NET PATIENT REVENUE BEFORE BAD DEBT PROVISION	(7,579,209.54)	(90,459,046.78)
BAD DEBT	361,639.44	4,611,829.89
NET PATIENT REVENUE	(7,217,570.10)	(85,847,216.89)
TOTAL OTHER REVENUE	(63,508.18)	(884,833.39)
NET REVENUE	(7,281,078.28)	(86,732,050.28)
OPERATING EXPENSES		
Salary & Wages	2,625,630.91	33,808,493.28

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/16

	12/31/16	12/31/16
Contract Labor	437,784.34	5,815,275.86
Benefits and Taxes	496,587.29	5,929,448.42
Supplies	936,826.54	11,235,282.89
Professional Fees	446,265.91	4,908,501.28
Contract Services	329,481.51	4,270,801.41
Repairs and Maintenance	367,942.77	3,933,417.85
Lease and Rentals	69,701.20	868,674.48
Utilities	91,615.48	1,413,270.06
Insurance	(32,319.36)	803,216.01
Taxes Non-Income	199,769.90	2,465,598.47
Other Operating Expenses	149,298.60	1,487,675.75
TOTAL OPERATING EXPENSES	6,118,585.09	76,939,655.76
EBITDA (INCOME) LOSS	(1,162,493.19)	(9,792,394.52)
Depreciation	396,375.53	4,634,294.52
Depreciation and Amortization	0.00	0.00
EBIT (INCOME) LOSS	(766,117.66)	(5,158,100.00)
Interest Expense / (Income)	449,669.38	5,317,605.01
NET OPERATING (INCOME) LOSS	(316,448.28)	159,505.01
Acqusition Costs	0.00	0.00
Other Non-Operating Expense	0.00	0.00
Management Fees & Allocations	217,956.00	2,512,851.00
TOTAL NON OPERATING EXPENSE(INCOME)	217,956.00	2,512,851.00
PRE-TAX (INCOME) LOSS	(98,492.28)	2,672,356.01
INCOME TAXES		
NET (INCOME) LOSS	(98,492.28)	2,672,356.01

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/17

	12/31/17	12/31/17
REVENUES		
IP REVENUE	(7,747,155.90)	(90,050,201.07)
OP REVENUE	(16,745,101.78)	(203,627,829.46)
OTHER PAT REVENUE	(2,210,958.93)	(27,112,114.64)
TOTAL GROSS PATIENT REVENUE	(26,703,216.61)	(320,790,145.17)
REVENUE DEDUCTIONS		
MEDICARE	6,217,516.10	87,955,702.76
MEDICARE MANAGED	1,830,460.74	20,237,297.64
MEDICAID	504,416.96	5,432,788.25
MANAGED MEDICAID	4,369,416.66	49,095,441.70
BCBS	2,699,211.83	32,127,759.45
HMO	0.00	0.00
PPO	0.00	0.00
UHC	527,091.97	6,861,557.86
COMMERCIAL	241,227.27	2,531,556.47
HIX	0.00	0.00
MRA	0.00	0.00
SAI	0.00	0.00
AETNA	9,538.63	55,165.53
CHAMPUS	447,275.04	2,947,561.04
WCOMP	346,567.35	562,083.90
FED/ST OTHER	0.00	0.00
CHARITY	24,364.74	411,010.47
SELF PAY	103,545.81	954,556.05
MCD PENDING	0.00	0.00
SELF PAY AFTER INS	0.00	0.00
OTHER	1,289,133.78	14,900,050.21
TOTAL REVENUE DEDUCTIONS	18,609,766.88	224,072,531.33
NET PATIENT REVENUE BEFORE BAD DEBT PROVISION	(8,093,449.73)	(96,717,613.84)
BAD DEBT	1,198,493.11	6,610,329.58
NET PATIENT REVENUE	(6,894,956.62)	(90,107,284.26)
TOTAL OTHER REVENUE	(70,381.10)	(496,750.02)
NET REVENUE	(6,965,337.72)	(90,604,034.28)
OPERATING EXPENSES		
Salary & Wages	3,404,956.70	35,816,373.77

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/17

	12/31/17	12/31/17
Contract Labor	528,541.93	5,777,797.38
Benefits and Taxes	465,383.10	6,812,631.35
Supplies	782,896.72	11,860,530.60
Professional Fees	406,878.27	5,855,653.65
Contract Services	419,665.33	4,391,752.37
Repairs and Maintenance	237,509.44	3,630,895.43
Lease and Rentals	38,376.82	801,832.29
Utilities	86,276.81	1,411,665.11
Insurance	69,691.62	774,910.81
Taxes Non-Income	86,781.06	2,285,146.72
Other Operating Expenses	26,332.15	1,772,654.66
TOTAL OPERATING EXPENSES	6,553,289.95	81,191,844.14
EBITDA (INCOME) LOSS	(412,047.77)	(9,412,190.14)
Depreciation	405,162.55	4,870,851.23
Depreciation and Amortization	0.00	0.00
EBIT (INCOME) LOSS	(6,885.22)	(4,541,338.91)
Interest Expense / (Income)	746,719.05	5,728,160.87
NET OPERATING (INCOME) LOSS	739,833.83	1,186,821.96
Acqusition Costs	0.00	0.00
Other Non-Operating Expense	0.00	0.00
Management Fees & Allocations	229,970.52	2,648,097.00
TOTAL NON OPERATING EXPENSE(INCOME)	229,970.52	2,648,097.00
PRE-TAX (INCOME) LOSS	969,804.35	3,834,918.96
INCOME TAXES		
NET (INCOME) LOSS	969,804.35	3,834,918.96

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/18

	12/31/18	12/31/18
REVENUES		
IP REVENUE	(7,677,620.85)	(92,869,814.76)
OP REVENUE	(17,128,585.92)	(214,686,945.99)
OTHER PAT REVENUE	(2,318,895.68)	(29,155,813.98)
TOTAL GROSS PATIENT REVENUE	(27,125,102.45)	(336,712,574.73)
REVENUE DEDUCTIONS		
MEDICARE	7,191,084.68	89,522,197.74
MEDICARE MANAGED	2,473,533.19	27,402,731.99
MEDICAID	697,700.58	6,220,460.59
MANAGED MEDICAID	3,574,121.18	48,048,461.99
BCBS	3,100,081.90	34,906,284.48
HMO	0.00	0.00
PPO	0.00	0.00
UHC	599,311.99	7,112,920.51
COMMERCIAL	166,600.47	1,705,921.10
HIX	0.00	0.00
MRA	0.00	0.00
SAI	0.00	0.00
AETNA	19,799.40	287,895.48
CHAMPUS	117,735.13	3,422,639.22
WCOMP	69,025.29	664,980.50
FED/ST OTHER	0.00	0.00
CHARITY	25,406.15	687,298.63
SELF PAY	84,070.64	1,445,760.43
MCD PENDING	0.00	0.00
SELF PAY AFTER INS	0.00	0.00
OTHER	1,367,119.05	15,979,121.84
TOTAL REVENUE DEDUCTIONS	19,485,589.65	237,406,674.50
NET PATIENT REVENUE BEFORE BAD DEBT PROVISION	(7,639,512.80)	(99,305,900.23)
BAD DEBT	420,174.00	7,223,747.88
NET PATIENT REVENUE	(7,219,338.80)	(92,082,152.35)
TOTAL OTHER REVENUE	(43,396.25)	(502,697.04)
NET REVENUE	(7,262,735.05)	(92,584,849.39)
OPERATING EXPENSES		
Salary & Wages	3,203,209.44	37,324,092.48

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/18

	12/31/18	12/31/18
Contract Labor	495,955.08	6,331,672.13
Benefits and Taxes	299,464.46	7,001,655.84
Supplies	834,544.41	12,748,610.48
Professional Fees	589,237.43	5,451,786.96
Contract Services	435,984.90	4,753,663.52
Repairs and Maintenance	341,974.26	4,031,239.14
Lease and Rentals	49,786.35	673,460.31
Utilities	80,720.96	1,458,077.85
Insurance	89,338.53	892,329.71
Taxes Non-Income	171,598.06	1,971,776.29
Other Operating Expenses	165,891.62	2,496,960.95
TOTAL OPERATING EXPENSES	6,757,705.50	85,135,325.66
EBITDA (INCOME) LOSS	(505,029.55)	(7,449,523.73)
Depreciation	416,550.30	4,776,766.62
Depreciation and Amortization	0.00	0.00
EBIT (INCOME) LOSS	(88,479.25)	(2,672,757.11)
Interest Expense / (Income)	12,003.00	121,494.02
NET OPERATING (INCOME) LOSS	(76,476.25)	(2,551,263.09)
Acqusition Costs	0.00	0.00
Other Non-Operating Expense	0.00	0.00
Management Fees & Allocations	218,331.00	2,688,401.00
TOTAL NON OPERATING EXPENSE(INCOME)	218,331.00	2,688,401.00
PRE-TAX (INCOME) LOSS	141,854.75	137,137.91
INCOME TAXES		
NET (INCOME) LOSS	141,854.75	137,137.91

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/19

	12/31/19	12/31/19
REVENUES		
IP REVENUE	(6,849,866.34)	(92,315,831.44)
OP REVENUE	(19,317,951.14)	(228,322,958.08)
OTHER PAT REVENUE	(1,794,062.08)	(22,985,084.20)
TOTAL GROSS PATIENT REVENUE	(27,961,879.56)	(343,623,873.72)
REVENUE DEDUCTIONS		
MEDICARE	6,254,473.35	80,858,469.40
MEDICARE MANAGED	3,003,953.43	40,007,070.36
MEDICAID	264,087.80	4,797,288.61
MANAGED MEDICAID	4,035,200.65	51,392,365.36
BCBS	4,151,142.70	41,598,084.67
HMO	0.00	0.00
PPO	0.00	0.00
UHC	566,266.15	7,140,274.01
COMMERCIAL	(4,805.83)	1,569,713.23
HIX	0.00	0.00
MRA	0.00	0.00
SAI	0.00	0.00
AETNA	15,131.26	133,620.30
CHAMPUS	86,331.28	2,506,077.63
WCOMP	5,872.05	480,512.75
FED/ST OTHER	0.00	0.00
CHARITY	18,887.62	440,940.98
SELF PAY	350,015.54	2,529,014.80
MCD PENDING	0.00	0.00
SELF PAY AFTER INS	0.00	0.00
OTHER	858,444.10	12,139,936.37
TOTAL REVENUE DEDUCTIONS	19,605,000.10	245,593,368.47
NET PATIENT REVENUE BEFORE BAD DEBT PROVISION	(8,356,879.46)	(98,030,505.25)
BAD DEBT	351,099.31	4,538,827.14
NET PATIENT REVENUE	(8,005,780.15)	(93,491,678.11)
TOTAL OTHER REVENUE	(37,279.86)	(576,681.61)
NET REVENUE	(8,043,060.01)	(94,068,359.72)
OPERATING EXPENSES		
Salary & Wages	2,973,686.03	35,682,505.78

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/19

	12/31/19	12/31/19
Contract Labor	526,174.42	5,863,166.40
Benefits and Taxes	1,138,924.86	7,790,264.55
Supplies	612,815.48	12,702,516.80
Professional Fees	432,326.53	5,710,615.01
Contract Services	451,909.28	5,259,506.18
Repairs and Maintenance	341,892.67	4,229,122.24
Lease and Rentals	69,709.22	694,173.76
Utilities	103,095.70	1,496,074.36
Insurance	126,515.88	1,505,497.15
Taxes Non-Income	168,383.17	2,044,208.05
Other Operating Expenses	165,255.82	1,791,063.82
TOTAL OPERATING EXPENSES	7,110,689.06	84,768,714.10
EBITDA (INCOME) LOSS	(932,370.95)	(9,299,645.62)
Depreciation	418,427.76	4,988,022.36
Depreciation and Amortization	0.00	0.00
EBIT (INCOME) LOSS	(513,943.19)	(4,311,623.26)
Interest Expense / (Income)	10,563.60	63,332.42
NET OPERATING (INCOME) LOSS	(503,379.59)	(4,248,290.84)
Acqusition Costs	0.00	0.00
Other Non-Operating Expense	0.00	0.00
Management Fees & Allocations	374,716.51	2,745,601.51
TOTAL NON OPERATING EXPENSE(INCOME)	374,716.51	2,745,601.51
PRE-TAX (INCOME) LOSS	(128,663.08)	(1,502,689.33)
INCOME TAXES		
NET (INCOME) LOSS	(128,663.08)	(1,502,689.33)

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/20

	12/31/20	12/31/20
REVENUES		
IP REVENUE	(6,883,922.20)	(84,618,321.45)
OP REVENUE	(18,997,437.18)	(211,521,299.74)
OTHER PAT REVENUE	(1,382,345.00)	(18,588,548.34)
TOTAL GROSS PATIENT REVENUE	(27,263,704.38)	(314,728,169.53)
REVENUE DEDUCTIONS		
MEDICARE	5,446,851.95	70,437,534.78
MEDICARE MANAGED	2,998,248.12	35,531,903.27
MEDICAID	125,943.25	1,845,802.40
MANAGED MEDICAID	4,077,648.37	51,026,073.53
BCBS	3,677,900.08	39,595,623.62
HMO	559.00	559.00
PPO	965,722.00	965,722.00
UHC	(178,287.94)	5,481,153.39
COMMERCIAL	145,337.57	2,561,271.30
HIX	35,622.00	35,622.00
MRA	122,113.00	122,113.00
SAI	442,200.00	442,200.00
AETNA	9.29	9,246.02
CHAMPUS	612,648.15	4,294,312.17
WCOMP	118,139.39	1,155,557.87
FED/ST OTHER	56,887.00	56,887.00
CHARITY	276,173.58	575,383.11
SELF PAY	(549,504.50)	3,630,564.00
MCD PENDING	70,647.00	70,647.00
SELF PAY AFTER INS	(507,496.00)	(507,496.00)
OTHER	12,447,788.45	20,820,484.48
TOTAL REVENUE DEDUCTIONS	30,385,149.76	238,151,163.94
NET PATIENT REVENUE BEFORE BAD DEBT PROVISION	3,121,445.38	(76,577,005.59)
BAD DEBT	(10,161,751.81)	(6,325,709.99)
NET PATIENT REVENUE	(7,040,306.43)	(82,902,715.58)
TOTAL OTHER REVENUE	(252,523.82)	(555,028.89)
NET REVENUE	(7,292,830.25)	(83,457,744.47)
OPERATING EXPENSES		
Salary & Wages	2,977,086.48	33,426,729.76

OTTUMWA REGIONAL HEALTH CENTER
CONSOLIDATED
12/31/20

	12/31/20	12/31/20
Contract Labor	395,879.03	4,802,156.82
Benefits and Taxes	661,463.92	7,776,765.12
Supplies	1,037,128.88	11,606,074.79
Professional Fees	490,027.86	5,266,217.90
Contract Services	617,542.18	8,026,394.85
Repairs and Maintenance	303,340.82	3,513,362.35
Lease and Rentals	89,414.83	747,722.73
Utilities	101,075.06	1,397,900.14
Insurance	62,413.75	1,482,112.12
Taxes Non-Income	177,665.99	2,069,578.89
Other Operating Expenses	(4,152,364.66)	(7,487,181.77)
TOTAL OPERATING EXPENSES	2,760,674.14	72,627,833.70
EBITDA (INCOME) LOSS	(4,532,156.11)	(10,829,910.77)
Depreciation	434,912.51	5,167,141.21
Depreciation and Amortization	0.00	0.00
EBIT (INCOME) LOSS	(4,097,243.60)	(5,662,769.56)
Interest Expense / (Income)	30,691.78	131,971.08
NET OPERATING (INCOME) LOSS	(4,066,551.82)	(5,530,798.48)
Acqusition Costs	0.00	0.00
Other Non-Operating Expense	0.00	0.00
Management Fees & Allocations	562,526.96	2,694,283.45
TOTAL NON OPERATING EXPENSE(INCOME)	562,526.96	2,694,283.45
PRE-TAX (INCOME) LOSS	(3,504,024.86)	(2,836,515.03)
INCOME TAXES		
NET (INCOME) LOSS	(3,504,024.86)	(2,836,515.03)

Ottumwa Regional Health Center
Income Statement
YTD ending December 2023 - Actual
All Entities

	Ottumwa Regional Health Center Consolidated
Routine Revenue	22,189,744
Ip Ancillary	48,702,291
Op Ancillary	273,111,124
Other Oper Income	324,852
Gross revenues	344,328,011
Medicare Current Yr	66,510,736
Medicaid Current Yr	(4,630,652)
Champus Contractuals	7,512,264
Py Contractuals	16,613
Hmo/Ppo Disnts Inc Me/Ma Mgd	181,031,554
Charity Discounts	120,303
Other Deductions	3,755,021
Total deductions	254,315,839
Revenues before provision for doubtful accounts	90,012,172
Provision for doubtful accounts	10,015,641
Net Revenue	**79,996,531**
Salaries	28,934,470
Contract Labor	7,629,425
Employee Benefits	5,720,662
Supplies	10,852,383
Professional Fees	8,407,854
Contract Services	14,482,519
Repairs & Maintenance	3,871,175
Rents & Leases	570,380
Utilities	1,749,244
Insurance	1,215,528
Non Income Taxes	4,126,239
Other Oper Expense	1,426,171
Total operating expenses	88,986,052
EBITDA	**(8,989,521)**
Depreciation	4,938,960
Interest Expense	6,443,049
Management Fees	2,724,433
Total capital and other expenses	14,106,441
Income before income taxes	(23,095,963)
Provision for income taxes	-
Net income	(23,095,963)

Inpatient Transfers 2015-2023

2,

Service	Year	Grand Total
Grand Total	**CY15-CY23**	**2,037**
Cardiology	CY15	53
Critical Care	CY15	46
Gastroenterology	CY15	17
Infectious Disease	CY15	10
Neonatology	CY15	6
Nephrology	CY15	10
Neurology	CY15	16
Obstetrics	CY15	9
Oncology	CY15	1
Orthopedics	CY15	7
Psychiatry	CY15	6
Pulmonary	CY15	18
Surgery	CY15	14
2015 Total	**CY15**	**213**
Cardiology	CY16	48
Critical Care	CY16	40
Hematology	CY16	4
Infectious Disease	CY16	16
Neonatology	CY16	15
Nephrology	CY16	8
Neurology	CY16	20
Obstetrics	CY16	3
Oncology	CY16	6
Orthopedics	CY16	4
Psychiatry	CY16	2
Pulmonary	CY16	21
Surgery	CY16	28
Trauma	CY16	9
Urology	CY16	8
2016 Total	**CY16**	**232**
Cardiology	CY17	52
Critical Care	CY17	23
Gynecology	CY17	1
Hematology	CY17	4
Infectious Disease	CY17	9
Medical	CY17	8
Neonatology	CY17	15
Nephrology	CY17	7
Neurology	CY17	19
Obstetrics	CY17	6
Oncology	CY17	2
Orthopedics	CY17	2
Pulmonary	CY17	31
Surgery	CY17	20

Trauma	CY17	6
Urology	CY17	2
2017 Total	**CY17**	**207**
Cardiology	CY18	58
Critical Care	CY18	11
Gastroenterology	CY18	2
Gynecology	CY18	1
Hematology	CY18	1
Infectious Disease	CY18	16
Interventional Radio	CY18	5
Medical	CY18	22
Multiple trauma care	CY18	1
Neonatology	CY18	12
Nephrology	CY18	8
Neurology	CY18	32
Obstetrics	CY18	1
Oncology	CY18	12
Orthopedics	CY18	2
Pediatric	CY18	1
Psychiatry	CY18	14
Pulmonary	CY18	33
Surgery	CY18	24
Trauma	CY18	2
Urology	CY18	8
2018 Total	**CY18**	**266**
Cardiology	CY19	65
Critical Care	CY19	12
Gastroenterology	CY19	3
Gynecology	CY19	1
Infectious Disease	CY19	18
Interventional Radio	CY19	9
Medical	CY19	12
Multiple trauma care	CY19	3
Neonatology	CY19	16
Nephrology	CY19	17
Neurology	CY19	40
Obstetrics	CY19	1
Oncology	CY19	16
Orthopedics	CY19	4
Pediatric	CY19	6
Psychiatry	CY19	3
Pulmonary	CY19	59
Surgery	CY19	18
Urology	CY19	9
2019 Total	**CY19**	**312**
Cardiology	CY20	44
Critical Care	CY20	21
Gynecology	CY20	2
Hematology	CY20	2

Infectious Disease	CY20	16
Interventional Radio	CY20	1
Medical	CY20	22
Multiple trauma care	CY20	1
Neonatology	CY20	10
Nephrology	CY20	7
Neurology	CY20	20
Obstetrics	CY20	2
Oncology	CY20	7
Orthopedics	CY20	7
Pediatric	CY20	4
Psychiatry	CY20	8
Pulmonary	CY20	88
Surgery	CY20	25
Trauma	CY20	2
Urology	CY20	3
2020 Total	**CY20**	**292**
Cardiology	CY21	35
Critical Care	CY21	9
Gastroenterology	CY21	1
Hematology	CY21	1
Infectious Disease	CY21	9
Interventional Radio	CY21	2
Medical	CY21	12
Neonatology	CY21	8
Nephrology	CY21	9
Neurology	CY21	17
Obstetrics	CY21	6
Oncology	CY21	5
Pediatric	CY21	5
Psychiatry	CY21	1
Pulmonary	CY21	75
Surgery	CY21	10
Trauma	CY21	1
Urology	CY21	10
2021 Total	**CY21**	**216**
Cardiology	CY22	38
Critical Care	CY22	5
Infectious Disease	CY22	2
Interventional Radio	CY22	4
Medical	CY22	12
Neonatology	CY22	16
Nephrology	CY22	10
Neurology	CY22	18
Obstetrics	CY22	1
Oncology	CY22	5
Orthopedics	CY22	2
Pediatric	CY22	6
Psychiatry	CY22	1

Pulmonary	CY22	28
Surgery	CY22	16
Trauma	CY22	1
Urology	CY22	4
2022 Total	**CY22**	**169**
Cardiology	CY23	31
Critical Care	CY23	5
Gastroenterology	CY23	2
Infectious Disease	CY23	1
Interventional Radio	CY23	2
Medical	CY23	12
Neonatology	CY23	8
Nephrology	CY23	4
Neurology	CY23	10
Obstetrics	CY23	3
Oncology	CY23	1
Orthopedics	CY23	7
Pediatric	CY23	5
Psychiatry	CY23	4
Pulmonary	CY23	22
Surgery	CY23	12
Urology	CY23	1
2023 Total	**CY23**	**130**

ED Transfers 2015 - 2023

Service	Year	Grand Total
Grand Total	**CY15-CY23**	**7,320**
Cardiology	CY2015	75
Critical Care	CY2015	6
Gastroenterology	CY2015	21
Hematology	CY2015	6
Medical	CY2015	9
Neonatology	CY2015	1
Nephrology	CY2015	5
Neurology	CY2015	103
Obstetrics	CY2015	7
Oncology	CY2015	4
Orthopedics	CY2015	15
Psychiatry	CY2015	228
Pulmonary	CY2015	42
Surgery	CY2015	42
Trauma	CY2015	42
Urology	CY2015	18
2015 Total	**CY2015**	**624**
Cardiology	CY2016	81
Critical Care	CY2016	46
Gastroenterology	CY2016	24
Hematology	CY2016	13
Infectious Disease	CY2016	4
Neonatology	CY2016	1
Nephrology	CY2016	8
Neurology	CY2016	78
Obstetrics	CY2016	3
Oncology	CY2016	8
Psychiatry	CY2016	262
Pulmonary	CY2016	24
Surgery	CY2016	17
Trauma	CY2016	83
Urology	CY2016	7
2016 Total	**CY2016**	**659**
Cardiology	CY2017	78
Critical Care	CY2017	49
Gastroenterology	CY2017	17
Hematology	CY2017	6
Infectious Disease	CY2017	6
Medical	CY2017	30
Multiple trauma care	CY2017	3
Nephrology	CY2017	11
Neurology	CY2017	82
Obstetrics	CY2017	2
Oncology	CY2017	3

Orthopedics	CY2017	5
Pediatric	CY2017	12
Psychiatry	CY2017	177
Pulmonary	CY2017	49
Surgery	CY2017	42
Trauma	CY2017	82
Urology	CY2017	11
2017 Total	**CY2017**	**665**
Cardiology	CY2018	123
Critical Care	CY2018	2
Gastroenterology	CY2018	5
Gynecology	CY2018	1
Hematology	CY2018	3
Infectious Disease	CY2018	19
Interventional Radio	CY2018	7
Medical	CY2018	95
Multiple trauma care	CY2018	29
Neonatology	CY2018	2
Nephrology	CY2018	44
Neurology	CY2018	114
Obstetrics	CY2018	3
Oncology	CY2018	25
Orthopedics	CY2018	10
Pediatric	CY2018	35
Psychiatry	CY2018	192
Pulmonary	CY2018	57
Surgery	CY2018	121
Trauma	CY2018	5
Urology	CY2018	21
2018 Total	**CY2018**	**913**
Cardiology	CY2019	117
Critical Care	CY2019	39
Gastroenterology	CY2019	25
Gynecology	CY2019	1
Hematology	CY2019	20
Infectious Disease	CY2019	25
Interventional Radio	CY2019	12
Medical	CY2019	44
Multiple trauma care	CY2019	11
Neonatology	CY2019	2
Nephrology	CY2019	35
Neurology	CY2019	116
Obstetrics	CY2019	2
Oncology	CY2019	26
Orthopedics	CY2019	15
Pediatric	CY2019	25
Psychiatry	CY2019	158
Pulmonary	CY2019	82
Surgery	CY2019	79

Trauma	CY2019	40
Urology	CY2019	22
2019 Total	**CY2019**	**896**
Cardiology	CY2020	128
Critical Care	CY2020	59
Gastroenterology	CY2020	1
Gynecology	CY2020	8
Hematology	CY2020	9
Infectious Disease	CY2020	22
Interventional Radio	CY2020	9
Medical	CY2020	125
Multiple trauma care	CY2020	20
Nephrology	CY2020	44
Neurology	CY2020	103
Obstetrics	CY2020	5
Oncology	CY2020	14
Orthopedics	CY2020	16
Pediatric	CY2020	30
Psychiatry	CY2020	129
Pulmonary	CY2020	182
Surgery	CY2020	107
Trauma	CY2020	51
Urology	CY2020	20
2020 Total	**CY2020**	**1,082**
Cardiology	CY2021	104
Critical Care	CY2021	1
Hematology	CY2021	2
Infectious Disease	CY2021	21
Interventional Radio	CY2021	8
Medical	CY2021	139
Multiple trauma care	CY2021	28
Neonatology	CY2021	2
Nephrology	CY2021	27
Neurology	CY2021	93
Obstetrics	CY2021	1
Oncology	CY2021	17
Orthopedics	CY2021	26
Pediatric	CY2021	41
Psychiatry	CY2021	91
Pulmonary	CY2021	144
Surgery	CY2021	76
Trauma	CY2021	4
Urology	CY2021	41
2021 Total	**CY2021**	**866**
Cardiology	CY2022	118
Critical Care	CY2022	3
Gynecology	CY2022	3
Infectious Disease	CY2022	10
Interventional Radio	CY2022	17

Medical	CY2022	99
Multiple trauma care	CY2022	26
Neonatology	CY2022	3
Nephrology	CY2022	42
Neurology	CY2022	101
Obstetrics	CY2022	5
Oncology	CY2022	14
Orthopedics	CY2022	23
Pediatric	CY2022	52
Psychiatry	CY2022	91
Pulmonary	CY2022	74
Surgery	CY2022	129
Trauma	CY2022	3
Urology	CY2022	19
2022 Total	**CY2022**	**832**
Cardiology	CY2023	89
Critical Care	CY2023	1
Gynecology	CY2023	4
Infectious Disease	CY2023	9
Interventional Radio	CY2023	9
Medical	CY2023	126
Multiple trauma care	CY2023	17
Nephrology	CY2023	24
Neurology	CY2023	93
Obstetrics	CY2023	10
Oncology	CY2023	13
Orthopedics	CY2023	30
Pediatric	CY2023	69
Psychiatry	CY2023	95
Pulmonary	CY2023	64
Surgery	CY2023	107
Trauma	CY2023	1
Urology	CY2023	22
2023 Total	**CY2023**	**783**

September 19, 2024

~~**DELIVERED VIA EMAIL**~~

Ottumwa Regional Legacy Foundation, Inc.
935 Pennsylvania Avenue
Ottumwa, Iowa 52501
Attention: Chairman

Re: Amendment to Asset Purchase Agreement

Dear Ladies and Gentlemen:

Reference is made to that certain Asset Purchase Agreement, dated as of April 30, 2010, as amended (the "**Purchase Agreement**"), among Ottumwa Regional Legacy Foundation, Inc. (f/k/a Ottumwa Regional Health Center, Incorporated), an Iowa non-profit, non-stock corporation (the "**ORHC**"), Regional Retirement Living, Inc., an Iowa non-profit, non-stock corporation ("**RRL**"), Regional Enterprises, Inc., an Iowa corporation ("**RE**" and, collectively, with ORHC and RRL, the "**Sellers**"), RCHP-Ottumwa, LLC (f/k/a RCHP-Ottumwa, Inc.), a Delaware limited liability company ("**Buyer**"), and RegionalCare Hospital Partners, LLC (f/k/a RegionalCare Hospital Partners, Inc.), a Delaware limited liability company ("**RCHP**"). Subsequent to the closing of the transactions contemplated by the Purchase Agreement, RRL and RE both dissolved and distributed their respective assets to ORHC, as the sole shareholder and successor in interest to each of RRL and RE. Pursuant to Section 10.7 of the Purchase Agreement, Buyer agreed to make certain annual routine capital expenditures in connection with the operation of the Hospital, and the parties now desire to enter this letter agreement (this "**Letter Agreement**") to amend Section 10.7 of the Purchase Agreement in accordance with the following:

1. Amendments. Section 10.7 of the Purchase Agreement is hereby deleted in its entirety and replaced with the following, with additions show in double-underline text:

> **10.7 General Capital Expenditures**. In addition to the capital expenditures set forth in Section 10.6, during the first five (5) years following the Closing Date, Buyer shall make annual routine capital expenditures in connection with the operation of the Hospital equal to at least two and one-half percent (2.5%) of the Hospital's net patient revenue. Beginning in the sixth year after the Closing, during such time as Buyer owns and operates the Hospital, Buyer shall make annual routine capital expenditures equal to at least five percent (5%) of the Hospital's net patient revenue. The Parties agree that (i) the foregoing capital expenditures shall be calculated in the aggregate over the term of Buyer's ownership and operation of the Hospital, such that excess capital expenditures may be carried over and applied by Buyer to satisfy the annual routine capital expenditure commitment during any subsequent year(s), provided that beginning in calendar year 2021 and each year thereafter during the commitment period the rolling five-year average of capital expenditures is equal to or greater than five percent (5%) of the Hospital's net patient revenue, (ii) Buyer may satisfy up to one and twenty-five hundredths percent (1.25%) of such annual routine capital expenditures commitment for calendar year 2021 with physician investments, and (iii) Buyer and ORHC shall meet on or prior to November 30, 2021 to determine what percentage of such annual routine capital expenditures

commitment for calendar year 2022 and each year thereafter that Buyer owns and operates the Hospital may be satisfied with physician investments; *provided, however*, that (x) in the event Buyer and ORHC are unable to mutually agree upon the physician investment percentage at such meeting on or prior to November 30, 2021, then the physician investment percentage of one and twenty-five hundredths percent (1.25%) shall continue for calendar year 2022 and each year thereafter until such time as Buyer and ORHC mutually agree upon a change in such physician investment percentage; and (y) Buyer shall not be required to satisfy any portion of the annual routine capital expenditure commitment with physician investments and shall not be required to make any minimum amount of physician investments. As used herein, "**routine capital expenditures**" shall include expenditures for unforeseen maintenance, new equipment, equipment replacement, facility renovations, operating and capital leases, other capital improvements and physician investments. As used herein, "**physician investments**" shall include expenditures for physician development and recruiting, physician retention costs, physician practice losses and other investments in physicians, including, but not limited to, sign-on bonuses, relocation costs, payments made under income guarantees, out of pocket costs and payments for tangible and intangible assets related to the acquisition of physician practices. The Board of Directors shall be responsible for overseeing the development of annual operating and capital budgets. Buyer's liability for the costs of remediation of asbestos and asbestos-containing materials on or at the Real Property (other than the Alta Vista Site) shall be offset, at Buyer's option, against either (i) the routine capital expenditure commitment set forth in this Section 10.7, or (ii) the funds allocated to complete the Infrastructure Projects set forth in Section 10.6.

2. Capitalization. Capitalized terms used but not otherwise defined herein shall have the meanings set forth in the Purchase Agreement.

3. Conflicts/Ratification. This Letter Agreement will constitute an amendment to the Purchase Agreement pursuant to Section 13.29 thereof with respect to the matters set forth herein. The balance of the terms of the Purchase Agreement shall remain in full force and effect.

4. Counterparts. This Letter Agreement may be executed in two (2) or more counterparts, each of which will be deemed to be an original copy of this Letter Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement. The exchange of copies of this Letter Agreement and of signature pages by facsimile or Portable Document Format (PDF) transmission shall constitute effective execution and delivery of this Letter Agreement as to the parties and may be used in lieu of any originals for all purposes.

[Signature Page Follows.]

IN WITNESS WHEREOF, the parties have caused this Letter Agreement to be executed as of the date first above written.

OTTUMWA REGIONAL LEGACY FOUNDATION, INC.

By: _____

Name: Kelly Gennes

Title: President / CEO

RCHP-OTTUMWA, LLC

By: _____

Name: William Foster

Title: CEO

Signed by:
Charlotte Lawrence
B92A4AD58CE5427...
Charlotte Lawrence

Secretary

REGIONALCARE HOSPITAL PARTNERS, LLC

By: Signed by: Charlotte Lawrence B92A4AD58CE5427...

Name: Charlotte Lawrence

Title: Secretary

[Signature Page to Letter Agreement]

Tuesday, April 27, 2010 10:13 AM

AHA Annual Survey - 2009

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status

Submitted

Date Started	Date Last Edited	Date Submitted
FEB-17-10	APR-27-10	APR-27-10

Survey Administrators

Thomas Siemers

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	04/27/2010	Thomas R Siemers

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	04/01/2008
	To (mm/dd/yyyy)	03/31/2009
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		365
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	04/01/2009

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	04/27/2010	Thomas R Siemers

Section B: Question	Description	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. CHECK ONLY ONE:		23 Other nongovernment, not-for-profit (including NFP Corporation)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:		10 General medical and surgical
	Other-specify treatment area:	
OTHER		
3a. Does your hospital restrict admissions primarily to children?		No
3b. Does the hospital itself operate subsidiary corporations?		Yes
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:		No
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	STATE	
3d. Is the hospital a participant in a network? If yes, please provide the name, city, state, and telephone number of your network(s).		No
	Name	
	Phone	
	Name	
	Phone	
	Name	
	Phone	

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
3e. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):		Yes
	Name	Premier
	City	San Diego
	State	CA
	Name	
	City	
	State	
	Name	
	City	
	State	
3f. Is your hospital owned in whole or in part by physicians or a physician group?		No
3g. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH(F) or a LTCH(C) colocated within a general acute care hospital.		
If you are colocated in a general acute care hospital, what is your host hospital's name,city and state?		
NPI		
4. NATIONAL PROVIDER IDENTIFIER (NPI)		
National Plan Provider		
a. Does your hospital have its new National Provider Identifier (NPI) from the National Plan and Provider Enumeration System?		Yes
Digital NPI		
If yes, please report the ten digit NPI		1528175981
SubPart NPI		
Does your hospital also have a Subpart NPI.?		Yes
National Identifier Provider (NPI)		
Subpart NPI 1		1952465320
		04 - Rehabilitation Unit
Subpart NPI 2		1902943970
		03 - Psychiatric Unit
Subpart NPI 3		1275746406
		10 - Other
Subpart NPI 4		1750383055
		10 - Other

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
Subpart NPI 5		1700905015 10 - Other
Subpart NPI 6		
Subpart NPI 7		
Subpart NPI 8		
Subpart NPI 9		
Subpart NPI 10		
Subpart NPI 11		
Subpart NPI 12		
Subpart NPI 13		
Subpart NPI 14		
Subpart NPI 15		
Subpart NPI 16		
Subpart NPI 17		
Subpart NPI 18		
Subpart NPI 19		
Subpart NPI 20		
Subpart NPI 21		
Subpart NPI 22		

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
Subpart NPI 23		
Subpart NPI 24		
Subpart NPI 25		
Subpart NPI 26		
Subpart NPI 27		
Subpart NPI 28		
Subpart NPI 29		
Subpart NPI 30		

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	04/27/2010	Thomas R Siemers

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
1. General medical - surgical care	X (#Beds: 37)				
2. Pediatric medical - surgical care	X (#Beds: 5)				
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	X (#Beds: 18)	2			
4. Medical surgical intensive care	X (#Beds: 8)				
5. Cardiac intensive care	(#Beds: ____)				X
6. Neonatal intensive care	X (#Beds: 3)				
7. Neonatal intermediate care	X (#Beds: 2)				
8. Pediatric intensive care	(#Beds: ____)				X
9. Burn care	(#Beds: ____)				X
10. Other special care	X (#Beds: 17)	(Specify: ____)			
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	(#Beds: ____)	(Specify: ____)			X
12. Physical rehabilitation	X (#Beds: 18)				
13. Alcoholism - drug abuse or dependency care	(#Beds: ____)				X
14. Psychiatric care	(#Beds: ____)				X
15. Skilled nursing care	(#Beds: ____)				X
16. Intermediate nursing care	(#Beds: ____)				X
17. Acute long term care	(#Beds: ____)				X
18. Other long-term care	(#Beds: ____)				X

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	☐ (#Beds: ____)	☐ (Specify: ____)	☐	☐	☒
20. Adult day care program	☐	☐	☐	☐	☒
21. Airborne infection isolation room (Please specify the number of rooms)	☒	☐ # Rooms: 2	☐	☐	☐
22. Alcoholism - drug abuse or dependency outpatient services	☒	☐	☐	☐	☐
23. Alzheimer Center	☐	☒	☐	☐	☐
24. Ambulance services	☒	☐	☐	☐	☐
25. Ambulatory surgery center	☐	☐	☐	☐	☒
26. Arthritis treatment center	☐	☐	☐	☐	☒
27. Assisted living	☐	☒	☐	☐	☐
28. Auxiliary	☒	☐	☐	☐	☐
29. Bariatric/weight control services	☐	☐	☐	☐	☒
30. Birthing room - LDR room - LDRP room	☒	☐	☐	☐	☐
31. Blood Donor Center	☐	☐	☐	☒	☐
32. Breast cancer screening / mammograms	☒	☐	☐	☐	☐
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services	☐	☐	☐	☐	☒
33b. Pediatric cardiology services	☐	☐	☐	☐	☒
33c. Adult diagnostic catheterization	☐	☐	☐	☐	☒
33d. Pediatric diagnostic catheterization	☐	☐	☐	☐	☒
33e. Adult interventional cardiac catheterization	☐	☐	☐	☐	☒
33f. Pediatric interventional cardiac catheterization	☐	☐	☐	☐	☒
33g. Adult cardiac surgery	☐	☐	☐	☐	☒
33h. Pediatric cardiac surgery	☐	☐	☐	☐	☒

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
33i. Adult cardiac electrophysiology	X				
33j. Pediatric cardiac electrophysiology					X
33k. Cardiac rehabilitation	X				
34. Case management	X				
35. Chaplaincy/pastoral care services	X				
36. Chemotherapy	X				
37. Children's wellness program					X
38. Chiropractic services					X
39. Community outreach	X				
40. Complementary and alternative medicine services					X
41. Computer assisted orthopedic surgery (CAOS)					X
42. Crisis prevention					X
43. Dental services					X
44. Emergency services: 44a. Emergency department	X				
44b. Satellite emergency department					
44c. Is the department open 24 hours a day, 7 days a week?		(24 hours: ____)			X
44d. Trauma center (certified) [Level of unit (1-3)]	X	3			
45. Enabling services					X
46. Endoscopic services 46a.Optical colonoscopy					X
46b. Endoscopic ultrasound	X				
46c. Ablation of Barrett's esophagus	X				
46d. Esophageal impedance study	X				
46e. Endoscopic retrograde cholangiopancreatography (ERCP)					X

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
47. Enrollment assistance services					X
48. Extracorporeal shock wave lithotripter (ESWL)	X				
49. Fertility clinic					X
50. Fitness center					X
51. Freestanding outpatient care center	X				
52. Geriatric services	X				
53. Health fair	X				
54. Community health education	X				
55. Genetic testing/counseling					X
56. Health screenings	X				
57. Health research					X
58. Hemodialysis				X	
59. HIV - AIDS services					X
60. Home health services	X				
61. Hospice program					X
62. Hospital - based outpatient care center - services	X				
63. Immunization program					X
64. Indigent care clinic					X
65. Linguistic/translation services	X				
66. Meals on wheels	X				
67. Mobile health services					X
68. Neurological services					X
69. Nutrition programs	X				

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
70. Occupational health services	X				
71. Oncology services	X				
72. Orthopedic services	X				
73. Outpatient surgery	X				
74. Pain management program	X				
75. Palliative care program					X
76. Palliative care inpatient unit					X
77. Patient Controlled Analgesia (PCA)	X				
78. Patient education center	X				
79. Patient representative services	X				
80. Physical rehabilitation services					
80a. Assistive technology center					X
80b. Electrodiagnostic services					
80c. Physical rehabilitation outpatient services	X				
80d. Prosthetic and orthotic services					X
80e. Robot-assisted walking therapy					X
80f. Simulated rehabilitation environment					X
81. Primary care department					X
82. Psychiatric services: 82a. Psychiatric child - adolescent services	X				
82b. Psychiatric consultation - liaison services	X				
82c. Psychiatric education services	X				
82d. Psychiatric emergency services	X				

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
82e. Psychiatric geriatric services	X				
82f. Psychiatric outpatient services	X				
82g. Psychiatric partial hospitalization program					X
83. Radiology, diagnostic: 83a. CT scanner	X				
83b. Diagnostic radioisotope facility	X				
83c. Electron beam computed tomography (EBCT)					X
83d. Full-field digital mammography(FFDM)	X				
83e. Magnetic resonance imaging (MRI)	X				
83f. Intraoperative magnetic resonance imaging	X				
83g. Multi-slice spiral computed tomography(<64 + slice CT)					X
83h. Multi-slice spiral computed tomography (64+ sclice)					X
83i. Positron emission tomography (PET)				X	
83j. Positron emission tomography/CT (PET/CT)				X	
83k. Single photon emission computerized tomography (SPECT)					X
83l. Ultrasound	X				
84. Radiology therapeutic: 84a. Image -guided Radiation Therapy(IGRT)					X
84b. Intensity-Modulated Radiation Therapy (IMRT)				X	
84c. Proton beam therapy					X
84d. Shaped Beam Radiation System					X
84e. Stereotactic radiosurgery					X
85. Retirement housing	X				

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
86. Robotic surgery					X
87. Sleep center	X				
88. Social work services	X				
89. Sports medicine					X
90. Support groups	X				
91. Swing bed services					X
92. Teen outreach services	X				
93. Tobacco treatment / cessation program	X				
94. Transplant services: 94a. Bone marrow transplant services					X
94b. Heart					X
94c. Kidney					X
94d. Liver					X
94e. Lung					X
94f. Tissue					X
94g. Other					X
95. Transportation to health facilities					X
96. Urgent care center					X
97. Virtual Colonoscopy	X				
98. Volunteer services department	X				
99. Women's health center / services	X				
100. Wound management services	X				

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section C: Question Physician Arrangements	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Do Not Provide
101a. Independent Practice Association	☐ (# Physicians: ____)	☐	☐	☒
101b. Group practice without walls	☐ (# Physicians: ____)	☐	☐	☒
101c. Open Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	☒
101d. Closed Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	☒
101e. Management Service Organization (MSO)	☐ (# Physicians: ____)	☐	☐	☒
101f. Integrated Salary Model	☒ (# Physicians: 18)	☐	☐	☐
101g. Equity Model	☐ (# Physicians: ____)	☐	☐	☒
101h. Foundation	☐ (# Physicians: ____)	☐	☐	☒
101i. Other:	☐ (# Physicians: ____)	☐	☐	☒

	Answer
102a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?	Yes
102b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that appy).	d. Other
102b. Other	Siroc, Bone Densitomety, Collaborati
102c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that appy).	
102c. Other	
102d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	Yes

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section C: Question Insurance Products and Capitation	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Joint Venture With Insurer	(5) Do Not Provide
103a. Health Maintenance Organization					X
103b. Preferred Provider Organization					X
103c. Indemnity Fee for Service Plan					X

Section C: Question Insurance Products and Capitation	Answer
104a. Health maintenance organization (HMO)	Yes
104b. If YES, how many contracts?	4
104c. Preferred provider organization (PPO	Yes
104d. If YES, how many contracts?	6
105a. What percentage of the hospital's net patient revenue is paid on a capitated basis? (If the hospital does not participate in capitated arrangements, please enter 0)	0
105b. What percentage of the hospital's net revenue is paid on a shared risk basis?	0
106. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
107. If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated payment, how many lives are covered?	

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	04/27/2010	Thomas R Siemers

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	108	135		
c. Bassinets set up and staffed for use at the end of the reporting period	5	5		
d. Births (exclude fetal deaths)	785	769		
e. Admissions (exclude newborns, include neonatal & swing admissions)	4,472	5,382		
f. Inpatient days (exclude newborns, include neonatal & swing days)	17,997	22,095		
g. Emergency department visits	26,109	25,302		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	128,961	146,392		
i. Inpatient surgical operations	1,171	1,135		
j. Number of operating rooms	5	5		
k. Outpatient surgical operations	8,361	8,680		

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days & deaths)				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	2,087	2,510		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care	0	0		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	11,113	13,371		
b. 2. How many Medicare inpatient days were Medicare Managed Care	0	0		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	833	918		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care	0	0		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	3,206	3,793		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care	0	0		

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net Patient revenue	78,622,064	77,610,090		
*b. Tax appropriations	0	0		
*c. Other operating revenue	3,335,205	2,622,592		
*d. Nonoperating revenue	-2,067,335	1,237,713		
*e. TOTAL REVENUE (add 3a thru 3d)	79,889,934	81,470,395		
f. Payroll expenses (only)	34,332,660	36,174,958		
g. Employee benefits	7,313,876	8,001,809		
h. Depreciation expense (for reporting period only)	4,795,142	4,662,708		
i. Interest expense	1,858,036	2,025,761		
j. TOTAL EXPENSES (Payroll plus all non - payroll expenses, including bad debt)	80,353,332	82,952,056		
Bad Debt conclusion				
k. Due to differing accounting standards in use, please indicate whether or not bad debt is included in: Total Expenses..... (d.3.j)	Yes	Yes		
k. Due to differing accounting standards in use, please indicate whether or not bad debt is included in: Net Patient Revenue (d.3.a.)	No	No		
*4. Revenue By type				
a. Total gross inpatient revenue	57,018,996	59,449,103		
b. Total gross outpatient revenue	92,522,864	89,883,260		
c. Total gross patient revenue	149,541,860	149,332,363		
*5. Uncompensated Care				
a. Bad debt expense	5,543,732	5,175,339		
b. Charity (Revenue forgone at full established rates. Include in gross revenue)	1,257,341	1,466,110		
c. Is your bad debt reported here (5a.1) reported on the basis of full charges?	No	No		

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	67,779,150	68,788,305	30,997,922	31,614,511
6a1b. Managed care revenue				
6a1c. Total (a + b)	67,779,150	68,788,305	30,997,922	31,614,511
Medicaid				
6a2. Medicaid:				
6a2a. Fee for service patient revenue	23,781,942		8,007,205	
6a2b. Managed care revenue				
6a2c. Medicaid Disproportionate Share Hospital Payments (DSH)				
6a2d. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments (DSH)				
6a2e. Total (a+b+c+d)	23,781,942	23,033,660	8,007,205	7,517,593
6a3. Other Government:	616,471	685,663	430,664	456,756
6b1. Self-pay	6,117,890	6,094,693	4,591,581	4,502,292
6b2a. Managed care (includes HMO and PPO)	12,048,483	12,086,650	7,914,901	7,383,509
6b2b. Other third - party payors	39,197,924	38,643,392	26,679,791	26,135,429
6b2c. Total Third - party payors (a+b)	51,246,407	50,730,042	34,594,692	33,518,938
6b3. All Other nongovernment				
*6c. TOTAL	149,541,860	149,332,363	78,622,064	77,610,090

	Answer	Answer (History)
6d. Are the financial data reported from your audited financial statement?	Yes	Yes
6e. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

	Answer	Answer (History)
7. Fixed Assets		
7a. Property, plant and equipment at cost	88,720,310	89,194,473
7b. Less: Accumulated depreciation	56,434,442	53,525,150
7c. Net property, plant and equipment (a - b)	32,285,868	35,669,323
7d. Total gross square feet of your physical plant used for or in support of your healthcare activities	414,303	414,303
8. Total Capital Expenses		
(Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.)	2,624,672	2,578,312

	Answer	Answer (History)
9. ENERGY CONSUMPTION		
a. Total energy usage (in MMBTU) for total gross square footage identified in 7 (d)	701,175	724,729
b. If you have obtained an Energy Star rating from the EPA, what is your rating?...		
*10. INFORMATION TECHNOLOGY		
a. IT Operating Expense	2,088,843	2,176,141
b. IT Capital Expense.	45,325	59,654
c. Number of Employed IT staff (in FTEs).	11.55	12
d. Number of outsourced IT staff (in FTEs).		
Electric Health Record		
e. Does your hospital have an electronic health record (see definition)?	Yes, partially implemented	Yes, partially implemented

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section D: Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (less then 35 hr/wk) On Payroll	Part-Time (History)	FTE
a. Physicians and dentists	15	18	0	0	14.24
b. Medical and dental residents/interns	0	0	0	0	0
c. Other trainees	0	0	0	0	0
d. Registered nurses	154	167	46	49	156.84
e. Licensed practical (vocational) nurses	10	12	5	3	11.36
f. Nursing assistive personnel	44	33	12	18	44.91
g. Radiology technicians	13	16	7	8	13.68
h. Laboratory technicians	0	0	0	0	0
i. Pharmacists,licensed	3	4	1	1	3.33
j. Pharmacy technicians	6	5	1	1	6.4
k. Respiratory therapists	5	5	1	1	5.32
l. All other personnel	383	401	108	107	453.83
m. Total facility personnel (add 11.a through 11.l)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 11.n and 11.o)	633	661	181	188	709.91
n. Nursing home type unit/facility Registered Nurses	0	0	0	0	0
o. Nursing home type unit/facility personnel(if applicable - please break out these personnel from the total facility number.)	0	0	0	0	0

Section D: Staffing (continued)

	Answer	Answer (History)
HOSPITALISTS		
a. Do hospitalists provide care for patients in your hospital?	No	No

	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (less then 35 hr/wk) On Payroll	Part-Time (History)	FTE
b. If yes, please report the number of full time, part time and FTE Hospitalists?					

	Answer	Answer (History)
c. If yes, please select the category below that best describes the employment model for your hospitalists?		

13. INTENSIVISTS

	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital.	No	

	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (less then 35 hr/wk) On Payroll	Part-Time (History)	FTE
1. Medical-surgical intensive care					
2. Cardiac intensive care					
3. Neonatal intensive care					
4. Pediatric intensive care					
5. Other intensive care					
6. Total					

If yes, please select the category below that best describes the employment model for your intensivists.

	Independent provider group	Employed by your hospital	Employed by a physician group	Employed by a university or school program	Other
1. Medical surgical intensive care	☐	☐	☐	☐	☐
2. Cardiac intensive care	☐	☐	☐	☐	☐
3. Neonatal intensive care	☐	☐	☐	☐	☐
4. Pediatric intensive care	☐	☐	☐	☐	☐
5. Other intensive care	☐	☐	☐	☐	☐

	Answer	Answer (History)
FOREIGN EDUCATED NURSES		
a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2009 vs. 2008?	Did not hire foreign nurses	Did not hire foreign nurses
b. From which countries/continents are you recruiting foreign-educated nurses? CHECK ALL THAT APPLY		

.

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	04/27/2010	Thomas R Siemers

Section E: Community Benefits	Answer
a. Does your hospital's mission statement include a focus on community benefit?	Yes
b. Does your hospital have a long - term plan for improving the health of its community?	Yes
c. Does your hospital have a specific budget for its community benefit activities?	Yes
d. Does your hospital have dedicated staff to manage community benefit activities?	Yes
e. Does your hospital provide support for community building activities (e.g. economic development, housing, environmental improvements, coalition building)?	Yes
f. Does your hospital make financial contributions (grants, donations, scholarships), provide in-kind support or participate in fundraising for community programs not directly affiliated with the hospital?	Yes
g. Does your hospital partner with your local school system to offer health or wellness programs to help your community?	Yes
h. Does your hospital work with other providers, public agencies, or community representatives to conduct a health status assessment of the community?	Yes
i. Does your hospital use health status indicators (such as rates of health problems or surveys of self - reported health) for defined populations to design new services or modify existing services	Yes
j1. Does your hospital work with other local providers, public agencies, or community representatives to develop a written assessment of the appropriate capacity for health services in the community?	Yes
j2. If yes, have you used the assessment to identify unmet health needs, excess capacity, or duplicative services in the community?	Yes
k. Does your hospital work with other providers to collect, track, and communicate clinical and health information across cooperating organizations?	Yes
l. Does your hospital either by itself or in conjunction with others disseminate reports to the community on the quality and costs of health care services	Yes
2. DIVERSITY, LANGUAGE AND LEADERSHIP	
a. Does your hospital gather information on a patient's race/ethnicity at any point during their stay?	Yes
b. Does your hospital gather information on a patient's primary language any point during their stay?	Yes
c. Does your hospital or health system currently have or plan to develop, implement or evaluate a leadership development program?	Yes
d. Does your hospital or health system currently have or plan to develop, execute or evaluate a diversity strategy or plan?	Yes
e. Does your hospital or health system engage in leadership succession planning?	Yes
f. Does your hospital or health system currently provide career development resources to administrators?	Yes

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information (Cont)	Completed	04/27/2010	Thomas R Siemers

Section F: Supplemental Information

	Answer
F. OTHER INFORMATION	
1. Does your hospital provide services through one or more satellite facilities?	Yes
2. Which of the following best describes the type of triage system your emergency department uses on a daily basis to determine which patients can wait to be seen and which need to be seen immediately.	a. Three (3) level system (emergent, urgent, non urgent, red, yellow, green)
Does your hospital outsource the HIM coding function under any of the following conditions?	
1. To handle backlog due to staff vacations or shortages.	No
2. Partially outsource during normal operations.	No
3. Completely outsourced during normal operations	No
4. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	Yes
	orhc.com
5. Use this space to describe your community benefit activities as well as any partners you are currently working with on such activities. Also use this space or additional sheets if more space is required for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	Health Fairs, School Based programs, Student Career Fairs, Homecare Equipment Loan, Informational Brochures, Race for the Cure, Humor Therapy, Relay for Life, Healthcare Scholarships, Teen Leaders in Action
6. Please indicate below whether or not you agree to these types of disclosure:	I hereby grant AHA permission to release my hospital's revenue data to external users that the AHA determines have a legitimate and worthwhile need to gain access to these data subject to the user's agreement with the AHA not to release hospital specific information.
Your Name & Title	[redacted]
Your Email Address	
Your Phone Number	
Your Fax Number	

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
2009 Iowa Department of Public Health	Completed	04/27/2010	Thomas R Siemers

State Survey: Question	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	We closed our inpatient psychiatric unit
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	Permanent
Bed Type Numbers - Beds and Utilization by Inpatient Service	
Questions 2a thru 2x relate to section D1a. of the AHA Survey. The total number of beds here should match the total facility numbers as reported in section D1a. for licensed beds.	
a. General Medical/Surgical(adult, include gynecology)	130
b. General Medical/Surgical (pediatric)	20
c. Obstetrics	18
d. Other Acute	0
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	10
f. Cardiac Intensive Care	0
g. Neonatal Intensive Care (exclude normal newborn)	4
h. Neonatal Intermediate Care	0
i. Pediatric Intensive Care	0
j. Burn Care	0
k. Other Special Care (definitive observation, step down, etc.)	17
l. Other Intensive Care	0

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
m. Rehabilitation	18
n. Chronic Disease	0
o. Alzheimer's	0
p. Hospice	0
q. Psychiatric Care	0
r. Alcoholism/Drug Abuse or Dependency Care	0
s. Mental Retardation	0
t. Skilled Nursing Care	0
u. Intermediate Care	0
v. Residential Care/Elderly Housing	0
w. SubAcute Care	0
x. Total Facility (Add lines a thru w.)	217
a. Private	1070
b. Semi-Private	1070
c. OB	1020
d. Pediatric	1020
e. Substance Abuse Treatment	1540
f. Detoxification	1540
g. Rehabilitation	885
h. Psychiatric	1070
i. Intensive Care Unit	2090

AHA Annual Survey - 2009

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
a. Amount of Charity	1257341
b. Amount of Hill-Burton	0
c. Bad Debt	5543732
d. Total Non-Reimbursed	6801073
5. Data Release	Yes

To comply with the Iowa uniform reporting requirement law, Iowa Hospital Association is authorized to release data to the Iowa Department of Public Health.

[redacted]

a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	23781942
b. Medicaid Contractual Adjustments	15774737
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	8007205
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	7610355
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	396850
a. Charity Care Charge-level (should equal D.5b)	1257341
b. Charity Care Cost-level	540657

Wednesday, June 29, 2011 10:26 AM

AHA Annual Survey - 2010

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status

Submitted

Date Started	Date Last Edited	Date Submitted
MAR-28-11	JUN-17-11	JUN-17-11

Survey Administrators

David Kreye

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	06/17/2011	David Kreye

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	05/01/2010
	To (mm/dd/yyyy)	12/31/2010
2a. Were you in operation 12 full months at the end of your reporting period?		No
2b. Number of days open during reporting period:		245
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	05/01/2010

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	06/17/2011	David Kreye

Section B: Question	Description	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. CHECK ONLY ONE:		33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:		10 General medical and surgical
	Other-specify treatment area:	
OTHER		
3a. Does your hospital restrict admissions primarily to children?		No
3b. Does the hospital itself operate subsidiary corporations?		Yes
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:		No
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	STATE	
3d. Is the hospital a participant in a network? If yes, please provide the name, city, state, and telephone number of your network(s).		No
	Name	
	Phone	
	Name	
	Phone	
	Name	
	Phone	
3e. Is your hospital owned in whole or in part by physicians or a physician group?		No

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
3f. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH(F) or a LTCH(C) colocated within a general acute care hospital.		
If you are colocated in a general acute care hospital, what is your host hospital's name,city and state?		
NPI		
4. NATIONAL PROVIDER IDENTIFIER (NPI)		
National Plan Provider		
a. Does your hospital have its new National Provider Identifier (NPI) from the National Plan and Provider Enumeration System?		Yes
Digital NPI		
If yes, please report the ten digit NPI		1013233741
SubPart NPI		
Does your hospital also have a Subpart NPI.?		Yes
National Identifier Provider (NPI)		
Subpart NPI 1		1477879195 04 - Rehabilitation Unit
Subpart NPI 2		1730407362 10 - Other
Subpart NPI 3		1548588171 10 - Other
Subpart NPI 4		1689990483 10 - Other
Subpart NPI 5		1477578075 10 - Other
Subpart NPI 6		1538487160 10 - Other
Subpart NPI 7		
Subpart NPI 8		
Subpart NPI 9		

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
Subpart NPI 10		
Subpart NPI 11		
Subpart NPI 12		
Subpart NPI 13		
Subpart NPI 14		
Subpart NPI 15		
Subpart NPI 16		
Subpart NPI 17		
Subpart NPI 18		
Subpart NPI 19		
Subpart NPI 20		
Subpart NPI 21		
Subpart NPI 22		
Subpart NPI 23		
Subpart NPI 24		
Subpart NPI 25		
Subpart NPI 26		
Subpart NPI 27		

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
Subpart NPI 28		
Subpart NPI 29		
Subpart NPI 30		

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	06/17/2011	David Kreye

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
1. General medical - surgical care	X (#Beds: 48)				
2. Pediatric medical - surgical care	X (#Beds: 4)				
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	X (#Beds: 10)	X 2			
4. Medical surgical intensive care	X (#Beds: 8)				
5. Cardiac intensive care	(#Beds: ____)				X
6. Neonatal intensive care	X (#Beds: 3)				
7. Neonatal intermediate care	X (#Beds: 2)				
8. Pediatric intensive care	(#Beds: ____)				X
9. Burn care	(#Beds: ____)				X
10. Other special care	(#Beds: ____)	(Specify: ____)			X
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	(#Beds: ____)	(Specify: ____)			X
12. Physical rehabilitation	X (#Beds: 13)				
13. Alcoholism - drug abuse or dependency care	(#Beds: ____)				X
14. Psychiatric care	(#Beds: ____)				X
15. Skilled nursing care	(#Beds: ____)				X
16. Intermediate nursing care	(#Beds: ____)				X
17. Acute long term care	(#Beds: ____)				X
18. Other long-term care	(#Beds: ____)				X
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	(#Beds: ____)	(Specify: ____)			X

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
20. Adult day care program					X
21. Airborne infection isolation room (Please specify the number of rooms)	X	# Rooms: 2			
22. Alcoholism - drug abuse or dependency outpatient services					X
23. Alzheimer Center		X			
24. Ambulance services	X				
25. Ambulatory surgery center					X
26. Arthritis treatment center					X
27. Assisted living		X			
28. Auxiliary	X				
29. Bariatric/weight control services					X
30. Birthing room - LDR room - LDRP room	X				
31. Blood Donor Center				X	
32. Breast cancer screening / mammograms	X				
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services					X
33b. Pediatric cardiology services					X
33c. Adult diagnostic catheterization	X				
33d. Pediatric diagnostic catheterization					X
33e. Adult interventional cardiac catheterization	X				
33f. Pediatric interventional cardiac catheterization					X
33g. Adult cardiac surgery					X
33h. Pediatric cardiac surgery					X
33i. Adult cardiac electrophysiology	X				

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
33j. Pediatric cardiac electrophysiology					X
33k. Cardiac rehabilitation	X				
34. Case management	X				
35. Chaplaincy/pastoral care services	X				
36. Chemotherapy	X				
37. Children's wellness program					X
38. Chiropractic services					X
39. Community outreach	X				
40. Complementary and alternative medicine services					X
41. Computer assisted orthopedic surgery (CAOS)					X
42. Crisis prevention					X
43. Dental services					X
44. Emergency services: 44a. Emergency department	X				
44b. Satellite emergency department					
44c. Is the department open 24 hours a day, 7 days a week?		(24 hours: ____)			X
44d. Trauma center (certified) [Level of unit (1-3)]	X	3			
45. Enabling services					X
46. Endoscopic services 46a.Optical colonoscopy					X
46b. Endoscopic ultrasound	X				
46c. Ablation of Barrett's esophagus	X				
46d. Esophageal impedance study	X				
46e. Endoscopic retrograde cholangiopancreatography (ERCP)					X
47. Enrollment assistance services					X

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
48. Extracorporeal shock wave lithotripter (ESWL)	X				
49. Fertility clinic					X
50. Fitness center					X
51. Freestanding outpatient care center	X				
52. Geriatric services	X				
53. Health fair	X				
54. Community health education	X				
55. Genetic testing/counseling					X
56. Health screenings	X				
57. Health research					X
58. Hemodialysis				X	
59. HIV - AIDS services					X
60. Home health services	X				
61. Hospice program					X
62. Hospital - based outpatient care center - services	X				
63. Immunization program					X
64. Indigent care clinic					X
65. Linguistic/translation services	X				
66. Meals on wheels					X
67. Mobile health services					X
68. Neurological services					X
69. Nutrition programs	X				
70. Occupational health services	X				

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
71. Oncology services	X				
72. Orthopedic services	X				
73. Outpatient surgery	X				
74. Pain management program	X				
75. Palliative care program					X
76. Palliative care inpatient unit					X
77. Patient Controlled Analgesia (PCA)	X				
78. Patient education center	X				
79. Patient representative services	X				
80. Physical rehabilitation services					
80a. Assistive technology center					X
80b. Electrodiagnostic services					X
80c. Physical rehabilitation outpatient services	X				
80d. Prosthetic and orthotic services					X
80e. Robot-assisted walking therapy					X
80f. Simulated rehabilitation environment					X
81. Primary care department					X
82. Psychiatric services:					
82a. Psychiatric child - adolescent services					X
82b. Psychiatric consultation - liaison services	X				
82c. Psychiatric education services	X				
82d. Psychiatric emergency services	X				
82e. Psychiatric geriatric services	X				

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
82f. Psychiatric outpatient services	X				
82g. Psychiatric partial hospitalization program					X
83. Radiology, diagnostic: 83a. CT scanner	X				
83b. Diagnostic radioisotope facility	X				
83c. Electron beam computed tomography (EBCT)					X
83d. Full-field digital mammography(FFDM)	X				
83e. Magnetic resonance imaging (MRI)	X				
83f. Intraoperative magnetic resonance imaging	X				
83g. Multi-slice spiral computed tomography(<64 + slice CT)					X
83h. Multi-slice spiral computed tomography (64+ slice)					X
83i. Positron emission tomography (PET)				X	
83j. Positron emission tomography/CT (PET/CT)				X	
83k. Single photon emission computerized tomography (SPECT)					X
83l. Ultrasound	X				
84. Radiology therapeutic: 84a. Image -guided Radiation Therapy(IGRT)					X
84b. Intensity-Modulated Radiation Therapy (IMRT)				X	
84c. Proton beam therapy					X
84d. Shaped Beam Radiation System					X
84e. Stereotactic radiosurgery					X
85. Retirement housing	X				
86. Robotic surgery					X

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
87. Rural health clinic					X
88. Sleep center	X				
89. Social work services	X				
90. Sports medicine					X
91. Support groups	X				
92. Swing bed services					X
93. Teen outreach services	X				
94. Tobacco treatment / cessation program	X				
95. Transplant services: 95a. Bone marrow transplant services					X
95b. Heart					X
95c. Kidney					X
95d. Liver					X
95e. Lung					X
95f. Tissue					X
95g. Other					X
96. Transportation to health facilities					X
97. Urgent care center					X
98. Virtual Colonoscopy	X				
99. Volunteer services department	X				
100. Women's health center / services	X				
101. Wound management services	X				

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section C: Question Physician Arrangements	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Do Not Provide
102a. Independent Practice Association	☐ (# Physicians: ____)	☐	☐	X
102b. Group practice without walls	☐ (# Physicians: ____)	☐	☐	X
102c. Open Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	X
102d. Closed Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	X
102e. Management Service Organization (MSO)	☐ (# Physicians: ____)	☐	☐	X
102f. Integrated Salary Model	X (# Physicians: 3)	☐	☐	☐
102g. Equity Model	☐ (# Physicians: ____)	☐	☐	X
102h. Foundation	☐ (# Physicians: ____)	☐	☐	X
102i. Other, please specify:	☐ (# Physicians: ____)	☐	☐	X

	Answer	Answer (History)
102b. Looking across all the relationships identified in question 102a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payers or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be at the hospital, system or network level)? # of physicians		
103a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?	Yes	Yes
103b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that appy).	d. Other	d. Other
103b. Other	Radiation Oncology, Lab services	Siroc, Bone Densitomety, Collaborative Lab
103c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that appy).		
103c. Other		
103d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	No	Yes

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section C: Question Insurance Products and Capitation	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Joint Venture With Insurer	(5) Do Not Provide
104a. Health Maintenance Organization					X
104b. Preferred Provider Organization					X
104c. Indemnity Fee for Service Plan					X

Section C: Question Insurance Products and Capitation	Answer
105a. Health maintenance organization (HMO)	Yes
105b. If YES, how many contracts?	4
105c. Preferred provider organization (PPO)	Yes
105d. If YES, how many contracts?	6
106a. What percentage of the hospital's net patient revenue is paid on a capitated basis? (If the hospital does not participate in capitated arrangements, please enter 0)	0
106b. What percentage of the hospital's net revenue is paid on a shared risk basis?	0
107. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
108. If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated payment, how many lives are covered?	

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	06/17/2011	David Kreye

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	88	108		
c. Bassinets set up and staffed for use at the end of the reporting period	5	5		
d. Births (exclude fetal deaths)	661	785		
e. Admissions (exclude newborns, include neonatal & swing admissions)	3,997	4,472		
f. Inpatient days (exclude newborns, include neonatal & swing days)	15,673	17,997		
g. Emergency department visits	25,742	26,109		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	132,344	128,961		
i. Inpatient surgical operations	870	1,171		
j. Number of operating rooms	5	5		
k. Outpatient surgical operations	7,929	8,361		

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days & deaths)				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	2,237	2,087		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care	140	0		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	10,750	11,113		
b. 2. How many Medicare inpatient days were Medicare Managed Care	522	0		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	936	833		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care	0	0		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	2,606	3,206		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care	0	0		

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net Patient revenue	53,930,359	78,622,064		
*b. Tax appropriations	0	0		
*c. Other operating revenue	1,271,783	3,335,205		
*d. Nonoperating revenue	247,475	-2,067,335		
*e. TOTAL REVENUE (add 3a thru 3d)	55,449,617	79,889,934		
f. Payroll expenses (only)	20,477,757	34,332,660		
g. Employee benefits	4,164,111	7,313,876		
h. Depreciation expense (for reporting period only)	3,364,166	4,795,142		
i. Interest expense	3,287,369	1,858,036		
j. Supply expense	5,882,476			
k. TOTAL EXPENSES (Payroll plus all non - payroll expenses, including bad debt)	54,380,250	80,353,332		
Bad Debt conclusion				
l. Due to differing accounting standards in use, please indicate whether or not bad debt is included in: Total Expenses..... (d.3.k)	Yes	Yes		
l. Due to differing accounting standards in use, please indicate whether or not bad debt is included in: Net Patient Revenue (d.3.a.)	No	No		
*4. Revenue By type				
a. Total gross inpatient revenue	38,355,119	57,018,996		
b. Total gross outpatient revenue	68,260,874	92,522,864		
c. Total gross patient revenue	106,615,993	149,541,860		
*5. Uncompensated Care				
a. Bad debt expense	4,664,361	5,543,732		
b. Charity (Revenue forgone at full established rates. Include in gross revenue)	618,582	1,257,341		
c. Is your bad debt reported here (5a.) reported on the basis of full charges?	Yes	No		

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	47,562,252	67,779,150	21,401,554	30,997,922
6a1b. Managed care revenue		0		0
6a1c. Total (a + b)	47,562,252	67,779,150	21,401,554	30,997,922
Medicaid				
6a2. Medicaid:				
6a2a. Fee for service patient revenue	17,745,095	23,781,942	7,139,847	8,007,205
6a2b. Managed care revenue		0		0
6a2c. Medicaid Disproportionate Share Hospital Payments (DSH)		0		0
6a2d. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments (DSH)		0		0
6a2e. Total (a+b+c+d)	17,745,095	23,781,942	7,139,847	8,007,205
6a3. Other Government:	474,909	616,471	253,298	430,664
6b1. Self-pay	5,736,238	6,117,890	5,121,318	4,591,581
6b2a. Managed care (includes HMO and PPO)	6,636,501	12,048,483	4,208,566	7,914,901
6b2b. Other third - party payors	28,460,998	39,197,924	15,805,776	26,679,791
6b2c. Total Third - party payors (a+b)	35,097,499	51,246,407	20,014,342	34,594,692
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	106,615,993	149,541,860	53,930,359	78,622,064

	Answer	Answer (History)
6d. Are the financial data reported from your audited financial statement?	No	Yes
6e. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

	Answer	Answer (History)
7. Fixed Assets		
7a. Property, plant and equipment at cost	51,639,287	88,720,310
7b. Accumulated depreciation	3,364,166	56,434,442
7c. Net property, plant and equipment (a - b)	48,275,121	32,285,868
7d. Total gross square feet of your physical plant used for or in support of your healthcare activities	226,100	414,303
8. Total Capital Expenses		
(Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.)	2,214,086	2,624,672

	Answer	Answer (History)
9. ENERGY CONSUMPTION		
a. Total energy usage (in MMBTU) for total gross square footage identified in 7 (d)		701,175
b. If you have obtained an Energy Star rating from the EPA, what is your rating?...	0	0
*10. INFORMATION TECHNOLOGY		
a. IT Operating Expense	1,098,357	2,088,843
b. IT Capital Expense.	18,698	45,325
c. Number of Employed IT staff (in FTEs).	11	12
d. Number of outsourced IT staff (in FTEs).	0	0
Electric Health Record		
e. Does your hospital have an electronic health record (see definition)?	Yes, partially implemented	Yes, partially implemented

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.		

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section D: Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians and dentists	7	15	1	0	7.5		
b. Medical and dental residents/interns	0	0	0	0	0		
c. Other trainees	0	0	0	0	0		
d. Registered nurses	143	154	50	46	155.07		
e. Licensed practical (vocational) nurses	5	10	2	5	5.53		
f. Nursing assistive personnel	35	44	18	12	38.77		
g. Radiology technicians	8	13	7	7	13.68		
h. Laboratory technicians	0	0	0	0	0		
i. Pharmacists,licensed	5	3	1	1	5.1		
j. Pharmacy technicians	4	6	1	1	4.53		
k. Respiratory therapists	4	5	3	1	5.4		
l. All other personnel	327	383	91	108	357.78		
m. Total facility personnel (add 11.a through 11.l)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 11.n and 11.o)	538	633	174	181	588.74		
n. Nursing home type unit/facility Registered Nurses	0	0	0	0	0		
o. Nursing home type unit/facility personnel(if applicable - please break out these personnel from the total facility number.)	0	0	0	0	0		

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

12. PRIVILEGED PHYSICIANS	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, obstetrics/gynecology, geriatrics)	4				
b. Emergency medicine					
c. Hospitalist					
d. Intensivist					
e. Radiologist/pathologist/anesthesiologist					
f. Other specialist	3				
g. Total (add 12a-12f)	7				

HOSPITALISTS	Answer	Answer (History)
13a. Do hospitalists provide care for patients in your hospital? (if yes, please report in D.12c.)	No	No
13b. If yes, please report the total number of full-time equivalents (FTE) hospitalists.		

14. INTENSIVISTS	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (if yes, please report in D.12d.)	No	No

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care				
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total				

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
ADVANCED PRACTICE REGISTERED NURSES		
a. Do advanced practice nurses provide care for patients in your hospital?(if no, please skip to 16.)	Yes	
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. Full-time	3	
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. Part-time	1	
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. FTE	3.2	
c. If yes, please indicate the type of service the nurses provide (Please check all that apply).	Primary care	
FOREIGN EDUCATED NURSES		
a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2010 vs. 2009?	Did not hire foreign nurses	Did not hire foreign nurses
b. From which countries/continents are you recruiting foreign-educated nurses? CHECK ALL THAT APPLY		

.

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	06/17/2011	David Kreye

Section E: Community Benefits	Answer
a. Does your hospital's mission statement include a focus on community benefit?	Yes
b. Does your hospital have a long - term plan for improving the health of its community?	Yes
c. Does your hospital have a specific budget for its community benefit activities?	Yes
d. Does your hospital have dedicated staff to manage community benefit activities?	Yes
e. Does your hospital provide support for community building activities (e.g. economic development, housing, environmental improvements, coalition building)?	No
f. Does your hospital make financial contributions (grants, donations, scholarships), provide in-kind support or participate in fundraising for community programs not directly affiliated with the hospital?	No
g. Does your hospital partner with your local school system to offer health or wellness programs to help your community?	Yes
h. Does your hospital work with other providers, public agencies, or community representatives to conduct a health status assessment of the community?	No
i. Does your hospital use health status indicators (such as rates of health problems or surveys of self - reported health) for defined populations to design new services or modify existing services	No
j1. Does your hospital work with other local providers, public agencies, or community representatives to develop a written assessment of the appropriate capacity for health services in the community?	No
j2. If yes, have you used the assessment to identify unmet health needs, excess capacity, or duplicative services in the community?	
k. Does your hospital work with other providers to collect, track, and communicate clinical and health information across cooperating organizations?	No
l. Does your hospital either by itself or in conjunction with others disseminate reports to the community on the quality and costs of health care services	No
2. DIVERSITY, LANGUAGE AND LEADERSHIP	
a. Does your hospital gather information on a patient's race/ethnicity at any point during their stay?	Yes
b. Does your hospital gather information on a patient's primary language any point during their stay?	Yes
c. Does your hospital or health system currently have or plan to develop, implement or evaluate a leadership development program?	No
d. Does your hospital or health system currently have or plan to develop, execute or evaluate a diversity strategy or plan?	No
e. Does your hospital or health system engage in leadership succession planning?	No
f. Does your hospital or health system currently provide career development resources to administrators?	Yes

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information (Cont)	Completed	06/17/2011	David Kreye

Section F: Supplemental Information

	Answer
F. OTHER INFORMATION	
a. Does your hospital provide services through one or more satellite facilities?	Yes
OTHER	
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	Yes
	HealthTrust Purchasing Group
	Brentwood
	TN
c. Does the hospital purchase medical/surgical supplies directly through a distributor?	No
If yes, please provide the name of the distributor.	
d. Which of the following best describes the type of triage system your emergency department uses on a daily basis to determine which patients can wait to be seen and which need to be seen immediately.	3. Five (5) level Emergency Severity Index (ESI)
Does your hospital outsource the HIM coding function under any of the following conditions?	
1. To handle backlog due to staff vacations or shortages.	No
2. Partially outsource during normal operations.	No
3. Completely outsourced during normal operations	No

f. Use this space to describe your community benefit activities as well as any partners you are currently working with on such activities. Also use this space or additional sheets if more space is required for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	
g. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	Yes
	orhc.com
h. Please indicate below whether or not you agree to these types of disclosure:	 I do not grant AHA permission to release my confidential data.
Your Name & Title	[redacted]
Your Email Address	
Your Phone Number	
Your Fax Number	

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
2010 Iowa Department of Public Health	Completed	06/17/2011	David Kreye

State Survey: Question	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	None
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	n/a
Bed Type Numbers - Beds and Utilization by Inpatient Service	
Questions 2a thru 2x relate to section D1a. of the AHA Survey. The total number of beds here should match the total facility numbers as reported in section D1a. for licensed beds.	
a. General Medical/Surgical(adult, include gynecology)	130
b. General Medical/Surgical (pediatric)	20
c. Obstetrics	18
d. Other Acute	
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	10
f. Cardiac Intensive Care	
g. Neonatal Intensive Care (exclude normal newborn)	4
h. Neonatal Intermediate Care	
i. Pediatric Intensive Care	
j. Burn Care	
k. Other Special Care (definitive observation, step down, etc.)	17
l. Other Intensive Care	

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
m. Rehabilitation	18
n. Chronic Disease	
o. Alzheimer's	
p. Hospice	
q. Psychiatric Care	
r. Alcoholism/Drug Abuse or Dependency Care	
s. Mental Retardation	
t. Skilled Nursing Care	
u. Intermediate Care	
v. Residential Care/Elderly Housing	
w. SubAcute Care	
x. Total Facility (Add lines a thru w.)	217
a. Private	1125
b. Semi-Private	1125
c. OB	1020
d. Pediatric	1020
e. Substance Abuse Treatment	0
f. Detoxification	2090
g. Rehabilitation	885
h. Psychiatric	0
i. Intensive Care Unit	2090

AHA Annual Survey - 2010

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
a. Amount of Charity	618582
b. Amount of Hill-Burton	0
c. Bad Debt	4664361
d. Total Non-Reimbursed	5282943
5. Data Release	Yes

To comply with the Iowa uniform reporting requirement law, Iowa Hospital Association is authorized to release data to the Iowa Department of Public Health.

[redacted]

a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	17745095
b. Medicaid Contractual Adjustments	10605248
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	7139847
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	11997405
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	-4857558
a. Charity Care Charge-level (should equal D.5b)	618582
b. Charity Care Cost-level	283308

Wednesday, August 22, 2012 3:42 PM

AHA Annual Survey - 2011

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status

Submitted

Date Started	Date Last Edited	Date Submitted
FEB-15-12	APR-19-12	APR-19-12

Survey Administrators

Philip Dionne

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	04/19/2012	Philip G Dionne

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy) To (mm/dd/yyyy)	01/01/2011 12/31/2011
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		365
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2012

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	04/19/2012	Philip G Dionne

Section B: Question	Description	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. CHECK ONLY ONE:		33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:		10 General medical and surgical
	Other-specify treatment area:	
OTHER		
3a. Does your hospital restrict admissions primarily to children?		No
3b. Does the hospital itself operate subsidiary corporations?		Yes
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:		No
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	STATE	
3d. Is the hospital a participant in a network? If yes, please provide the name, city, state, and telephone number of your network(s).		No
	Name	
	Phone	
	Name	
	Phone	
	Name	
	Phone	
3e. Is your hospital owned in whole or in part by physicians or a physician group?		No
3f. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH or a LTCH arranged within a general acute care hospital.		

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
If you are arranged in a general acute care hospital, what is your host hospital's name,city and state?		
NPI		
4. NATIONAL PROVIDER IDENTIFIER (NPI)		
National Plan Provider		
a. Does your hospital have its new National Provider Identifier (NPI) from the National Plan and Provider Enumeration System?		Yes
Digital NPI		
If yes, please report the ten digit NPI		1013233741
SubPart NPI		
Does your hospital also have a Subpart NPI.?		Yes
National Identifier Provider (NPI)		
Subpart NPI 1		1477879195 04 - Rehabilitation Unit
Subpart NPI 2		1730407362 10 - Other
Subpart NPI 3		1548588171 10 - Other
Subpart NPI 4		1689990483 10 - Other
Subpart NPI 5		1477578075 10 - Other
Subpart NPI 6		1538487160 10 - Other
Subpart NPI 7		
Subpart NPI 8		
Subpart NPI 9		
Subpart NPI 10		

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
Subpart NPI 11		
Subpart NPI 12		
Subpart NPI 13		
Subpart NPI 14		
Subpart NPI 15		
Subpart NPI 16		
Subpart NPI 17		
Subpart NPI 18		
Subpart NPI 19		
Subpart NPI 20		
Subpart NPI 21		
Subpart NPI 22		
Subpart NPI 23		
Subpart NPI 24		
Subpart NPI 25		
Subpart NPI 26		
Subpart NPI 27		
Subpart NPI 28		

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
Subpart NPI 29		
Subpart NPI 30		

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	04/19/2012	Philip G Dionne

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
1. General medical - surgical care	X (#Beds: 48)				
2. Pediatric medical - surgical care	X (#Beds: 4)				
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	X (#Beds: 10)	X 2			
4. Medical surgical intensive care	X (#Beds: 8)				
5. Cardiac intensive care	(#Beds: ____)				X
6. Neonatal intensive care	X (#Beds: 3)				
7. Neonatal intermediate care	X (#Beds: 2)				
8. Pediatric intensive care	(#Beds: ____)				X
9. Burn care	(#Beds: ____)				X
10. Other special care	(#Beds: ____)	(Specify: ____)			X
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	(#Beds: ____)	(Specify: ____)			X
12. Physical rehabilitation	X (#Beds: 13)				
13. Alcoholism - drug abuse or dependency care	(#Beds: ____)				X
14. Psychiatric care	(#Beds: ____)				X
15. Skilled nursing care	(#Beds: ____)				X
16. Intermediate nursing care	(#Beds: ____)				X
17. Acute long term care	(#Beds: ____)				X
18. Other long-term care	(#Beds: ____)				X
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	(#Beds: ____)	(Specify: ____)			X

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
20. Adult day care program					X
21. Airborne infection isolation room (Please specify the number of rooms)	X	# Rooms: 2			
22. Alcoholism - drug abuse or dependency outpatient services					X
23. Alzheimer Center		X			
24. Ambulance services	X				
25. Ambulatory surgery center					X
26. Arthritis treatment center					X
27. Assisted living		X			
28. Auxiliary	X				
29. Bariatric/weight control services					X
30. Birthing room - LDR room - LDRP room	X				
31. Blood Donor Center				X	
32. Breast cancer screening / mammograms	X				
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services					X
33b. Pediatric cardiology services					X
33c. Adult diagnostic catheterization	X				
33d. Pediatric diagnostic catheterization					X
33e. Adult interventional cardiac catheterization	X				
33f. Pediatric interventional cardiac catheterization					X
33g. Adult cardiac surgery					X
33h. Pediatric cardiac surgery					X
33i. Adult cardiac electrophysiology	X				

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
33j. Pediatric cardiac electrophysiology					X
33k. Cardiac rehabilitation	X				
34. Case management	X				
35. Chaplaincy/pastoral care services	X				
36. Chemotherapy	X				
37. Children's wellness program					X
38. Chiropractic services					X
39. Community outreach	X				
40. Complementary and alternative medicine services					X
41. Computer assisted orthopedic surgery (CAOS)					X
42. Crisis prevention					X
43. Dental services					X
44. Emergency services: 44a. Emergency department	X				
44b. Pediatric emergency department					
44c. Satellite emergency department					
44d. Is the department open 24 hours a day, 7 days a week?		(24 hours: ____)			X
44e. Trauma center (certified) [Level of unit (1-3)]	X	3			
45. Enabling services					X
46. Endoscopic services 46a.Optical colonoscopy					X
46b. Endoscopic ultrasound	X				
46c. Ablation of Barrett's esophagus	X				
46d. Esophageal impedance study	X				
46e. Endoscopic retrograde cholangiopancreatography (ERCP)					X

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
47. Enrollment (insurance) assistance services					X
48. Extracorporeal shock wave lithotripter (ESWL)	X				
49. Fertility clinic					X
50. Fitness center					X
51. Freestanding outpatient care center	X				
52. Geriatric services	X				
53. Health fair	X				
54. Community health education	X				
55. Genetic testing/counseling					X
56. Health screenings	X				
57. Health research					X
58. Hemodialysis				X	
59. HIV - AIDS services					X
60. Home health services	X				
61. Hospice program					X
62. Hospital - based outpatient care center - services	X				
63. Immunization program					X
64. Indigent care clinic					X
65. Linguistic/translation services	X				
66. Meals on wheels					X
67. Mobile health services					X
68. Neurological services					X
69. Nutrition programs	X				

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
70. Occupational health services	X				
71. Oncology services	X				
72. Orthopedic services	X				
73. Outpatient surgery	X				
74. Pain management program	X				
75. Palliative care program					X
76. Palliative care inpatient unit					X
77. Patient Controlled Analgesia (PCA)	X				
78. Patient education center	X				
79. Patient representative services	X				
80. Physical rehabilitation services					
80a. Assistive technology center					X
80b. Electrodiagnostic services					X
80c. Physical rehabilitation outpatient services	X				
80d. Prosthetic and orthotic services					X
80e. Robot-assisted walking therapy					X
80f. Simulated rehabilitation environment					X
81. Primary care department					X
82. Psychiatric services: 82a. Psychiatric child - adolescent services					X
82b. Psychiatric consultation - liaison services	X				
82c. Psychiatric education services					X
82d. Psychiatric emergency services	X				

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
82e. Psychiatric geriatric services					X
82f. Psychiatric outpatient services					X
82g. Psychiatric partial hospitalization program					X
82h. Psychiatric residential treatment					X
83. Radiology, diagnostic: 83a. CT scanner	X				
83b. Diagnostic radioisotope facility	X				
83c. Electron beam computed tomography (EBCT)					X
83d. Full-field digital mammography(FFDM)	X				
83e. Magnetic resonance imaging (MRI)	X				
83f. Intraoperative magnetic resonance imaging	X				
83g. Multi-slice spiral computed tomography(<64 + slice CT)					X
83h. Multi-slice spiral computed tomography (64+ slice)					X
83i. Positron emission tomography (PET)				X	
83j. Positron emission tomography/CT (PET/CT)				X	
83k. Single photon emission computerized tomography (SPECT)					X
83l. Ultrasound	X				
84. Radiology therapeutic: 84a. Image -guided Radiation Therapy(IGRT)					X
84b. Intensity-Modulated Radiation Therapy (IMRT)				X	
84c. Proton beam therapy					X
84d. Shaped Beam Radiation System					X
84e. Stereotactic radiosurgery					X

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
85. Retirement housing	X				
86. Robotic surgery	X				
87. Rural health clinic					X
88. Sleep center	X				
89. Social work services	X				
90. Sports medicine					X
91. Support groups	X				
92. Swing bed services					X
93. Teen outreach services					X
94. Tobacco treatment / cessation program	X				
95. Transplant services: 95a. Bone marrow transplant services					X
95b. Heart					X
95c. Kidney					X
95d. Liver					X
95e. Lung					X
95f. Tissue					X
95g. Other					X
96. Transportation to health facilities					X
97. Urgent care center					X
98. Virtual Colonoscopy	X				
99. Volunteer services department	X				
100. Women's health center / services	X				
101. Wound management services	X				

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section C: Question Physician Arrangements	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Do Not Provide
102a. Independent Practice Association	☐ (# Physicians: ____)	☐	☐	X
102b. Group practice without walls	☐ (# Physicians: ____)	☐	☐	X
102c. Open Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	X
102d. Closed Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	X
102e. Management Service Organization (MSO)	☐ (# Physicians: ____)	☐	☐	X
102f. Integrated Salary Model	X (# Physicians: 3)	☐	☐	☐
102g. Equity Model	☐ (# Physicians: ____)	☐	☐	X
102h. Foundation	☐ (# Physicians: ____)	☐	☐	X
102i. Other, please specify:	☐ (# Physicians: ____)	☐	☐	X

		Answer	Answer (History)
C. Physician Arrangements			
102b. Looking across all the relationships identified in question 102a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payers or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be at the hospital, system or network level)?	# of physicians	0	
Group C 'Joint Venture Physician'			
103a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?		Yes	Yes
103b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that appy).		d. Other	d. Other
103b. Other		Lab services	Radiation Oncology, Lab services
103c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that appy).			
103c. Other			
103d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?		No	No
104a. Has your hospital or health care system established an accountable care organization (ACO)?		No	

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
104b. If yes, please indicate the patient population that participates in the ACO. (Check all that apply):		
104b. Other		
105. Does your hospital have an established medical home program?	No	
106. Does your hospital participate in a bundled payment program involving inpatient, physician, and/or post acute care services where the hospital receives a single payment from a payer for a package of services and then distributes payments to participating providers of care (such as a single fee for hospital and physician services for a specific procedure, e.g. hip replacement, CABG)?	No	
107. Please indicate below what percentage of your hospital's net patient revenue is paid based on the following payment mechanisms:		
a. Fee for Service - DRG	28	
b. Fee for Service - Per Diem	0	
c. Fee for Service plus Shared Savings	0	
d. Bundled payments (inpatient plus physician and/or post acute care)	0	
e. Partial and global capitation payments	0	
f. Other	72	
Total	100	

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section C: Question Insurance Products and Capitation	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Joint Venture With Insurer	(5) Do Not Provide
108a. Health Maintenance Organization					X
108b. Preferred Provider Organization					X
108c. Indemnity Fee for Service Plan					X

Section C: Question Insurance Products and Capitation	Answer
109a. Health maintenance organization (HMO)	Yes
109b. If YES, how many contracts?	4
109c. Preferred provider organization (PPO)	Yes
109d. If YES, how many contracts?	6
110. What percentage of the hospital's net patient revenue is paid on a capitated basis? (If the hospital does not participate in capitated arrangements, please enter 0)	0
111. What percentage of the hospital's net revenue is paid on a shared risk basis?	0
112. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
113. If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated payment, how many lives are covered?	

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	04/19/2012	Philip G Dionne

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	88	88		
c. Bassinets set up and staffed for use at the end of the reporting period	5	5		
d. Births (exclude fetal deaths)	605	661		
e. Admissions (exclude newborns, include neonatal & swing admissions)	3,398	3,997		
f. Inpatient days (exclude newborns, include neonatal & swing days)	14,587	15,673		
g. Emergency department visits	24,812	25,742		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	123,658	132,344		
i. Inpatient surgical operations	903	870		
j. Number of operating rooms	5	5		
k. Outpatient surgical operations	7,443	7,929		

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days & deaths)				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	2,054	2,237		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care	127	140		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	9,886	10,750		
b. 2. How many Medicare inpatient days were Medicare Managed Care	485	522		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	893	936		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care	0	0		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	2,384	2,606		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care	0	0		

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net Patient revenue	78,012,522	53,930,359		
*b. Tax appropriations	0	0		
*c. Other operating revenue	1,522,489	1,271,783		
*d. Nonoperating revenue	18,807	247,475		
*e. TOTAL REVENUE (add 3a thru 3d)	79,553,818	55,449,617		
f. Payroll expenses (only)	25,016,055	20,477,757		
g. Employee benefits	6,046,391	4,164,111		
h. Depreciation expense (for reporting period only)	4,806,336	3,364,166		
i. Interest expense	5,028,024	3,287,369		
j. Supply expense	8,522,463	5,882,476		
k. TOTAL EXPENSES (Payroll plus all non - payroll expenses, including bad debt)	77,554,361	54,380,250		
Bad Debt conclusion				
l. Due to differing accounting standards in use, please indicate whether or not bad debt is included in: Total Expenses..... (d.3.k)	Yes	Yes		
l. Due to differing accounting standards in use, please indicate whether or not bad debt is included in: Deductions from net Patient Revenue (d.3.a.)	No	No		
*4. Revenue By type				
a. Total gross inpatient revenue	59,910,709	38,355,119		
b. Total gross outpatient revenue	116,975,778	68,260,874		
c. Total gross patient revenue	176,886,487	106,615,993		
*5. Uncompensated Care & Provider Taxes				
a. Bad debt expense	7,615,212	4,664,361		
b. Financial Assistance (includes Charity) (Revenue forgone at full established rates. Include in gross revenue)	1,381,933	618,582		
c. Is your bad debt reported here (5a.) reported on the basis of full charges?	Yes	Yes		
d. Does your state have a provider Medicaid tax/assessment program	Yes			
e. If yes, please report the total gross amount paid into the program	373,350			
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Total Expenses..... (d.3.k)	No			
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Deductions from net Patient Revenue (d.3.a.)	Yes			

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	78,909,062	47,562,252	30,955,369	21,401,554
6a1b. Managed care revenue	0	0	0	0
6a1c. Total (a + b)	78,909,062	47,562,252	30,955,369	21,401,554
Medicaid				
6a2. Medicaid:				
6a2a. Fee for service patient revenue	29,433,911	17,745,095	10,328,858	7,139,847
6a2b. Managed care revenue	0	0	0	0
6a2c. Medicaid Disproportionate Share Hospital Payments (DSH)		0	0	0
6a2d. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments (DSH)		0	0	0
6a2e. Total (a+b+c+d)	29,433,911	17,745,095	10,328,858	7,139,847
6a3. Other Government:	795,990	474,909	366,659	253,298
6b1. Self-pay	9,516,493	5,736,238	7,411,190	5,121,318
6b2a. Managed care (includes HMO and PPO)	11,002,339	6,636,501	6,084,977	4,208,566
6b2b. Other third - party payors	47,228,692	28,460,998	22,865,469	15,805,776
6b2c. Total Third - party payors (a+b)	58,231,031	35,097,499	28,950,446	20,014,342
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	176,886,487	106,615,993	78,012,522	53,930,359

6d. Are the financial data reported from your audited financial statement?	No	No
6e. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

	Answer	Answer (History)
7. Fixed Assets		
7a. Property, plant and equipment at cost	60,619,375	51,639,287
7b. Accumulated depreciation	8,042,485	3,364,166

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

	Answer	Answer (History)
7c. Net property, plant and equipment (a - b)	52,576,890	48,275,121
7d. Total gross square feet of your physical plant used for or in support of your healthcare activities	226,100	226,100
8. Total Capital Expenses		
(Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.)	8,980,087	2,214,086
9. ENERGY CONSUMPTION		
9. Energy Consumption		
a. Have obtained an Energy Star rating from the EPA?	No	
b. If you have obtained an Energy Star rating from the EPA, what is your rating?...		0
*10. INFORMATION TECHNOLOGY		
a. IT Operating Expense	1,321,257	1,098,357
b. IT Capital Expense.	13,993	18,698
c. Number of Employed IT staff (in FTEs).	9.50	11
d. Number of outsourced IT staff (in FTEs).	0	0
Electric Health Record		
e. Does your hospital have an electronic health record (see definition)?	Yes, partially impl	Yes, partially implemented
f. Do you plan to attest as a Meaningful User of certified EHR technology and if so, in what federal fiscal year (FFY) will you achieve meaningful use for the first time?	Do Not Know	
*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.		
*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.		

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

Section D: Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	3		1		1.82		
b. Dentists	0		0		0		
c. Medical and dental residents/interns	0	0	0	0	0		
d. Other trainees	0	0	0	0	0		
e. Registered nurses	135	143	48	50	138.45		
f. Licensed practical (vocational) nurses	5	5	7	2	5.34		
g. Nursing assistive personnel	39	35	16	18	33.92		
h. Radiology technicians	20	8	13	7	20.9		
i. Laboratory technicians	2	0	1	0	0.68		
j. Pharmacists,licensed	3	5	1	1	3		
k. Pharmacy technicians	4	4	1	1	4.13		
l. Respiratory therapists	6	4	3	3	6.18		
m. All other personnel	277	327	96	91	276.28		
n. Total facility personnel (add 11.a through 11.m)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 11.o and 11.p)	494	538	187	174	490.7		
o. Nursing home type unit/facility Registered Nurses	0	0	0	0	0		
p. Nursing home type unit/facility personnel(if applicable - please break out these personnel from the total facility number.)	0	0	0	0	0		

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

12. PRIVILEGED PHYSICIANS	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, obstetrics/gynecology, geriatrics)	4				
b. Emergency medicine					
c. Hospitalist					
d. Intensivist					
e. Radiologist/pathologist/anesthesiologist					
f. Other specialist	3				
g. Total (add 12a-12f)	7				

HOSPITALISTS	Answer	Answer (History)
13a. Do hospitalists provide care for patients in your hospital? (if yes, please report in D.12c.)	No	No
13b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE		

14. INTENSIVISTS	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (if yes, please report in D.12d.)	No	No

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care				
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total				

	Answer	Answer (History)
---PDF Spacer---(0 lines)		
ADVANCED PRACTICE REGISTERED NURSES		
a. Do advanced practice nurses provide care for patients in your hospital?(if no, please skip to 16.)	Yes	Yes
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. Full-time	3	3
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. Part-time	1	1
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. FTE	3.2	3
c. If yes, please indicate the type of service the nurses provide (Please check all that apply).	Primary care	Primary care
FOREIGN EDUCATED NURSES		
a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2011 vs. 2010?	Did not hire foreign nurses	Did not hire foreign nurses
b. From which countries/continents are you recruiting foreign-educated nurses? CHECK ALL THAT APPLY		

.

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	04/19/2012	Philip G Dionne

Section E: Community Benefits

1. CARE COORDINATION

Please indicate activities that your organization is engaged in to coordinate care across settings and extent to which they are used.

	Not Used At All	Used Minimally	Used Moderately	Used Widely	Used Hospital-Wide
a. Chronic care management processes or programs to manage patients with high-volume, high-cost diseases.	☐	☐	☐	☒	☐
b. Use of predictive analytic tools to identify individual patients at high risk for poor outcomes or extraordinary resource use.	☐	☐	☐	☒	☐
c. Prospective management of patients at high-risk for poor outcomes or extraordinary resource use by experienced case managers.	☐	☐	☐	☒	☐
d. Assignment of case managers to patients at risk for hospital admission or readmission for outpatient follow-up.	☐	☐	☐	☐	☒
e. Medication reconciliation as part of an established plan of care.	☐	☐	☐	☐	☒
f. Provision of visit summaries to patients as part of all outpatient encounters and scheduling of follow-up visits and/or specialty referrals at the time of the initial encounter.	☐	☐	☐	☐	☒
g. Post-hospital discharge continuity of care program with scaled intensiveness based upon a severity or risk profile for adult medical-surgical patients in defined diagnostic categories or severity profiles.	☐	☐	☐	☐	☒
h. Arrangement of home visits by physicians, advanced practice nurses or other professionals for homebound and complex patients for whom office visits constitute a physical hardship.	☐	☐	☐	☐	☒

Describe your hospital's processes for facilitating safe transitions. Check the appropriate box for each process administered.

How is the process administered?	Verbally	Paper (mail or fax)	Electronic	Other	Is the process; Standard	or Ad Hoc
a. Identifying patients who transition between setting of care.	☐	☐	☒	☐	☐	☐
b. Sharing clinical information between setting of care.	☐	☒	☐	☐	☐	☐
c. Providing patient discharge summaries to primary care providers.	☐	☒	☐	☐	☐	☐
d. Providing patient discharge summaries to other providers (e.g. rehabilitation hospitals).	☐	☒	☐	☐	☐	☐
e. Tracking the status of transitions including the timing of information exchange.	☐	☐	☐	☐	☐	☒

2. DIVERSITY, LANGUAGE AND LEADERSHIP

a. Does your hospital gather information on a patient's race/ethnicity at any point during their stay?	Yes
b. Does your hospital gather information on a patient's primary language any point during their stay?	Yes
c. Does your hospital or health system currently have or plan to develop, execute, or evaluate a diversity strategy or plan?	No
d. Does your hospital educate all clinical staff during orientation about how to address the unique cultural and linguistic factors affecting the care of diverse patients and communities?	No
e. Does your hospital require all employees to attend diversity training?	Yes
f. Does the hospital's strategic plan include goals for improving quality of care of culturally and linguistically-diverse patient population?	

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information (Cont)	Completed	04/19/2012	Philip G Dionne

Section F: Supplemental Information

	Answer
F. OTHER INFORMATION	
a. Does your hospital provide services through one or more satellite facilities?	Yes
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	Yes
	HealthTrust Purchasing Group
	Brentwood
	TN
c. Does the hospital purchase medical/surgical supplies directly through a distributor?	No
If yes, please provide the name(s) of the distributor.	
d. Which of the following best describes the type of triage system your emergency department uses on a daily basis to determine which patients can wait to be seen and which need to be seen immediately.	3. Five (5) level Emergency Severity Index (ESI)
e. Does your hospital outsource the HIM coding function under any of the following conditions?	
1. To handle backlog due to staff vacations or shortages.	No
2. Partially outsource during normal operations.	No
3. Completely outsourced during normal operations	No

f. Does your hospital use social media applications to conduct patient outreach or engage patients?	a. Yes
g. If yes, which social media applications does your hospital use for patient outreach or engagement (check all that apply)?	4. Hospital's own website
h. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	6
i. Use this space to describe your community benefit activities as well as any partners you are currently working with on such activities. Also use this space or additional sheets if more space is required for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	
j. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	Yes
	www.orhc.com
k. Please indicate below whether or not you agree to these types of disclosure:	I do not grant AHA permission to release my confidential data.
Your Name & Title	[redacted]
Your Email Address	
Your Phone Number	
Your Fax Number	

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
2010 Iowa Department of Public Health	Completed	04/19/2012	Philip G Dionne

State Survey: Question	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	None
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	n/a
Bed Type Numbers - Beds and Utilization by Inpatient Service	
Questions 2a thru 2x relate to section D1a. of the AHA Survey. The total number of beds here should match the total facility numbers as reported in section D1a. for licensed beds.	
a. General Medical/Surgical(adult, include gynecology)	147
b. General Medical/Surgical (pediatric)	20
c. Obstetrics	18
d. Other Acute	0
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	10
f. Cardiac Intensive Care	0
g. Neonatal Intensive Care (exclude normal newborn)	4
h. Neonatal Intermediate Care	0
i. Pediatric Intensive Care	0
j. Burn Care	0
k. Other Special Care (definitive observation, step down, etc.)	0
l. Other Intensive Care	0

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
m. Rehabilitation	18
n. Chronic Disease	0
o. Alzheimer's	0
p. Hospice	0
q. Psychiatric Care	0
r. Alcoholism/Drug Abuse or Dependency Care	0
s. Mental Retardation	0
t. Skilled Nursing Care	0
u. Intermediate Care	0
v. Residential Care/Elderly Housing	0
w. SubAcute Care	0
x. Total Facility (Add lines a thru w.)	217
a. Private	1070
b. Semi-Private	1070
c. OB	1020
d. Pediatric	1020
e. Substance Abuse Treatment	0
f. Detoxification	1540
g. Rehabilitation	885
h. Psychiatric	0
i. Intensive Care Unit	2090

AHA Annual Survey - 2011

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
a. Amount of Charity	1381933
b. Amount of Hill-Burton	0
c. Bad Debt	8076361
d. Total Non-Reimbursed	9458294
5. Data Release	Yes

To comply with the Iowa uniform reporting requirement law, Iowa Hospital Association is authorized to release data to the Iowa Department of Public Health.

[redacted]

a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	29433911
b. Medicaid Contractual Adjustments	19105053
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	10328858
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	15070162
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	-4741304
a. Charity Care Charge-level (should equal D.5b)	1381933
b. Charity Care Cost-level	707549

Monday, July 15, 2013 10:8 AM

AHA Annual Survey - 2012

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status

Submitted

Date Started	Date Last Edited	Date Submitted
APR-17-13	JUN-25-13	JUN-25-13

Survey Administrators

Philip Dionne

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	06/25/2013	Philip G Dionne

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	01/01/2012
	To (mm/dd/yyyy)	12/31/2012
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		366
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2012

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	06/25/2013	Philip G Dionne

Section B: Question	Description	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. CHECK ONLY ONE:		33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:		10 General medical and surgical
	Other-specify treatment area:	
OTHER		
3a. Does your hospital restrict admissions primarily to children?		No
3b. Does the hospital itself operate subsidiary corporations?		Yes
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:		No
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	STATE	
3d. Is the hospital a participant in a network? If yes, please provide the name, city, state, and telephone number of your network(s).		No
	Name	
	Phone	
	Name	
	Phone	
	Name	
	Phone	
3e. Is your hospital owned in whole or in part by physicians or a physician group?		No
3f. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH or a LTCH arranged within a general acute care hospital.		

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
If you are arranged in a general acute care hospital, what is your host hospital's name,city and state?		
NPI		
4. NATIONAL PROVIDER IDENTIFIER (NPI)		
National Plan Provider		
a. Does your hospital have its National Provider Identifier (NPI) from the National Plan and Provider Enumeration System?		Yes
Digital NPI		
If yes, please report the ten digit NPI		1013233741
SubPart NPI		
Does your hospital also have a Subpart NPI.?		Yes
National Identifier Provider (NPI)		
Subpart NPI 1		1477879195 04 - Rehabilitation Unit
Subpart NPI 2		1730407362 10 - Other
Subpart NPI 3		1548588171 10 - Other
Subpart NPI 4		1689990483 10 - Other
Subpart NPI 5		1477578075 10 - Other
Subpart NPI 6		1538487160 10 - Other
Subpart NPI 7		
Subpart NPI 8		
Subpart NPI 9		
Subpart NPI 10		

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
Subpart NPI 11		
Subpart NPI 12		
Subpart NPI 13		
Subpart NPI 14		
Subpart NPI 15		
Subpart NPI 16		
Subpart NPI 17		
Subpart NPI 18		
Subpart NPI 19		
Subpart NPI 20		
Subpart NPI 21		
Subpart NPI 22		
Subpart NPI 23		
Subpart NPI 24		
Subpart NPI 25		
Subpart NPI 26		
Subpart NPI 27		
Subpart NPI 28		

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
Subpart NPI 29		
Subpart NPI 30		

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	06/25/2013	Philip G Dionne

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
1. General medical - surgical care	X (#Beds: 47)				
2. Pediatric medical - surgical care	X (#Beds: 8)				
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	X (#Beds: 18)	2			
4. Medical surgical intensive care	(#Beds: ____)				X
5. Cardiac intensive care	(#Beds: ____)				X
6. Neonatal intensive care	X (#Beds: 4)				
7. Neonatal intermediate care	(#Beds: ____)				X
8. Pediatric intensive care	(#Beds: ____)				X
9. Burn care	(#Beds: ____)			X	
10. Other special care	(#Beds: ____)	(Specify: ____)			X
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	X (#Beds: 10)	____			
12. Physical rehabilitation	X (#Beds: 18)				
13. Alcoholism - drug abuse or dependency care	(#Beds: ____)			X	
14. Psychiatric care	(#Beds: ____)			X	
15. Skilled nursing care	(#Beds: ____)			X	
16. Intermediate nursing care	(#Beds: ____)				X
17. Acute long term care	(#Beds: ____)				X
18. Other long-term care	(#Beds: ____)				X
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	(#Beds: ____)	(Specify: ____)			X

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
20. Adult day care program					X
21. Airborne infection isolation room (Please specify the number of rooms)	X	# Rooms: 6			
22. Alcoholism - drug abuse or dependency outpatient services					X
23. Alzheimer Center	X				
24. Ambulance services	X				
25. Ambulatory surgery center	X				
26. Arthritis treatment center					X
27. Assisted living	X				
28. Auxiliary	X				
29. Bariatric/weight control services					X
30. Birthing room - LDR room - LDRP room	X				
31. Blood Donor Center				X	
32. Breast cancer screening / mammograms	X				
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services	X				
33b. Pediatric cardiology services					X
33c. Adult diagnostic catheterization	X				
33d. Pediatric diagnostic catheterization					X
33e. Adult interventional cardiac catheterization	X				
33f. Pediatric interventional cardiac catheterization					X
33g. Adult cardiac surgery					X
33h. Pediatric cardiac surgery					X
33i. Adult cardiac electrophysiology					X

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
33j. Pediatric cardiac electrophysiology					X
33k. Cardiac rehabilitation	X				
34. Case management	X				
35. Chaplaincy/pastoral care services	X				
36. Chemotherapy	X				
37. Children's wellness program					X
38. Chiropractic services					X
39. Community outreach	X				
40. Complementary and alternative medicine services					X
41. Computer assisted orthopedic surgery (CAOS)					X
42. Crisis prevention					X
43. Dental services					X
44. Emergency services: 44a. Emergency department	X				
44b. Pediatric emergency department					X
44c. Satellite emergency department					
44d. Is the department open 24 hours a day, 7 days a week?		(24 hours: ____)			X
44e. Trauma center (certified) [Level of unit (1-3)]	X	4			
45. Enabling services					X
46. Endoscopic services 46a.Optical colonoscopy	X				
46b. Endoscopic ultrasound					X
46c. Ablation of Barrett's esophagus					X
46d. Esophageal impedance study					X
46e. Endoscopic retrograde cholangiopancreatography (ERCP)					X

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
47. Enrollment (insurance) assistance services					X
48. Extracorporeal shock wave lithotripter (ESWL)	X				
49. Fertility clinic					X
50. Fitness center	X				
51. Freestanding outpatient care center					X
52. Geriatric services	X				
53. Health fair	X				
54. Community health education	X				
55. Genetic testing/counseling					X
56. Health screenings	X				
57. Health research					X
58. Hemodialysis	X				
59. HIV - AIDS services					X
60. Home health services	X				
61. Hospice program					X
62. Hospital - based outpatient care center - services					X
63. Immunization program					X
64. Indigent care clinic					X
65. Linguistic/translation services					X
66. Meals on wheels					X
67. Mobile health services					X
68. Neurological services					X
69. Nutrition programs					X

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
70. Occupational health services	X				
71. Oncology services	X				
72. Orthopedic services	X				
73. Outpatient surgery	X				
74. Pain management program	X				
75. Palliative care program					X
76. Palliative care inpatient unit					X
77. Patient Controlled Analgesia (PCA)	X				
78. Patient education center					X
79. Patient representative services	X				
80. Physical rehabilitation services					
80a. Assistive technology center					X
80b. Electrodiagnostic services					X
80c. Physical rehabilitation outpatient services					X
80d. Prosthetic and orthotic services					X
80e. Robot-assisted walking therapy					X
80f. Simulated rehabilitation environment					X
81. Primary care department					X
82. Psychiatric services: 82a. Psychiatric child - adolescent services					X
82b. Psychiatric consultation - liaison services					X
82c. Psychiatric education services					X
82d. Psychiatric emergency services					X

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
82e. Psychiatric geriatric services					X
82f. Psychiatric outpatient services					X
82g. Psychiatric partial hospitalization program					X
82h. Psychiatric residential treatment					X
83. Radiology, diagnostic: 83a. CT scanner	X				
83b. Diagnostic radioisotope facility	X				
83c. Electron beam computed tomography (EBCT)					X
83d. Full-field digital mammography(FFDM)	X				
83e. Magnetic resonance imaging (MRI)				X	
83f. Intraoperative magnetic resonance imaging					X
83g. Magnetoencephalography (MEG)					X
83h. Multi-slice spiral computed tomography(<64 + slice CT)	X				
83i. Multi-slice spiral computed tomography (64+ slice)	X				
83j. Positron emission tomography (PET)				X	
83k. Positron emission tomography/CT (PET/CT)				X	
83l. Single photon emission computerized tomography (SPECT)	X				
83m. Ultrasound	X				
84. Radiology therapeutic: 84a. Image -guided Radiation Therapy(IGRT)	X				
84b. Intensity-Modulated Radiation Therapy (IMRT)	X				
84c. Proton beam therapy					X
84d. Shaped Beam Radiation System	X				

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
84e. Stereotactic radiosurgery				X	
85. Retirement housing	X				
86. Robotic surgery	X				
87. Rural health clinic					X
88. Sleep center	X				
89. Social work services	X				
90. Sports medicine	X				
91. Support groups					X
92. Swing bed services					X
93. Teen outreach services					X
94. Tobacco treatment / cessation program	X				
95. Transplant services: 95a. Bone marrow transplant services					X
95b. Heart					X
95c. Kidney					X
95d. Liver					X
95e. Lung					X
95f. Tissue	X				
95g. Other	X				
96. Transportation to health facilities					X
97. Urgent care center	X				
98. Virtual Colonoscopy					X
99. Volunteer services department	X				
100. Women's health center / services	X				

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided by my network (in my local community)	(4) Provided through a formal contractual aranother provider that is not in my system or network (In my local community)	(5) Do Not Provide
101. Wound management services	X				

Section C: Question Physician Arrangements	(1) My Hospital		(2) My Health System	(3) My Health Network	(4) Do Not Provide
102a. Independent Practice Association		(# Physicians: ____)			X
102b. Group practice without walls		(# Physicians: ____)			X
102c. Open Physician - Hospital Organization (PHO)		(# Physicians: ____)			X
102d. Closed Physician - Hospital Organization (PHO)		(# Physicians: ____)			X
102e. Management Service Organization (MSO)		(# Physicians: ____)			X
102f. Integrated Salary Model	X	(# Physicians: 3)			
102g. Equity Model		(# Physicians: ____)			X
102h. Foundation		(# Physicians: ____)			X
102i. Other, please specify:		(# Physicians: ____)			X

		Answer	Answer (History)
C. Physician Arrangements			
102b. Looking across all the relationships identified in question 102a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payers or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be at the hospital, system or network level)?	# of physicians		0
Group C 'Joint Venture Physician'			
103a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?		Yes	Yes
103b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that appy).		d. Other	d. Other
103b. Other		Lab, Radiation Oncology, Medical Oncology	Lab services
103c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that appy).			

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
103c. Other		
103d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	No	No
104a. Has your hospital or health care system established an accountable care organization (ACO)?	No	No
104b. If yes, please indicate the patient population that participates in the ACO. (Check all that apply):		
104b. Other		
105. Does your hospital have an established medical home program?	No	No
106. Does your hospital participate in a bundled payment program involving inpatient, physician, and/or post acute care services where the hospital receives a single payment from a payer for a package of services and then distributes payments to participating providers of care (such as a single fee for hospital and physician services for a specific procedure, e.g. hip replacement, CABG)?	No	No

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section C: Question Insurance Products and Capitation	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Joint Venture With Insurer	(5) Do Not Provide
107a. Health Maintenance Organization					X
107b. Preferred Provider Organization					X
107c. Indemnity Fee for Service Plan					X

Section C: Question Insurance Products and Capitation	Answer
108a. Health maintenance organization (HMO)	Yes
108b. If YES, how many contracts?	4
108c. Preferred provider organization (PPO)	Yes
108d. If YES, how many contracts?	6
109. What percentage of the hospital's net patient revenue is paid on a capitated basis? (If the hospital does not participate in capitated arrangements, please enter 0)	0
110. What percentage of the hospital's net revenue is paid on a shared risk basis?	0
111. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
112. If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated payment, how many lives are covered?	0

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	06/25/2013	Philip G Dionne

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	105	88		
c. Bassinets set up and staffed for use at the end of the reporting period	10	5		
d. Births (exclude fetal deaths)	570	605		
e. Admissions (exclude newborns, include neonatal & swing admissions)	3,370	3,398		
f. Inpatient days (exclude newborns, include neonatal & swing days)	13,764	14,587		
g. Emergency department visits	22,953	24,812		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	115,660	123,658		
i. Inpatient surgical operations	790	903		
j. Number of operating rooms	6	5		
k. Outpatient surgical operations	5,680	7,443		

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days & deaths)				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	1,841	2,054		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care	110	127		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	9,213	9,886		
b. 2. How many Medicare inpatient days were Medicare Managed Care	452	485		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	816	893		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care	0	0		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	2,338	2,384		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care	0	0		

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	80,255,998	78,012,522		
*b. Tax appropriations	0	0		
*c. Other operating revenue	882,467	1,522,489		
*d. Nonoperating revenue	42,346	18,807		
*e. TOTAL REVENUE (add 3a thru 3d)	81,180,811	79,553,818		
f. Payroll expenses (only)	24,878,592	25,016,055		
g. Employee benefits	5,473,803	6,046,391		
h. Depreciation expense (for reporting period only)	4,734,589	4,806,336		
i. Interest expense	5,250,106	5,028,024		
j. Supply expense	9,318,111	8,522,463		
k. TOTAL EXPENSES (Payroll plus all non-payroll expenses. Exclude bad debt)	80,351,961	77,554,361		
*4. Revenue By type				
a. Total gross inpatient revenue	67,685,760	59,910,709		
b. Total gross outpatient revenue	144,241,134	116,975,778		
c. Total gross patient revenue	211,926,894	176,886,487		
*5. Uncompensated Care & Provider Taxes				
a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	8,252,171	7,615,212		
b. Financial Assistance (includes Charity) (Revenue forgone at full established rates. Include in gross revenue)	1,075,891	1,381,933		
c. Is your bad debt reported here (5a.) reported on the basis of full charges?	Yes	Yes		
d. Does your state have a provider Medicaid tax/assessment program	Yes	Yes		
e. If yes, please report the total gross amount paid into the program	496,467	373,350		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Total Expenses..... (d.3.k)	No	No		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Deductions from net Patient Revenue (d.3.a.)	Yes	Yes		

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	98,332,884	78,909,062	27,969,601	30,955,369
6a1b. Managed care revenue	0	0	0	0
6a1c. Total (a + b)	98,332,884	78,909,062	27,969,601	30,955,369
Medicaid				
6a2. Medicaid:				
6a2a. Fee for service patient revenue	32,973,526	29,433,911	8,751,654	10,328,858
6a2b. Managed care revenue	0	0	0	0
6a2c. Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2d. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2e. Total (a+b+c+d)	32,973,526	29,433,911	8,751,654	10,328,858
6a3. Other Government:	0	795,990	0	366,659
6b1. Self-pay	9,848,870	9,516,493	9,848,870	7,411,190
6b2a. Managed care (includes HMO and PPO)	15,156,223	11,002,339	7,214,059	6,084,977
6b2b. Other third - party payors	55,615,391	47,228,692	26,471,814	22,865,469
6b2c. Total Third - party payors (a+b)	70,771,614	58,231,031	33,685,873	28,950,446
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	211,926,894	176,886,487	80,255,998	78,012,522

6d. Are the financial data reported from your audited financial statement?	No	No
6e. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

	Answer	Answer (History)
7. Fixed Assets		
7a. Property, plant and equipment at cost	67,992,702	60,619,375
7b. Accumulated depreciation	12,663,795	8,042,485
7c. Net property, plant and equipment (a - b)	55,328,907	52,576,890
7d. Total gross square feet of your physical plant used for or in support of your healthcare activities	226,100	226,100
8. Total Capital Expenses		
(Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.)	7,373,327	8,980,087
*9. INFORMATION TECHNOLOGY		
a. IT Operating Expense	1,434,320	1,321,257
b. IT Capital Expense.	1,390,690	13,993
c. Number of Employed IT staff (in FTEs).	9.50	10
d. Number of outsourced IT staff (in FTEs).	0	0
Electric Health Record		
e. Does your hospital have an electronic health record (see definition)?	Yes, partially impl	Yes, partially implemented

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

Section D: 10. Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	16	3	1	1			
b. Dentists	0	0	0	0			
c. Medical and dental residents/interns	0	0	0	0			
d. Other trainees	0	0	0	0			
e. Registered nurses	124	135	49	48			
f. Licensed practical (vocational) nurses	6	5	16	7			
g. Nursing assistive personnel	30	39	16	16			
h. Radiology technicians	5	20	9	13			
i. Laboratory technicians	13	2	1	1			
j. Pharmacists,licensed	3	3	2	1			
k. Pharmacy technicians	4	4	1	1			
l. Respiratory therapists	3	6	1	3			
m. All other personnel	313	277	95	96			
n. Total facility personnel (add 10.a through 10.m)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 10.o and 10.p)	517	494	191	187			
o. Nursing home type unit/facility Registered Nurses		0		0			
p. Nursing home type unit/facility personnel(if applicable - please break out these personnel from the total facility number.)		0		0			

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

11. PRIVILEGED PHYSICIANS	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, obstetrics/gynecology, geriatrics)	8	0	0	23	31
b. Emergency medicine	5	3	0	3	11
c. Hospitalist	1	0	20	0	21
d. Intensivist	0	0	0	0	0
e. Radiologist/pathologist/anesthesiologist	0	1	25	2	28
f. Other specialist	3	0	2	58	63
g. Total (add 11a-11f)	17	4	47	86	154

HOSPITALISTS

	Answer	Answer (History)
12a. Do hospitalists provide care for patients in your hospital? (if yes, please report in D.11c.)	Yes	No
12b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	4.5	

13. INTENSIVISTS

	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 14.) (if yes, please report in D.11d.)	No	No

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care				
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total				

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
ADVANCED PRACTICE REGISTERED NURSES		
a. Do advanced practice nurses provide care for patients in your hospital?(if no, please skip to 15.)	Yes	Yes
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. Full-time	0	3
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. Part-time	3	1
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. FTE	1.4	3
c. If yes, please indicate the type of service the nurses provide (Please check all that apply).	Primary care, Emergency department care	Primary care
FOREIGN EDUCATED NURSES		
a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2012 vs. 2011?	Did not hire foreign nurses	Did not hire foreign nurses
b. From which countries/continents are you recruiting foreign-educated nurses? CHECK ALL THAT APPLY		

.

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	06/25/2013	Philip G Dionne

Section E: Supplemental Information

1. CARE COORDINATION

Please indicate activities that your organization is engaged in to coordinate care across settings and extent to which they are used.

	Not Used At All	Used Minimally	Used Moderately	Used Widely	Used Hospital-Wide
a. Use of predictive analytic tools to identify individual patients at high risk for poor outcomes or extraordinary resource use.	X				
b. Telephonic outreach to discharge patients within 72 hours of discharge.	X				

2. DIVERSITY, LANGUAGE AND LEADERSHIP

a. Does your hospital gather information on a patient's race/ethnicity at any point during their stay?	Yes
b. Does your hospital gather information on a patient's primary language at any point during their stay?	Yes
c. Does your hospital or health system currently have or plan to develop, execute, or evaluate a diversity strategy or plan?	Yes
d. Does your hospital educate all clinical staff during orientation about how to address the unique cultural and linguistic factors affecting the care of diverse patients and communities?	Yes
e. Does your hospital require all employees to attend diversity training?	Yes
f. Does the hospital's strategic plan include goals for improving quality of care of culturally and linguistically-diverse patient population?	No

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information (Cont)	Completed	06/25/2013	Philip G Dionne

Section F: Supplemental Information

	Answer
F. OTHER INFORMATION	
a. Does your hospital provide services through one or more satellite facilities?	Yes
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	Yes
	HealthTrust Purchasing Group
	Brentwood
	TN
c. Does the hospital purchase medical/surgical supplies directly through a distributor?	Yes
If yes, please provide the name(s) of the distributor.	Owens and Minor
d. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	13
e. Use this space to describe your community benefit activities as well as any partners you are currently working with on such activities. Also use this space or additional sheets if more space is required for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	
f. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	Yes

	www.ottumwaregionalhealth.com
g. Please indicate below whether or not you agree to these types of disclosure:	I do not grant AHA permission to release my confidential data.
Your Name & Title	[redacted]
Your Email Address	
Your Phone Number	
Your Fax Number	

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
2012 Iowa Department of Public Health	Completed	06/25/2013	Philip G Dionne

State Survey: Question	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	None
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	n/a
Bed Type Numbers - Beds and Utilization by Inpatient Service	
Questions 2a thru 2x relate to section D1a. of the AHA Survey. The total number of beds here should match the total facility numbers as reported in section D1a. for licensed beds.	
a. General Medical/Surgical(adult, include gynecology)	167
b. General Medical/Surgical (pediatric)	0
c. Obstetrics	18
d. Other Acute	0
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	10
f. Cardiac Intensive Care	0
g. Neonatal Intensive Care (exclude normal newborn)	4
h. Neonatal Intermediate Care	0
i. Pediatric Intensive Care	0
j. Burn Care	0
k. Other Special Care (definitive observation, step down, etc.)	0
l. Other Intensive Care	0

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
m. Rehabilitation	18
n. Chronic Disease	0
o. Alzheimer's	0
p. Hospice	0
q. Psychiatric Care	0
r. Alcoholism/Drug Abuse or Dependency Care	0
s. Mental Retardation	0
t. Skilled Nursing Care	0
u. Intermediate Care	0
v. Residential Care/Elderly Housing	0
w. SubAcute Care	0
x. Total Facility (Add lines a thru w.)	217
a. Private	1070
b. Semi-Private	1070
c. OB	1020
d. Pediatric	1020
e. Substance Abuse Treatment	0
f. Detoxification	0
g. Rehabilitation	885
h. Psychiatric	0
i. Intensive Care Unit	2090

AHA Annual Survey - 2012

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
a. Amount of Charity	11075891
b. Amount of Hill-Burton	0
c. Bad Debt	8252141
d. Total Non-Reimbursed	9328062
5. Data Release	

To comply with the Iowa uniform reporting requirement law, Iowa Hospital Association is authorized to release data to the Iowa Department of Public Health.

[redacted]

a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	32973526
b. Medicaid Contractual Adjustments	24221872
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	8751654
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	13189410
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	4437756
a. Charity Care Charge-level (should equal D.5b)	1075891
b. Charity Care Cost-level	430356

Monday, September 15, 2014 8:40 AM

AHA Annual Survey - 2013

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status

Submitted

Date Started	Date Last Edited	Date Submitted
FEB-17-14	APR-18-14	APR-18-14

Survey Administrators

Philip Noel

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	04/18/2014	Philip J Noel

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	01/01/2013
	To (mm/dd/yyyy)	12/31/2013
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		365
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2013

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	04/18/2014	Philip J Noel

Section B: Question	Description	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. CHECK ONLY ONE:		33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:		10 General medical and surgical
	Other-specify treatment area:	
OTHER		
3a. Does your hospital restrict admissions primarily to children?		No
3b. Does the hospital itself operate subsidiary corporations?		Yes
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:		No
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	STATE	
3d. Is the hospital a participant in a network? If yes, please provide the name, city, state, and telephone number of your network(s).		No
	Name	
	Phone	
	Name	
	Phone	
	Name	
	Phone	
3e. Is your hospital owned in whole or in part by physicians or a physician group?		No
3f. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH or a LTCH arranged within a general acute care hospital.		

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
If you are arranged in a general acute care hospital, what is your host hospital's name,city and state?		

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	04/18/2014	Philip J Noel

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
1. General medical - surgical care	X (#Beds: 21)			
2. Pediatric medical - surgical care	X (#Beds: 4)			
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	X (#Beds: 17) Level: 2			
4. Medical surgical intensive care	(#Beds: ____)			X
5. Cardiac intensive care	(#Beds: ____)			X
6. Neonatal intensive care	X (#Beds: 4)			
7. Neonatal intermediate care	(#Beds: ____)			X
8. Pediatric intensive care	(#Beds: ____)			X
9. Burn care	(#Beds: ____)			X
10. Other special care	X (#Beds: 15) Desc: Tele			
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	X (#Beds: 10) Desc: Med/Surg Cardiac Intensive Care			
12. Physical rehabilitation	X (#Beds: 13)			
13. Alcoholism - drug abuse or dependency care	(#Beds: ____)			X
14. Psychiatric care	(#Beds: ____)			X
15. Skilled nursing care	(#Beds: ____)			X
16. Intermediate nursing care	(#Beds: ____)			X
17. Acute long term care	(#Beds: ____)			X
18. Other long-term care	(#Beds: ____)			X
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	(#Beds: ____) (Specify: ____)			X

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
20. Adult day care program				X
21. Airborne infection isolation room (Please specify the number of rooms)	X # Rooms: 5			
22. Alcoholism - drug abuse or dependency outpatient services				X
23. Alzheimer Center	X			
24. Ambulance services	X			
25. Ambulatory surgery center	X			
26. Arthritis treatment center				X
27. Assisted living	X			
28. Auxiliary	X			
29. Bariatric/weight control services				X
30. Birthing room - LDR room - LDRP room	X			
31. Blood Donor Center			X	
32. Breast cancer screening / mammograms	X			
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services	X			
33b. Pediatric cardiology services				X
33c. Adult diagnostic catheterization	X			
33d. Pediatric diagnostic catheterization				X
33e. Adult interventional cardiac catheterization	X			
33f. Pediatric interventional cardiac catheterization				X
33g. Adult cardiac surgery				X
33h. Pediatric cardiac surgery				X
33i. Adult cardiac electrophysiology				X
33j. Pediatric cardiac electrophysiology				X

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
33k. Cardiac rehabilitation	X			
34. Case management	X			
35. Chaplaincy/pastoral care services	X			
36. Chemotherapy	X			
37. Children's wellness program				X
38. Chiropractic services				X
39. Community outreach	X			
40. Complementary and alternative medicine services				X
41. Computer assisted orthopedic surgery (CAOS)				X
42. Crisis prevention				X
43. Dental services				X
44. Emergency services: 44a. Emergency department	X			
44b. Pediatric emergency department	X			
44c. Satellite emergency department		(24 hours: ____)		X
44d. Is the department open 24 hours a day, 7 days a week?				
44e. Trauma center (certified) [Level of unit (1-3)]	X 3			
45. Enabling services				X
46. Endoscopic services 46a.Optical colonoscopy	X			
46b. Endoscopic ultrasound	X			
46c. Ablation of Barrett's esophagus	X			
46d. Esophageal impedance study	X			
46e. Endoscopic retrograde cholangiopancreatography (ERCP)	X			
47. Enrollment (insurance) assistance services				X

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
48. Extracorporeal shock wave lithotripter (ESWL)	X			
49. Fertility clinic				X
50. Fitness center	X			
51. Freestanding outpatient care center	X			
52. Geriatric services	X			
53. Health fair	X			
54. Community health education	X			
55. Genetic testing/counseling				X
56. Health screenings	X			
57. Health research				X
58. Hemodialysis	X			
59. HIV - AIDS services				X
60. Home health services	X			
61. Hospice program			X	
62. Hospital - based outpatient care center - services	X			
63. Immunization program				X
64. Indigent care clinic				X
65. Linguistic/translation services			X	
66. Meals on wheels				X
67. Mobile health services				X
68. Neurological services	X			
69. Nutrition programs	X			
70. Occupational health services	X			
71. Oncology services	X			

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
72. Orthopedic services	X			
73. Outpatient surgery	X			
74. Pain management program	X			
75. Palliative care program				X
76. Palliative care inpatient unit				X
77. Patient Controlled Analgesia (PCA)	X			
78. Patient education center				X
79. Patient representative services				X
80. Physical rehabilitation services				X
80a. Assistive technology center				
80b. Electrodiagnostic services				X
80c. Physical rehabilitation outpatient services	X			
80d. Prosthetic and orthotic services				X
80e. Robot-assisted walking therapy				X
80f. Simulated rehabilitation environment				X
81. Primary care department				X
82. Psychiatric services: 82a. Psychiatric child - adolescent services				X
82b. Psychiatric consultation - liaison services				X
82c. Psychiatric education services				X
82d. Psychiatric emergency services				X
82e. Psychiatric geriatric services				X
82f. Psychiatric outpatient services				X
82g. Psychiatric partial hospitalization program				X

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
82h. Psychiatric residential treatment				X
83. Radiology, diagnostic: 83a. CT scanner	X			
83b. Diagnostic radioisotope facility	X			
83c. Electron beam computed tomography (EBCT)				X
83d. Full-field digital mammography(FFDM)	X			
83e. Magnetic resonance imaging (MRI)			X	
83f. Intraoperative magnetic resonance imaging				X
83g. Magnetoencephalography (MEG)				X
83h. Multi-slice spiral computed tomography(<64 + slice CT)	X			
83i. Multi-slice spiral computed tomography (64+ slice)	X			
83j. Positron emission tomography (PET)			X	
83k. Positron emission tomography/CT (PET/CT)			X	
83l. Single photon emission computerized tomography (SPECT)	X			
83m. Ultrasound	X			
84. Radiology therapeutic: 84a. Image -guided Radiation Therapy(IGRT)	X			
84b. Intensity-Modulated Radiation Therapy (IMRT)	X			
84c. Proton beam therapy				X
84d. Shaped Beam Radiation System	X			
84e. Stereotactic radiosurgery			X	
85. Retirement housing	X			
86. Robotic surgery	X			
87. Rural health clinic	X			
88. Sleep center	X			

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or it's subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
89. Social work services	X			
90. Sports medicine	X			
91. Support groups				X
92. Swing bed services				X
93. Teen outreach services				X
94. Tobacco treatment / cessation program	X			
95. Transplant services: 95a. Bone marrow transplant services				X
95b. Heart				X
95c. Kidney				X
95d. Liver				X
95e. Lung				X
95f. Tissue				X
95g. Other				X
96. Transportation to health facilities				X
97. Urgent care center	X			
98. Virtual Colonoscopy				X
99. Volunteer services department	X			
100. Women's health center / services	X			
101. Wound management services	X			

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Section C: Question Physician Arrangements	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Do Not Provide
102a. Independent Practice Association	☐ (# Physicians: ____)	☐	☐	X
102b. Group practice without walls	☐ (# Physicians: ____)	☐	☐	X
102c. Open Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	X
102d. Closed Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	X
102e. Management Service Organization (MSO)	☐ (# Physicians: ____)	☐	☐	X
102f. Integrated Salary Model	X (# Physicians: 11)	☐	☐	☐
102g. Equity Model	☐ (# Physicians: ____)	☐	☐	X
102h. Foundation	☐ (# Physicians: ____)	☐	☐	X
102i. Other, please specify:	☐ (# Physicians: ____)	☐	☐	X

		Answer	Answer (History)
C. Physician Arrangements			
102b. Looking across all the relationships identified in question 102a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payers or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be at the hospital, system or network level)?	# of physicians	0	
Group C 'Joint Venture Physician'			
103a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?		No	Yes
103b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that appy).			d. Other
103b. Other			Lab, Radiation Oncology, Medical Oncology
103c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that appy).			
103c. Other			
103d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?		No	No
104a. Has your hospital or health care system established an accountable care organization (ACO)?		No	No
104b. If yes, please indicate the patient population that participates in the ACO. (Check all that apply):			

	Answer	Answer (History)
104b. Other		
105. Does your hospital have an established medical home program?	No	No
106. Does your hospital participate in a bundled payment program involving inpatient, physician, and/or post acute care services where the hospital receives a single payment from a payer for a package of services and then distributes payments to participating providers of care (such as a single fee for hospital and physician services for a specific procedure, e.g. hip replacement, CABG)?	No	No

Section C: Question Insurance Products and Capitation	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Joint Venture With Insurer	(5) Do Not Provide
107a. Health Maintenance Organization					X
107b. Preferred Provider Organization					X
107c. Indemnity Fee for Service Plan					X

Section C: Question Insurance Products and Capitation	Answer
108a. Health maintenance organization (HMO)	No
108b. If YES, how many contracts?	
108c. Preferred provider organization (PPO)	No
108d. If YES, how many contracts?	
109. What percentage of the hospital's net patient revenue is paid on a capitated basis? (If the hospital does not participate in capitated arrangements, please enter 0)	0
110. What percentage of the hospital's net revenue is paid on a shared risk basis?	0
111. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
112. If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated payment, how many lives are covered?	0
113. Does your hospital have contracts with commercial payers where payment is tied to performance on quality/safety metrics?	No

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	04/18/2014	Philip J Noel

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	84	105		
c. Bassinets set up and staffed for use at the end of the reporting period	10	10		
d. Births (exclude fetal deaths)	525	570		
e. Admissions (exclude newborns, include neonatal & swing admissions)	3,329	3,370		
f. Inpatient days (exclude newborns, include neonatal & swing days)	14,364	13,764		
g. Emergency department visits	19,625	22,953		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	121,324	115,660		
i. Inpatient surgical operations	875	790		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	5,132	5,680		

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days & deaths)				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	1,870	1,841		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care	168	110		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	9,988	9,213		
b. 2. How many Medicare inpatient days were Medicare Managed Care	755	452		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	787	816		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care	0	0		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	2,204	2,338		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care	0	0		

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	71,552,255	80,255,998		
*b. Tax appropriations	0	0		
*c. Other operating revenue	2,840,869	882,467		
*d. Nonoperating revenue	0	42,346		
*e. TOTAL REVENUE (add 3a thru 3d)	74,393,124	81,180,811		
f. Payroll expenses (only)	26,712,160	24,878,592		
g. Employee benefits	5,312,554	5,473,803		
h. Depreciation expense (for reporting period only)	5,539,483	4,734,589		
i. Interest expense	5,265,352	5,250,106		
j. Supply expense	12,412,955	9,318,111		
k. All other expenses	22,581,180			
l. TOTAL EXPENSES (Payroll plus all non-payroll expenses. Exclude bad debt)	77,823,684	80,351,961		
*4. Revenue By type				
a. Total gross inpatient revenue	72,967,870	67,685,760		
b. Total gross outpatient revenue	167,062,330	144,241,134		
c. Total gross patient revenue	240,030,200	211,926,894		
*5. Uncompensated Care & Provider Taxes				
a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	13,694,090	8,252,171		
b. Financial Assistance (includes Charity) (Revenue forgone at full established rates. Include in gross revenue)	615,908	1,075,891		
c. Is your bad debt reported here (5a.) reported on the basis of full charges?	Yes	Yes		
d. Does your state have a provider Medicaid tax/assessment program	Yes	Yes		
e. If yes, please report the total gross amount paid into the program	496,467	496,467		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Total Expenses..... (d.3.k)	No	No		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Deductions from net Patient Revenue (d.3.a.)	Yes	Yes		

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	116,410,200	98,332,884	30,914,495	27,969,601
6a1b. Managed care revenue	0	0	0	0
6a1c. Total (a + b)	116,410,200	98,332,884	30,914,495	27,969,601
Medicaid				
6a2. Medicaid:				
6a2a. Fee for service patient revenue	32,507,100	32,973,526	7,855,230	8,751,654
6a2b. Managed care revenue	0	0	0	0
6a2c. Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2d. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2e. Total (a+b+c+d)	32,507,100	32,973,526	7,855,230	8,751,654
6a3. Other Government:	0	0	0	0
6b1. Self-pay	6,653,200	9,848,870	800,000	9,848,870
6b2a. Managed care (includes HMO and PPO)	15,729,000	15,156,223	4,247,900	7,214,059
6b2b. Other third - party payors	68,730,700	55,615,391	27,734,630	26,471,814
6b2c. Total Third - party payors (a+b)	84,459,700	70,771,614	31,982,530	33,685,873
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	240,030,200	211,926,894	71,552,255	80,255,998

6d. Are the financial data reported from your audited financial statement?	Yes	No
6e. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

	Answer	Answer (History)
7. Fixed Assets		
7a. Property, plant and equipment at cost	75,116,262	67,992,702
7b. Accumulated depreciation	18,729,705	12,663,795
7c. Net property, plant and equipment (a - b)	56,386,557	55,328,907
7d. Total gross square feet of your physical plant used for or in support of your healthcare activities	202,105	226,100
8. Total Capital Expenses		
(Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.)	8,259,126	7,373,327
*9. INFORMATION TECHNOLOGY		
a. IT Operating Expense	2,131,253	1,434,320
b. IT Capital Expense.	5,041,480	1,390,690
c. Number of Employed IT staff (in FTEs).	7.72	10
d. Number of outsourced IT staff (in FTEs).	0	0
Electric Health Record		
e. Does your hospital have an electronic health record (see definition)?	Yes, partially implemented	Yes, partially implemented

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

Section D: 10. Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	9	16	2	1			
b. Dentists	0	0	0	0		0	
c. Medical and dental residents/interns	0	0	0	0		0	
d. Other trainees	0	0	0	0		0	
e. Registered nurses	114	124	19	49		14	
f. Licensed practical (vocational) nurses	10	6	1	16			
g. Nursing assistive personnel	10	30	3	16		2	
h. Radiology technicians	8	5	1	9			
i. Laboratory technicians	13	13	0	1		1	
j. Pharmacists,licensed	3	3	0	2			
k. Pharmacy technicians	4	4	0	1			
l. Respiratory therapists	3	3	0	1			
m. All other personnel	279	313	51	95		28	
n. Total facility personnel (add 10.a through 10.m)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 10.o and 10.p)	453	517	77	191		45	
o. Nursing home type unit/facility Registered Nurses	0		0				
p. Nursing home type unit/facility personnel(if applicable - please break out these personnel from the total facility number.)	0	0	0	0			

	Answer	Answer (History)
q. For your employed RNs reported above (D.10.e), please report the number of full time equivalents who are involved in direct patient care.		

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

11. PRIVILEGED PHYSICIANS	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, obstetrics/gynecology, geriatrics)	2	0	0	23	31
b. Emergency medicine	4	3	0	3	11
c. Hospitalist	0	0	21		21
d. Intensivist	0	0	0	0	0
e. Radiologist/pathologist/anesthesiologist	0	1	25	2	28
f. Other specialist	5	0	2	58	63
g. Total (add 11a-11f)	11	4	48	86	154

HOSPITALISTS

	Answer	Answer (History)
12a. Do hospitalists provide care for patients in your hospital? (if yes, please report in D.11c.)	Yes	Yes
12b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	4.5	4.5

13. INTENSIVISTS

	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 14.) (if yes, please report in D.11d.)	No	No

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care				
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total				

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
ADVANCED PRACTICE REGISTERED NURSES		
a. Do advanced practice nurses provide care for patients in your hospital?(if no, please skip to 15.)	Yes	Yes
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. Full-time	3	0
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. Part-time	3	3
b. If yes, please report the number of full time, part time and FTE advanced practice nurses employed or contracted to provide care for patients in your hospital. FTE		1
c. If yes, please indicate the type of service the nurses provide (Please check all that apply).	Primary care, Emergency department care	Primary care, Emergency department care
FOREIGN EDUCATED NURSES		
a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2013 vs. 2012?	Did not hire foreign nurses	Did not hire foreign nurses
b. From which countries/continents are you recruiting foreign-educated nurses? CHECK ALL THAT APPLY		

.

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	04/18/2014	Philip J Noel

Section E: Supplemental Information

	Answer
a. Does your hospital provide services through one or more satellite facilities?	Yes
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	Yes
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	HealthTrust
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	Brentwood
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	TN
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	
c. Does the hospital purchase medical/surgical supplies directly through a distributor?	No
If yes, please provide the name(s) of the distributor.	
If yes, please provide the name(s) of the distributor.	
If yes, please provide the name(s) of the distributor.	
d. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

Section E: Supplemental Information Continued

	Answer
e. Use this space to describe your community benefit activities as well as any partners you are currently working with on such activities. Also use this space or additional sheets if more space is required for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	
f. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	Yes
f. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	www.ottumwaregionalhealth.com
g. Please indicate below whether or not you agree to these types of disclosure:	 I do not grant AHA permission to release my confidential data.
Your Name & Title	[redacted]
Your Name & Title	
Your Email Address	
Your Phone Number	
Your Fax Number	

Section Title	Status	Last Edit Date	Last Edit By
2013 Iowa Department of Public Health	Completed	04/18/2014	Philip J Noel

State Survey: Question	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	Re-opened Telemetry unit. It had previously been combined with Medical Surgical unit.
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	Permanent

Bed Type Numbers - Beds and Utilization by Inpatient Service

Questions 2a thru 2x relate to section D1a. of the AHA Survey. The total number of beds here should match the total facility numbers as reported in section D1a. for licensed beds.

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
a. General Medical/Surgical(adult, include gynecology)	
b. General Medical/Surgical (pediatric)	
c. Obstetrics	
d. Other Acute	
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	
f. Cardiac Intensive Care	
g. Neonatal Intensive Care (exclude normal newborn)	
h. Neonatal Intermediate Care	
i. Pediatric Intensive Care	
j. Burn Care	
k. Other Special Care (definitive observation, step down, etc.)	
l. Other Intensive Care	
m. Rehabilitation	
n. Chronic Disease	
o. Alzheimer's	
p. Hospice	
q. Psychiatric Care	
r. Alcoholism/Drug Abuse or Dependency Care	
s. Mental Retardation	
t. Skilled Nursing Care	
u. Intermediate Care	
v. Residential Care/Elderly Housing	
w. SubAcute Care	

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
x. Total Facility (Add lines a thru w.)	
a. Private	1124
b. Semi-Private	1124
c. OB	1071
d. Pediatric	1071
e. Substance Abuse Treatment	0
f. Detoxification	0
g. Rehabilitation	929
h. Psychiatric	0
i. Intensive Care Unit	2195
a. Amount of Charity	615908
b. Amount of Hill-Burton	0
c. Bad Debt	13694090
d. Total Non-Reimbursed	14309998
5. Data Release	

To comply with the Iowa uniform reporting requirement law, Iowa Hospital Association is authorized to release data to the Iowa Department of Public Health.

[redacted]

a. Total facility SWING BED Admissions	0

AHA Annual Survey - 2013

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	32507100
b. Medicaid Contractual Adjustments	24651866
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	7855234
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	8431800
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	576566
a. Charity Care Charge-level (should equal D.5b)	615908
b. Charity Care Cost-level	159756

Wednesday, September 23, 2015 4:25 PM

AHA Annual Survey - 2014

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status

Submitted

Date Started	Date Last Edited	Date Submitted
APR-23-15	AUG-06-15	AUG-06-15

Survey Administrators

Philip Noel

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	04/27/2015	Philip J Noel

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	01/01/2014
	To (mm/dd/yyyy)	12/31/2014
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		365
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2015

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	04/27/2015	Philip J Noel

Section B: Question	Description	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. SELECT ONLY ONE:		33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:		10 General medical and surgical
	Other-specify treatment area:	
OTHER		
3a. Does your hospital restrict admissions primarily to children?		No
3b. Does the hospital itself operate subsidiary corporations?		No
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:		No
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
3d. Is the hospital a participant in a network? If yes, please provide the name, city, state, and telephone number of your network(s).		No
	Name	
	City	
	State	
	Phone	
	Name	
	City	
	State	
	Phone	
	Name	
	City	
	State	
	Phone	

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
3e. Is your hospital owned in whole or in part by physicians or a physician group?		No
3f. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH or a LTCH arranged within a general acute care hospital.		
If you are arranged in a general acute care hospital, what is your host hospital's name, city and state?		

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	04/27/2015	Philip J Noel

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
1. General medical - surgical care	X (#Beds: 24)			
2. Pediatric medical - surgical care	X (#Beds: 4)			
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	X (#Beds: 17) Level: 2			
4. Medical-surgical intensive care	(#Beds: ____)			X
5. Cardiac intensive care	(#Beds: ____)			X
6. Neonatal intensive care	(#Beds: ____)			X
7. Neonatal intermediate care	X (#Beds: 4)			
8. Pediatric intensive care	(#Beds: ____)			X
9. Burn care	(#Beds: ____)			X
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	X (#Beds: 15) Desc: Telemetry			
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	X (#Beds: 10) Desc: Med/Surg Cardiac Intensive Care			
12. Physical rehabilitation	X (#Beds: 13)			
13. Alcoholism - drug abuse or dependency care	(#Beds: ____)			X
14. Psychiatric care	X (#Beds: 14)			
15. Skilled nursing care	(#Beds: ____)			X
16. Intermediate nursing care	(#Beds: ____)			X
17. Acute long-term care	(#Beds: ____)			X
18. Other long-term care	(#Beds: ____)			X
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	(#Beds: ____) (Specify: ____)			X

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
20. Adult day care program				X
21. Airborne infection isolation room (Please specify the number of rooms)	X # Rooms: 5			
22. Alcoholism - drug abuse or dependency outpatient services				X
23. Alzheimer Center	X			
24. Ambulance services	X			
25. Ambulatory surgery center	X			
26. Arthritis treatment center				X
27. Assisted living	X			
28. Auxiliary	X			
29. Bariatric/weight control services				X
30. Birthing room - LDR room - LDRP room	X			
31. Blood Donor Center			X	
32. Breast cancer screening / mammograms	X			
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services	X			
33b. Pediatric cardiology services				X
33c. Adult diagnostic catheterization	X			
33d. Pediatric diagnostic catheterization				X
33e. Adult interventional cardiac catheterization	X			
33f. Pediatric interventional cardiac catheterization				X
33g. Adult cardiac surgery				X
33h. Pediatric cardiac surgery				X
33i. Adult cardiac electrophysiology				X
33j. Pediatric cardiac electrophysiology				X

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
33k. Cardiac rehabilitation	X			
34. Case management	X			
35. Chaplaincy/pastoral care services	X			
36. Chemotherapy	X			
37. Children's wellness program				X
38. Chiropractic services				X
39. Community outreach	X			
40. Complementary and alternative medicine services				X
41. Computer assisted orthopedic surgery (CAOS)				X
42. Crisis prevention				X
43. Dental services				X
44. Emergency services: 44a. Emergency department	X			
44b. Pediatric emergency department	X			
44c. Satellite emergency department		(24 hours: ____)		X
44d. Is the department open 24 hours a day, 7 days a week?				
44e. Trauma center (certified) [Level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	X 3			
45. Enabling services				X
46. Endoscopic services 46a.Optical colonoscopy	X			
46b. Endoscopic ultrasound	X			
46c. Ablation of Barrett's esophagus	X			
46d. Esophageal impedance study	X			
46e. Endoscopic retrograde cholangiopancreatography (ERCP)	X			

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
47. Enrollment (insurance) assistance services				X
48. Extracorporeal shock wave lithotripter (ESWL)	X			
49. Fertility clinic				X
50. Fitness center	X			
51. Freestanding outpatient care center	X			
52. Geriatric services	X			
53. Health fair	X			
54. Community health education	X			
55. Genetic testing/counseling				X
56. Health screenings	X			
57. Health research				X
58. Hemodialysis	X			
59. HIV - AIDS services				X
60. Home health services	X			
61. Hospice program			X	
62. Hospital - based outpatient care center - services	X			
63. Immunization program				X
64. Indigent care clinic				X
65. Linguistic/translation services			X	
66. Meals on wheels				X
67. Mobile health services				X
68. Neurological services	X			
69. Nutrition programs	X			
70. Occupational health services	X			

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
71. Oncology services	X			
72. Orthopedic services	X			
73. Outpatient surgery	X			
74. Pain management program	X			
75. Palliative care program				X
76. Palliative care inpatient unit				X
77. Patient Controlled Analgesia (PCA)	X			
78. Patient education center				X
79. Patient representative services				X
80. Physical rehabilitation services				X
80a. Assistive technology center				
80b. Electrodiagnostic services				X
80c. Physical rehabilitation outpatient services	X			
80d. Prosthetic and orthotic services				X
80e. Robot-assisted walking therapy				X
80f. Simulated rehabilitation environment				X
81. Primary care department				X
82. Psychiatric services: 82a. Psychiatric child - adolescent services				X
82b. Psychiatric consultation - liaison services				X
82c. Psychiatric education services				X
82d. Psychiatric emergency services				X
82e. Psychiatric geriatric services	X			
82f. Psychiatric outpatient services				X

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
82g. Psychiatric partial hospitalization program				X
82h. Psychiatric residential treatment				X
83. Radiology, diagnostic: 83a. CT scanner	X			
83b. Diagnostic radioisotope facility	X			
83c. Electron beam computed tomography (EBCT)				X
83d. Full-field digital mammography(FFDM)	X			
83e. Magnetic resonance imaging (MRI)			X	
83f. Intraoperative magnetic resonance imaging				X
83g. Magnetoencephalography (MEG)				X
83h. Multi-slice spiral computed tomography(<64 + slice CT)	X			
83i. Multi-slice spiral computed tomography (64+ slice)	X			
83j. Positron emission tomography (PET)			X	
83k. Positron emission tomography/CT (PET/CT)			X	
83l. Single photon emission computerized tomography (SPECT)	X			
83m. Ultrasound	X			
84. Radiology therapeutic: 84a. Image-guided Radiation Therapy(IGRT)	X			
84b. Intensity-Modulated Radiation Therapy (IMRT)	X			
84c. Proton beam therapy				X
84d. Shaped Beam Radiation System	X			
84e. Stereotactic radiosurgery			X	
85. Retirement housing				X
86. Robotic surgery	X			
87. Rural health clinic	X			

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
88. Sleep center	X			
89. Social work services	X			
90. Sports medicine	X			
91. Support groups				X
92. Swing bed services				X
93. Teen outreach services				X
94. Tobacco treatment / cessation program	X			
95. Transplant services: 95a. Bone marrow				X
95b. Heart				X
95c. Kidney				X
95d. Liver				X
95e. Lung				X
95f. Tissue				X
95g. Other				X
96. Transportation to health facilities				X
97. Urgent care center	X			
98. Virtual Colonoscopy				X
99. Volunteer services department	X			
100. Women's health center / services	X			
101. Wound management services	X			

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Section C: Question Physician Arrangements	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Do Not Provide
102a. Independent Practice Association	☐ (# Physicians: ____)	☐	☐	☒
102b. Group practice without walls	☐ (# Physicians: ____)	☐	☐	☒
102c. Open Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	☒
102d. Closed Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	☒
102e. Management Service Organization (MSO)	☐ (# Physicians: ____)	☐	☐	☒
102f. Integrated Salary Model	☒ (# Physicians: 14)	☐	☐	☐
102g. Equity Model	☐ (# Physicians: ____)	☐	☐	☒
102h. Foundation	☐ (# Physicians: ____)	☐	☐	☒
102i. Other, please specify:	☐ (# Physicians: ____)	☐	☐	☒

		Answer	Answer (History)
C. Physician Arrangements			
102b. Looking across all the relationships identified in question 102a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payors or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be at the hospital, system or network level)?	# of physicians	0	0
103a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?		No	No
103b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that apply).			
103b. Other			
103c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that apply).			
103c. Other			
103d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?		No	No
104a. Has your hospital or health care system established an accountable care organization (ACO)?		No	No

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
104b. If yes, please indicate the patient population that participates in the ACO. (Check all that apply):		
104b. Other		
105. Does your hospital have an established medical home program?	No	No
106. Does your hospital participate in a bundled payment program involving inpatient, physician, and/or post acute care services where the hospital receives a single payment from a payor for a package of services and then distributes payments to participating providers of care (such as a single fee for hospital and physician services for a specific procedure, e.g., hip replacement, CABG)?	No	No

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Section C: Question Insurance Products and Capitation	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Joint Venture With Insurer	(5) Do Not Provide
107a. Health Maintenance Organization					X
107b. Preferred Provider Organization					X
107c. Indemnity Fee for Service Plan					X

Section C: Question Insurance Products and Capitation	Answer
108a. Health maintenance organization (HMO)	No
108b. If YES, how many contracts?	
108c. Preferred provider organization (PPO)	No
108d. If YES, how many contracts?	
109. What percentage of the hospital's net patient revenue is paid on a capitated basis? (If the hospital does not participate in capitated arrangements, please enter 0)	0
110. What percentage of the hospital's net patient revenue is paid on a shared risk basis?	0
111. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
112. If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated payment, how many lives are covered?	0
113. Does your hospital have contracts with commercial payors where payment is tied to performance on quality/safety metrics?	No
114. Does your hospital conduct an internal survey of the hospital's quality/safety culture at least every 18 months?	Yes
114a. If yes, please indicate the response rate for the most recent survey.	88.51
114b. If yes, are valid results available at the level of individual units (e.g., medical ICUs, cardiothoracic surgery)?	Yes

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	04/27/2015	Philip J Noel

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	101	84		
c. Bassinets set up and staffed for use at the end of the reporting period	10	10		
d. Births (exclude fetal deaths)	484	525		
e. Admissions (exclude newborns, include neonatal & swing admissions)	3,421	3,329		
f. Inpatient days (exclude newborns, include neonatal & swing days)	15,105	14,364		
g. Emergency department visits	19,375	19,625		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	112,599	121,324		
i. Inpatient surgical operations	921	875		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	5,017	5,132		

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days & deaths)				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	1,776	1,870		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care?	169	168		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	9,625	9,988		
b. 2. How many Medicare inpatient days were Medicare Managed Care?	830	755		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	670	787		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care?	0	0		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	2,389	2,204		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care?	0	0		

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	69,090,590	71,552,255		
*b. Tax appropriations	0	0		
*c. Other operating revenue	945,803	2,840,869		
*d. Nonoperating revenue	0	0		
*e. TOTAL REVENUE (add 3a thru 3d)	70,036,393	74,393,124		
f. Payroll expenses (only)	22,242,247	26,712,160		
g. Employee benefits	4,936,993	5,312,554		
h. Depreciation expense (for reporting period only)	5,501,791	5,539,483		
i. Interest expense	5,197,324	5,265,352		
j. Supply expense	10,209,540	12,412,955		
k. All other expenses	22,999,875	22,581,180		
l. TOTAL EXPENSES (Add 3f thru 3k.)	71,087,770	77,823,684		
*4. Revenue By type				
a. Total gross inpatient revenue	78,884,457	72,967,870		
b. Total gross outpatient revenue	155,832,510	167,062,330		
c. Total gross patient revenue	234,716,967	240,030,200		
*5. Uncompensated Care & Provider Taxes				
a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	5,072,133	13,694,090		
b. Financial Assistance (includes Charity) (Revenue forgone at full established rates. Include in gross revenue)	680,991	615,908		
c. Is your bad debt (5a.) reported on the basis of full charges?	Yes	Yes		
d. Does your state have a provider Medicaid tax/assessment program?	Yes	Yes		
e. If yes, please report the total gross amount paid into the program	496,467	496,467		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Total Expenses.....	No	No		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Deductions from net Patient Revenue.....	Yes	Yes		

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	109,184,839	116,410,200	33,256,600	30,914,495
6a1b. Managed care revenue	0	0	0	0
6a1c. Total (a + b)	109,184,839	116,410,200	33,256,600	30,914,495
Medicaid				
6a2. Medicaid:				
6a2a. Fee for service patient revenue	46,960,634	32,507,100	9,491,696	7,855,230
6a2b. Managed care revenue	0	0	0	0
6a2c. Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2d. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2e. Total (a+b+c+d)	46,960,634	32,507,100	9,491,696	7,855,230
6a3. Other Government:	0	0	0	0
6b1. Self-pay	3,523,862	6,653,200	528,582	800,000
6b2a. Managed care (includes HMO and PPO)	13,730,359	15,729,000	5,437,266	4,247,900
6b2b. Other third - party payors	61,317,273	68,730,700	20,376,446	27,734,630
6b2c. Total Third - party payors (a+b)	75,047,632	84,459,700	25,813,712	31,982,530
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	234,716,967	240,030,200	69,090,590	71,552,255

6d. Are the financial data reported from your audited financial statement?	Yes	Yes
6e. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

	Answer	Answer (History)
7. Fixed Assets		
7a. Property, plant and equipment at cost	78,340,541	75,116,262
7b. Accumulated depreciation	23,338,860	18,729,705
7c. Net property, plant and equipment (a - b)	55,001,681	56,386,557
7d. Total gross square feet of your physical plant used for or in support of your healthcare activities	202,105	202,105
8. Total Capital Expenses		
Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.	4,941,612	8,259,126
*9. INFORMATION TECHNOLOGY		
a. IT Operating Expense	1,827,744	2,131,253
b. IT Capital Expense.	602,023	5,041,480
c. Number of Employed IT staff (in FTEs).	7.67	8
d. Number of outsourced IT staff (in FTEs).	0	0
Electric Health Record		
e. Does your hospital have an electronic health record (see definition)?	Yes, partially implemented	Yes, partially implemented

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.		

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

Section D: 10. Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	14	9	2	2			0
b. Dentists	0	0	0	0			0
c. Medical and dental residents/interns	0	0	0	0			0
d. Other trainees	0	0	0	0			0
e. Registered nurses	118	114	25	19		11	14
f. Licensed practical (vocational) nurses	9	10	1	1		1	0
g. Nursing assistive personnel	6	10	12	3		11	2
h. Radiology technicians	5	8	1	1		0	0
i. Laboratory technicians	12	13	1	0		2	1
j. Pharmacists, licensed	3	3	0	0		0	0
k. Pharmacy technicians	4	4	0	0		1	0
l. Respiratory therapists	6	3	0	0		1	0
m. All other personnel	293	279	35	51		17	28
n. Total facility personnel (add 10.a through 10.m)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 10.o and 10.p)	470	453	77	77		44	45
o. Nursing home type unit/facility Registered Nurses	0	0	0	0	0	0	
p. Nursing home type unit/facility personnel	0	0	0	0	0	0	

	Answer	Answer (History)
q. For your employed RNs reported above (D.10.e), please report the number of full time equivalents who are involved in direct patient care.	142.6	

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

11. PRIVILEGED PHYSICIANS	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, obstetrics/gynecology, geriatrics)	7	1	0	6	14
b. Emergency medicine	7	4	0	3	14
c. Hospitalist	0	0	10	0	10
d. Intensivist	0	0	0	0	0
e. Radiologist/pathologist/anesthesiologist	0	0	37	6	43
f. Other specialist	4	5	48	24	81
g. Total (add 11a-11f)	18	10	95	39	162

	Answer	Answer (History)
12. HOSPITALISTS		
12a. Do hospitalists provide care for patients in your hospital? (if yes, please report in D.11c.)	Yes	Yes
12b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	5	5

	Answer	Answer (History)
13. INTENSIVISTS		
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 14.) (if yes, please report in D.11d.)	No	No

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care				
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total				

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
14. ADVANCED PRACTICE REGISTERED NURSES		
a. Do advanced practice nurses/physician assistants provide care for patients in your hospital?(if no, please skip to 15.)	Yes	Yes
b. If yes, please report the number of full time, part time and FTE advanced practice nurses/physician assistants who provide care for patients in your hospital. Full-time	5	3
b. If yes, please report the number of full time, part time and FTE advanced practice nurses/physician assistants who provide care for patients in your hospital. Part-time	16	
b. If yes, please report the number of full time, part time and FTE advanced practice nurses/physician assistants who provide care for patients in your hospital. FTE		
c. If yes, please indicate the type of service provided. (Please check all that apply)	Anesthesia services, Emergency department care, Other specialty care	Primary care, Emergency department care
15. FOREIGN EDUCATED NURSES		
a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2014 vs. 2013?	Did not hire foreign nurses	Did not hire foreign nurses
b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)		

.

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	04/27/2015	Philip J Noel

Section E: Supplemental Information

	Answer
a. Does your hospital provide services through one or more satellite facilities?	Yes
b. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	Yes
	HealthTrust
	Brentwood
	TN
c. Does the hospital purchase medical/surgical supplies directly through a distributor?	No
If yes, please provide the name(s) of the distributor.	
If yes, please provide the name(s) of the distributor.	
If yes, please provide the name(s) of the distributor.	
d. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	
e. Us this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	
f. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	Yes
f. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	www.ottumwaregionalhealth.com

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

Section E: Supplemental Information Continued

	Answer
g. Please indicate below whether or not you agree to these types of disclosure:	 I do not grant AHA permission to release my confidential data.
Your Name & Title	[redacted]
Your Name & Title	
Your Email Address	
Your Phone Number	
Your Fax Number	

Section Title	Status	Last Edit Date	Last Edit By
2014 Iowa Department of Public Health	Completed	08/06/2015	Philip J Noel

State Survey: Question	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	Opened a 14 bed geriatric psychiatric unit.
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	Permanent

Bed Type Numbers - Beds and Utilization by Inpatient Service

Questions 2a thru 2x relate to section D1a. of the AHA Survey. The total number of beds here should match the total facility numbers as reported in section D1a. for licensed beds.

a. General Medical/Surgical(adult, include gynecology)	
b. General Medical/Surgical (pediatric)	
c. Obstetrics	
d. Other Acute	
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	
f. Cardiac Intensive Care	

State Survey: Question	Answer
g. Neonatal Intensive Care (exclude normal newborn)	
h. Neonatal Intermediate Care	
i. Pediatric Intensive Care	
j. Burn Care	
k. Other Special Care (definitive observation, step down, etc.)	
l. Other Intensive Care	
m. Rehabilitation	
n. Chronic Disease	
o. Alzheimer's	
p. Hospice	
q. Psychiatric Care	
r. Alcoholism/Drug Abuse or Dependency Care	
s. Mental Retardation	
t. Skilled Nursing Care	
u. Intermediate Care	
v. Residential Care/Elderly Housing	
w. SubAcute Care	
x. Total Facility (Add lines a thru w.)	
a. Private	1214
b. Semi-Private	1214
c. OB	1157
d. Pediatric	1157

State Survey: Question	Answer
e. Substance Abuse Treatment	0
f. Detoxification	0
g. Rehabilitation	1004
h. Psychiatric	1385
i. Intensive Care Unit	2371
a. Amount of Charity	680991
b. Amount of Hill-Burton	0
c. Bad Debt	5072133
d. Total Non-Reimbursed	165626376
5. Data Release	Yes

To comply with the Iowa uniform reporting requirement law, Iowa Hospital Association is authorized to release data to the Iowa Department of Public Health.

[redacted]

a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	46960634
b. Medicaid Contractual Adjustments	36904997
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	9491696
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	12074438

AHA Annual Survey - 2014

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	-2582742
a. Charity Care Charge-level (should equal D.5b)	175207
b. Charity Care Cost-level	0

Thursday, May 5, 2016 4:32 PM

AHA Annual Survey - 2015

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue 1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status

In Progress

Date Started	Date Last Edited	Date Submitted
MAY-04-16	MAY-05-16	

Survey Administrators

Philip Noel

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	In Progress	05/05/2016	Philip J Noel

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy) To (mm/dd/yyyy)	01/01/2015 12/31/2015
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		365
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2016

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	In Progress	05/05/2016	Philip J Noel

Section B: Question	Description	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. SELECT ONLY ONE:		33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:		10 General medical and surgical
OTHER	Other-specify treatment area:	
3a. Does your hospital restrict admissions primarily to children?		No
3b. Does the hospital itself operate subsidiary corporations?		No
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:		No
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
3d. Is the hospital a participant in a network? If yes, please provide the name, city, state, and telephone number of your network(s).		No
	Name	
	City	
	State	
	Phone	
	Name	
	City	
	State	
	Phone	
	Name	
	City	
	State	
	Phone	

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
3e. Is your hospital owned in whole or in part by physicians or a physician group?		No
3f. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH or a LTCH arranged within a general acute care hospital.		
If you are arranged in a general acute care hospital, what is your host hospital's name, city and state?		

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	In Progress	05/05/2016	Philip J Noel

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (in my local community)	(4) Do Not Provide
1. General medical - surgical care	☐ (#Beds: ____)	☐	☐	☐
2. Pediatric medical - surgical care	☐ (#Beds: ____)	☐	☐	☐
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	☐ (#Beds: ____) (Level: ____)	☐	☐	☐
4. Medical-surgical intensive care	☐ (#Beds: ____)	☐	☐	☒
5. Cardiac intensive care	☐ (#Beds: ____)	☐	☐	☒
6. Neonatal intensive care	☐ (#Beds: ____)	☐	☐	☒
7. Neonatal intermediate care	☒ (#Beds: 4)	☐	☐	☐
8. Pediatric intensive care	☐ (#Beds: ____)	☐	☐	☒
9. Burn care	☐ (#Beds: ____)	☐	☐	☒
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	☐ (#Beds: ____) (Specify: ____)	☐	☐	☐
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	☐ (#Beds: ____) (Specify: ____)	☐	☐	☐
12. Physical rehabilitation	☒ (#Beds: 13)	☐	☐	☐
13. Alcoholism - drug abuse or dependency care	☐ (#Beds: ____)	☐	☐	☒
14. Psychiatric care	☒ (#Beds: 14)	☐	☐	☐
15. Skilled nursing care	☐ (#Beds: ____)	☐	☐	☒
16. Intermediate nursing care	☐ (#Beds: ____)	☐	☐	☒
17. Acute long-term care	☐ (#Beds: ____)	☐	☐	☒
18. Other long-term care	☐ (#Beds: ____)	☐	☐	☒

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	☐ (#Beds: ____) (Specify: ____)	☐	☐	☒
20. Adult day care program	☐	☐	☐	☒
21. Airborne infection isolation room (Please specify the number of rooms)	☒ # Rooms: 5	☐	☐	☐
22. Alcoholism - drug abuse or dependency outpatient services	☐	☐	☐	☒
23. Alzheimer Center	☐	☐	☐	☒
24. Ambulance services	☒	☐	☐	☐
25. Ambulatory surgery center	☒	☐	☐	☐
26. Arthritis treatment center	☐	☐	☐	☒
27. Assisted living	☐	☐	☐	☒
28. Auxiliary	☒	☐	☐	☐
29. Bariatric/weight control services	☐	☐	☐	☒
30. Birthing room - LDR room - LDRP room	☒	☐	☐	☐
31. Blood Donor Center	☐	☐	☒	☐
32. Breast cancer screening / mammograms	☒	☐	☐	☐
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services	☒	☐	☐	☐
33b. Pediatric cardiology services	☐	☐	☐	☒
33c. Adult diagnostic catheterization	☒	☐	☐	☐
33d. Pediatric diagnostic catheterization	☐	☐	☐	☒
33e. Adult interventional cardiac catheterization	☒	☐	☐	☐
33f. Pediatric interventional cardiac catheterization	☐	☐	☐	☒
33g. Adult cardiac surgery	☐	☐	☐	☒
33h. Pediatric cardiac surgery	☐	☐	☐	☒

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (in my local community)	(4) Do Not Provide
33i. Adult cardiac electrophysiology				X
33j. Pediatric cardiac electrophysiology				X
33k. Cardiac rehabilitation	X			
34. Case management	X			
35. Chaplaincy/pastoral care services	X			
36. Chemotherapy	X			
37. Children's wellness program				X
38. Chiropractic services				X
39. Community outreach	X			
40. Complementary and alternative medicine services				X
41. Computer assisted orthopedic surgery (CAOS)				X
42. Crisis prevention				X
43. Dental services				X
44. Emergency services: 44a. Emergency department	X			
44b. Pediatric emergency department	X			
44c. Satellite emergency department	(24 hours: ____)			X
44d. Is the department open 24 hours a day, 7 days a week?				
44e. Trauma center (certified) [Level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	X 3			
45. Enabling services				X
46. Endoscopic services 46a.Optical colonoscopy	X			
46b. Endoscopic ultrasound	X			
46c. Ablation of Barrett's esophagus	X			
46d. Esophageal impedance study	X			

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
46e. Endoscopic retrograde cholangiopancreatography (ERCP)				X
47. Enrollment (insurance) assistance services	X			
48. Extracorporeal shock wave lithotripter (ESWL)	X			
49. Fertility clinic				X
50. Fitness center	X			
51. Freestanding outpatient care center	X			
52. Geriatric services	X			
53. Health fair	X			
54. Community health education	X			
55. Genetic testing/counseling				X
56. Health screenings	X			
57. Health research				X
58. Hemodialysis	X			
59. HIV - AIDS services				X
60. Home health services	X			
61. Hospice program			X	
62. Hospital - based outpatient care center - services	X			
63. Immunization program				X
64. Indigent care clinic				X
65. Linguistic/translation services			X	
66. Meals on wheels				X
67. Mobile health services				X
68. Neurological services	X			

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (in my local community)	(4) Do Not Provide
69. Nutrition programs	X			
70. Occupational health services	X			
71. Oncology services				X
72. Orthopedic services	X			
73. Outpatient surgery	X			
74. Pain management program	X			
75. Palliative care program				X
76. Palliative care inpatient unit				X
77. Patient Controlled Analgesia (PCA)	X			
78. Patient education center				X
79. Patient representative services	X			
80. Physical rehabilitation services				X
80a. Assistive technology center				
80b. Electrodiagnostic services				X
80c. Physical rehabilitation outpatient services	X			
80d. Prosthetic and orthotic services				X
80e. Robot-assisted walking therapy				X
80f. Simulated rehabilitation environment				X
81. Primary care department				X
82. Psychiatric services: 82a. Psychiatric child - adolescent services				X
82b. Psychiatric consultation - liaison services				X
82c. Psychiatric education services				X
82d. Psychiatric emergency services	X			

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
82e. Psychiatric geriatric services	X			
82f. Psychiatric outpatient services				X
82g. Psychiatric partial hospitalization program				X
82h. Psychiatric residential treatment				X
83. Radiology, diagnostic: 83a. CT scanner	X			
83b. Diagnostic radioisotope facility	X			
83c. Electron beam computed tomography (EBCT)				X
83d. Full-field digital mammography(FFDM)	X			
83e. Magnetic resonance imaging (MRI)	X			
83f. Intraoperative magnetic resonance imaging				X
83g. Magnetoencephalography (MEG)				X
83h. Multi-slice spiral computed tomography(<64 + slice CT)	X			
83i. Multi-slice spiral computed tomography (64+ slice)	X			
83j. Positron emission tomography (PET)			X	
83k. Positron emission tomography/CT (PET/CT)			X	
83l. Single photon emission computerized tomography (SPECT)	X			
83m. Ultrasound	X			
84. Radiology therapeutic: 84a. Image-guided Radiation Therapy(IGRT)	X			
84b. Intensity-Modulated Radiation Therapy (IMRT)	X			
84c. Proton beam therapy				X
84d. Shaped Beam Radiation System	X			
84e. Stereotactic radiosurgery			X	
85. Retirement housing				X

Section C: Question Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
86. Robotic surgery	X			
87. Rural health clinic				X
88. Sleep center	X			
89. Social work services	X			
90. Sports medicine	X			
91. Support groups	X			
92. Swing bed services				X
93. Teen outreach services				X
94. Tobacco treatment / cessation program	X			
95. Transplant services: 95a. Bone marrow				X
95b. Heart				X
95c. Kidney				X
95d. Liver				X
95e. Lung				X
95f. Tissue				X
95g. Other				X
96. Transportation to health facilities				X
97. Urgent care center	X			
98. Virtual Colonoscopy				X
99. Volunteer services department	X			
100. Women's health center / services	X			
101. Wound management services	X			

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Section C: Question Physician Arrangements	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Do Not Provide
102a. Independent Practice Association	☐ (# Physicians: ____)	☐	☐	☒
102b. Group practice without walls	☐ (# Physicians: ____)	☐	☐	☒
102c. Open Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	☒
102d. Closed Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	☒
102e. Management Service Organization (MSO)	☐ (# Physicians: ____)	☐	☐	☒
102f. Integrated Salary Model	☒ (# Physicians: 19)	☐	☐	☐
102g. Equity Model	☐ (# Physicians: ____)	☐	☐	☒
102h. Foundation	☐ (# Physicians: ____)	☐	☐	☒
102i. Other, please specify:	☐ (# Physicians: ____)	☐	☐	☒

		Answer	Answer (History)
C. Physician Arrangements			
102b. Looking across all the relationships identified in question 102a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payors or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be at the hospital, system or network level)?	# of physicians	19	0
103a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?		No	No
103b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that apply).			
103b. Other			
103c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that apply).			
103c. Other			
103d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?		No	No
104a. Has your hospital or health care system established an accountable care organization (ACO)?		No	No

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
104b. If yes, please indicate the patient population that participates in the ACO. (Check all that apply):		
104b. Other		
105. Does your hospital have an established medical home program?	No	No
106. Does your hospital participate in a bundled payment program involving inpatient, physician, and/or post acute care services where the hospital receives a single payment from a payor for a package of services and then distributes payments to participating providers of care (such as a single fee for hospital and physician services for a specific procedure, e.g., hip replacement, CABG)?	No	No

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Section C: Question Insurance Products and Capitation	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Joint Venture With Insurer	(5) Do Not Provide
107a. Health Maintenance Organization	☐	☐	☐	☐	☒
107b. Preferred Provider Organization	☐	☐	☐	☐	☒
107c. Indemnity Fee for Service Plan	☐	☐	☐	☐	☒

Section C: Question Insurance Products and Capitation	Answer
108a. Health maintenance organization (HMO)	No
108b. If YES, how many contracts?	
108c. Preferred provider organization (PPO)	No
108d. If YES, how many contracts?	
109. What percentage of the hospital's net patient revenue is paid on a capitated basis? (If the hospital does not participate in capitated arrangements, please enter 0)	0
110. What percentage of the hospital's net patient revenue is paid on a shared risk basis?	0
111. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
112. If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated payment, how many lives are covered?	
113. Does your hospital have contracts with commercial payors where payment is tied to performance on quality/safety metrics?	No
114. Does your hospital conduct an internal survey of the hospital's quality/safety culture at least every 18 months?	Yes
114a. If yes, please indicate the response rate for the most recent survey.	88.5
114b. If yes, are valid results available at the level of individual units (e.g., medical ICUs, cardiothoracic surgery)?	Yes

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	In Progress	05/05/2016	Philip J Noel

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	101	101		
c. Bassinets set up and staffed for use at the end of the reporting period	10	10		
d. Births (exclude fetal deaths)	475	484		
e. Admissions (exclude newborns, include neonatal & swing admissions)	3,165	3,421		
f. Inpatient days (exclude newborns, include neonatal & swing days)	14,850	15,105		
g. Emergency department visits	19,239	19,375		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	87,702	112,599		
i. Inpatient surgical operations	907	921		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	5,293	5,017		

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days & deaths)				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	1,701	1,776		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care?	144	169		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	10,009	9,625		
b. 2. How many Medicare inpatient days were Medicare Managed Care?	667	830		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	629	670		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care?	0	0		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	2,468	2,389		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care?	0	0		

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	71,656,382	69,090,590		
*b. Tax appropriations	0	0		
*c. Other operating revenue	709,402	945,803		
*d. Nonoperating revenue	10,438	0		
*e. TOTAL REVENUE (add 3a thru 3d)	72,376,222	70,036,393		
f. Payroll expenses (only)	22,429,335	22,242,247		
g. Employee benefits	5,673,044	4,936,993		
h. Depreciation expense (for reporting period only)	5,819,267	5,501,791		
i. Interest expense	5,182,431	5,197,324		
j. Supply expense	9,533,617	10,209,540		
k. All other expenses	22,760,194	22,999,875		
l. TOTAL EXPENSES (Add 3f thru 3k.)	71,397,888	71,087,770		
*4. Revenue By type				
a. Total gross inpatient revenue	76,758,717	78,884,457		
b. Total gross outpatient revenue	163,619,516	155,832,510		
c. Total gross patient revenue	240,378,233	234,716,967		
*5. Uncompensated Care & Provider Taxes				
a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	3,700,209	5,072,133		
b. Financial Assistance (includes Charity) (Revenue forgone at full established rates. Include in gross revenue)	672,348	680,991		
c. Is your bad debt (5a.) reported on the basis of full charges?	Yes	Yes		
d. Does your state have a provider Medicaid tax/assessment program?	Yes	Yes		
e. If yes, please report the total gross amount paid into the program	496,467	496,467		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Total Expenses.....	Yes	No		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Deductions from net Patient Revenue.....	No	Yes		

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	113,464,844	109,184,839	35,413,702	33,256,600
6a1b. Managed care revenue	0	0	0	0
6a1c. Total (a + b)	113,464,844	109,184,839	35,413,702	33,256,600
Medicaid				
6a2. Medicaid:				
6a2a. Fee for service patient revenue	50,093,890	46,960,634	8,839,486	9,491,696
6a2b. Managed care revenue	0	0	0	0
6a2c. Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2d. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2e. Total (a+b+c+d)	50,093,890	46,960,634	8,839,486	9,491,696
6a3. Other Government:	0	0	0	0
6b1. Self-pay	3,213,409	3,523,862	485,576	528,582
6b2a. Managed care (includes HMO and PPO)	60,643,935	13,730,359	22,499,809	5,437,266
6b2b. Other third - party payors	12,962,060	61,317,273	4,045,459	20,376,446
6b2c. Total Third - party payors (a+b)	73,605,995	75,047,632	26,545,268	25,813,712
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	240,378,137	234,716,967	71,284,032	69,090,590

6d. Are the financial data reported from your audited financial statement?	Yes	Yes
6e. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	Yes	No

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

	Answer	Answer (History)
7. Fixed Assets		
7a. Property, plant and equipment at cost	80,618,859	78,340,541
7b. Accumulated depreciation	29,158,127	23,338,860
7c. Net property, plant and equipment (a - b)	51,460,732	55,001,681
7d. Total gross square feet of your physical plant used for or in support of your healthcare activities	202,105	202,105
8. Total Capital Expenses		
Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.	2,278,319	4,941,612
*9. INFORMATION TECHNOLOGY		
a. IT Operating Expense	2,109,238	1,827,744
b. IT Capital Expense.	1,239,620	602,023
c. Number of Employed IT staff (in FTEs).	7	8
d. Number of outsourced IT staff (in FTEs).	0	0
Electric Health Record		
e. Does your hospital have an electronic health record (see definition)?	Yes, fully implemented	Yes, partially implemented

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Total Facility Beds, Utilization, Finances & Staffing

Section D: 10. Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	0	14	0	2	0		
b. Dentists	0	0	0	0	0		
c. Medical and dental residents/interns	0	0	0	0	0		
d. Other trainees	0	0	0	0	0		
e. Registered nurses	121	118	41	25	132.6	32	11
f. Licensed practical (vocational) nurses	2	9	0	1	1.7	1	1
g. Nursing assistive personnel	26	6	13	12	31.2	6	11
h. Radiology technicians	5	5	3	1	6.4	1	0
i. Laboratory technicians	10	12	6	1	11.3	3	2
j. Pharmacists, licensed	4	3	0	0	4	0	0
k. Pharmacy technicians	4	4	2	0	4.8	1	1
l. Respiratory therapists	4	6	3	0	6.4	1	1
m. All other personnel	208	293	69	35	219.3	31	17
n. Total facility personnel (add 10.a through 10.m)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 10.o and 10.p)	384	470	137	77	417.7	76	44
o. Nursing home type unit/facility Registered Nurses	0	0	0	0	0	0	0
p. Nursing home type unit/facility personnel	0	0	0	0	0	0	0

	Answer	Answer (History)
q. For your employed RNs reported above (D.10.e, column 3), please report the number of full time equivalents who are involved in direct patient care.	132.6	143

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

11. PRIVILEGED PHYSICIANS	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, obstetrics/gynecology, geriatrics)	0	1	16	8	25
b. Emergency medicine	0	0	9	0	9
c. Hospitalist	0	0	10	0	10
d. Intensivist	0	0	0	0	0
e. Radiologist/pathologist/anesthesiologist	0	1	50	0	51
f. Other specialist	0	0	60	28	88
g. Total (add 11a-11f)	0	2	145	36	183

12. HOSPITALISTS	Answer	Answer (History)
12a. Do hospitalists provide care for patients in your hospital? (if yes, please report in D.11c.)	Yes	Yes
12b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	6.3	5

13. INTENSIVISTS	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 14.) (if yes, please report in D.11d.)	No	No

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care		☐		☐
2. Cardiac intensive care		☐		☐
3. Neonatal intensive care		☐		☐
4. Pediatric intensive care		☐		☐
5. Other intensive care		☐		☐
6. Total		☐		☐

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
14. ADVANCED PRACTICE REGISTERED NURSES / PHYSICIAN ASSISTANTS		
a. Do advanced practice nurses/physician assistants provide care for patients in your hospital?(if no, please skip to 15.)	Yes	
b. If yes, please report the number of full time, part time and FTE advanced practice nurses/physician assistants who provide care for patients in your hospital.		
Advanced Practice Registered Nurses Full-time	3	5
Advanced Practice Registered Nurses Part-time	5	16
Advanced Practice Registered Nurses FTE	3	
Physician Assistants Full-time	2	
Physician Assistants Part-time	0	
Physician Assistants FTE	2	
c. If yes, please indicate the type of service provided. (Please check all that apply)	Emergency department care, Other	Anesthesia services, Emergency department care, Other specialty care
15. FOREIGN EDUCATED NURSES		
a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2015 vs. 2014?	Did not hire foreign nurses	Did not hire foreign nurses
b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)		

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	In Progress	05/05/2016	Philip J Noel

Section E: Supplemental Information

	Answer
1. Does your hospital provide services through one or more satellite facilities?	Yes
2. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	Yes
	HealthTrust
	Brentwood
	TN
3. Does the hospital purchase medical/surgical supplies directly through a distributor?	No
If yes, please provide the name(s) of the distributor.	
If yes, please provide the name(s) of the distributor.	
If yes, please provide the name(s) of the distributor.	
4. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	

5. Describe the extent of your hospital's current partnerships with the following types of organizations for community or population health improvement initiatives	Not Involved	Collaboration	Formal Alliance
a. Health care providers outside your system	X		
b. Local or state public health organizations	X		
c. Local or state human/social service organizations	X		
d. Other local or state government	X		
e. Non-profit organizations	X		
f. Faith-based organizations	X		
g. Health insurance companies	X		
h. Schools	X		
i. Local businesses or chambers of commerce	X		

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

Section E: Supplemental Information Continued

	Answer
j. Other (list):	X
6. Us this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	
7. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	Yes
7. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	www.ottumwaregionalhealth.com
8. Please indicate below whether or not you agree to these types of disclosure:	
Your Name & Title	[redacted]
Your Name & Title	
Your Email Address	
Your Phone Number	
Your Fax Number	

Section Title	Status	Last Edit Date	Last Edit By
2014 Iowa Department of Public Health	Completed	05/05/2016	Philip J Noel

State Survey: Question	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	None
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	n/a

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
Bed Type Numbers - Beds and Utilization by Inpatient Service	
Questions 2a thru 2x relate to section D1a. of the AHA Survey. The total number of beds here should match the total facility numbers as reported in section D1a. for licensed beds.	
a. General Medical/Surgical(adult, include gynecology)	24
b. General Medical/Surgical (pediatric)	4
c. Obstetrics	17
d. Other Acute	
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	10
f. Cardiac Intensive Care	
g. Neonatal Intensive Care (exclude normal newborn)	
h. Neonatal Intermediate Care	4
i. Pediatric Intensive Care	
j. Burn Care	
k. Other Special Care (definitive observation, step down, etc.)	15
l. Other Intensive Care	
m. Rehabilitation	13
n. Chronic Disease	
o. Alzheimer's	
p. Hospice	
q. Psychiatric Care	14
r. Alcoholism/Drug Abuse or Dependency Care	
s. Mental Retardation	
t. Skilled Nursing Care	

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
u. Intermediate Care	
v. Residential Care/Elderly Housing	
w. SubAcute Care	
x. Total Facility (Add lines a thru w.)	101
a. Private	1275
b. Semi-Private	1275
c. OB	1215
d. Pediatric	1215
e. Substance Abuse Treatment	0
f. Detoxification	0
g. Rehabilitation	1054
h. Psychiatric	1454
i. Intensive Care Unit	2490
a. Amount of Charity	221875
b. Amount of Hill-Burton	0
c. Bad Debt	3700209
d. Total Non-Reimbursed	169094106
5. Data Release	Yes

To comply with the Iowa uniform reporting requirement law, Iowa Hospital Association is authorized to release data to the Iowa Department of Public Health.

AHA Annual Survey - 2015

Ottumwa Regional Health Center (6621105)

State Survey: Question	Answer
[redacted]	
a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	50093890
b. Medicaid Contractual Adjustments	41254403
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	8839486
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	11226147
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	-2386661
a. Charity Care Charge-level (should equal D.5b)	672348
b. Charity Care Cost-level	198343
9. a. How many total Auxiliary members and Volunteers (both adult and teen) did you have in your hospital?	45
9. b. How many total hours of service did the auxilians and volunteers give to the hospital?	19238
9. c. Total funds contributed to the hospital by the auxiliary and volunteer department?	0

AHA Annual Survey - 2016

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status
Submitted

Date Started	Date Last Edited	Date Submitted
MAR-23-17	MAY-12-17	MAY-12-17

Survey Administrators
Philip Noel

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	05/12/2017	Philip J Noel

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	01/01/2016
	To (mm/dd/yyyy)	12/31/2016
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		366
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2017

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	05/12/2017	Philip J Noel

Section B: Question	Description	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. SELECT ONLY ONE:		33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:		10 General medical and surgical
	Other-specify treatment area:	
OTHER		
3a. Does your hospital restrict admissions primarily to children?		No
3b. Does the hospital itself operate subsidiary corporations?		No
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:		No
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
3d. Is the hospital a participant in a network? If yes, please provide the name, city, state, and telephone number of your network(s).		No
	Name	
	City	

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
	State	
	Phone	
	Name	
	City	
	State	
	Phone	
	Name	
	City	
	State	
	Phone	
3e. Is your hospital owned in whole or in part by physicians or a physician group?		No
3f. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH		
If you are arranged in a general acute care hospital, what is your host hospital's name, city and state?		

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	05/12/2017	Philip J Noel

Section C: Facilities and Services

	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
1. General medical - surgical care	[X] (#Beds: 24)	[ ]	[ ]	[ ]
2. Pediatric medical - surgical care	[X] (#Beds: 4)	[ ]	[ ]	[ ]
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	[X] (#Beds: 17) Level: 2	[ ]	[ ]	[ ]
4. Medical-surgical intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
5. Cardiac intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
6. Neonatal intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
7. Neonatal intermediate care	[X] (#Beds: 4)	[ ]	[ ]	[ ]
8. Pediatric intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
9. Burn care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	[X] (#Beds: 15) Desc: Telemetry	[ ]	[ ]	[ ]
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	[X] (#Beds: 10) Desc: Med/Surg Cardiac Intensive Care	[ ]	[ ]	[ ]
12. Physical rehabilitation	[X] (#Beds: 13)	[ ]	[ ]	[ ]
13. Alcoholism - drug abuse or dependency care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
14. Psychiatric care	[X] (#Beds: 14)	[ ]	[ ]	[ ]
15. Skilled nursing care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
16. Intermediate nursing care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
17. Acute long-term care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
18. Other long-term care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	[ ] (#Beds: ____) (Specify: ____)	[ ]	[ ]	[X]
20. Adult day care program	[ ]	[ ]	[ ]	[X]
21. Airborne infection isolation room (Please specify the number of rooms)	[X] # Rooms: 5	[ ]	[ ]	[ ]
22. Alcoholism - drug abuse or dependency outpatient services	[ ]	[ ]	[ ]	[X]

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
23. Alzheimer Center				X
24. Ambulance services	X			
25. Ambulatory surgery center				X
26. Arthritis treatment center				X
27. Assisted living				X
28. Auxiliary	X			
29. Bariatric/weight control services				X
30. Birthing room - LDR room - LDRP room	X			
31. Blood Donor Center			X	
32. Breast cancer screening / mammograms	X			
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services	X			
33b. Pediatric cardiology services				X
33c. Adult diagnostic catheterization	X			
33d. Pediatric diagnostic catheterization				X
33e. Adult interventional cardiac catheterization	X			
33f. Pediatric interventional cardiac catheterization				X
33g. Adult cardiac surgery				X
33h. Pediatric cardiac surgery				X
33i. Adult cardiac electrophysiology				X
33j. Pediatric cardiac electrophysiology				X
33k. Cardiac rehabilitation	X			
34. Case management	X			
35. Chaplaincy/pastoral care services	X			
36. Chemotherapy				X
37. Children's wellness program				X
38. Chiropractic services				X
39. Community outreach	X			
40. Complementary and alternative medicine services				X

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
41. Computer assisted orthopedic surgery (CAOS)	☐	☐	☐	☒
42. Crisis prevention	☐	☐	☐	☒
43. Dental services	☐	☐	☐	☒
44. Emergency services: 44a. Emergency department	☒	☐	☐	☐
44b. Pediatric emergency department	☒	☐	☐	☐
44c. Satellite emergency department	☐ (24 hours: ____)	☐	☐	☒
44d. Is the department open 24 hours a day, 7 days a week?				
44e. Trauma center (certified) [Level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	☒ 3	☐	☐	☐
45. Enabling services	☐	☐	☐	☒
46. Endoscopic services: 46a.Optical colonoscopy	☒	☐	☐	☐
46b. Endoscopic ultrasound	☒	☐	☐	☐
46c. Ablation of Barrett's esophagus	☒	☐	☐	☐
46d. Esophageal impedance study	☒	☐	☐	☐
46e. Endoscopic retrograde cholangiopancreatography (ERCP)	☐	☐	☐	☒
47. Enrollment (insurance) assistance services	☒	☐	☐	☐
48. Extracorporeal shock wave lithotripter (ESWL)	☒	☐	☐	☐
49. Fertility clinic	☐	☐	☐	☒
50. Fitness center	☒	☐	☐	☐
51. Freestanding outpatient care center	☒	☐	☐	☐
52. Geriatric services	☒	☐	☐	☐
53. Health fair	☒	☐	☐	☐
54. Community health education	☒	☐	☐	☐
55. Genetic testing/counseling	☐	☐	☐	☒
56. Health screenings	☒	☐	☐	☐
57. Health research	☐	☐	☐	☒
58. Hemodialysis	☒	☐	☐	☐

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
59. HIV - AIDS services				X
60. Home health services	X			
61. Hospice program			X	
62. Hospital - based outpatient care center - services	X			
63. Immunization program				X
64. Indigent care clinic				X
65. Linguistic/translation services			X	
66. Meals on wheels				X
67. Mobile health services				X
68. Neurological services	X			
69. Nutrition programs	X			
70. Occupational health services	X			
71. Oncology services				X
72. Orthopedic services	X			
73. Outpatient surgery	X			
74. Pain management program	X			
75. Palliative care program				X
76. Palliative care inpatient unit				X
77. Patient Controlled Analgesia (PCA)	X			
78. Patient education center				X
79. Patient representative services	X			
80. Physical rehabilitation services:				X
80a. Assistive technology center				
80b. Electrodiagnostic services				X
80c. Physical rehabilitation outpatient services	X			
80d. Prosthetic and orthotic services				X
80e. Robot-assisted walking therapy				X
80f. Simulated rehabilitation environment				X
81. Primary care department				X

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
82. Psychiatric services: 82a. Psychiatric child - adolescent services	☐	☐	☐	☒
82b. Psychiatric consultation - liaison services	☐	☐	☐	☒
82c. Psychiatric education services	☐	☐	☐	☒
82d. Psychiatric emergency services	☒	☐	☐	☐
82e. Psychiatric geriatric services	☒	☐	☐	☐
82f. Psychiatric outpatient services	☐	☐	☐	☒
82g. Psychiatric partial hospitalization program	☐	☐	☐	☒
82h. Psychiatric residential treatment	☐	☐	☐	☒
83. Radiology, diagnostic: 83a. CT scanner	☒	☐	☐	☐
83b. Diagnostic radioisotope facility	☒	☐	☐	☐
83c. Electron beam computed tomography (EBCT)	☐	☐	☐	☒
83d. Full-field digital mammography(FFDM)	☒	☐	☐	☐
83e. Magnetic resonance imaging (MRI)	☒	☐	☐	☐
83f. Intraoperative magnetic resonance imaging	☐	☐	☐	☒
83g. Magnetoencephalography (MEG)	☐	☐	☐	☒
83h. Multi-slice spiral computed tomography(<64 + slice CT)	☒	☐	☐	☐
83i. Multi-slice spiral computed tomography (64+ slice)	☒	☐	☐	☐
83j. Positron emission tomography (PET)	☒	☐	☐	☐
83k. Positron emission tomography/CT (PET/CT)	☒	☐	☐	☐
83l. Single photon emission computerized tomography (SPECT)	☒	☐	☐	☐
83m. Ultrasound	☒	☐	☐	☐
84. Radiology therapeutic: 84a. Image-guided Radiation Therapy(IGRT)	☒	☐	☐	☐
84b. Intensity-Modulated Radiation Therapy (IMRT)	☒	☐	☐	☐
84c. Proton beam therapy	☐	☐	☐	☒
84d. Shaped Beam Radiation System	☒	☐	☐	☐

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
84e. Stereotactic radiosurgery				X
85. Retirement housing				X
86. Robotic surgery	X			
87. Rural health clinic				X
88. Sleep center	X			
89. Social work services	X			
90. Sports medicine	X			
91. Support groups	X			
92. Swing bed services				X
93. Teen outreach services				X
94. Tobacco treatment / cessation program	X			
95. Transplant services: 95a. Bone marrow				X
95b. Heart				X
95c. Kidney				X
95d. Liver				X
95e. Lung				X
95f. Tissue				X
95g. Other				X
96. Transportation to health facilities				X
97. Urgent care center				X
98. Violence Prevention Programs: 98a. For the workplace				X
98b. For the community				X
99. Virtual Colonoscopy				X
100. Volunteer services department	X			
101. Women's health center / services	X			
102. Wound management services	X			

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section C: Question Physician Arrangements	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Do Not Provide
103a. Independent Practice Association	☐ (# Physicians: ____)	☐	☐	☒
103b. Group practice without walls	☐ (# Physicians: ____)	☐	☐	☒
103c. Open Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	☒
103d. Closed Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	☒
103e. Management Service Organization (MSO)	☐ (# Physicians: ____)	☐	☐	☒
103f. Integrated Salary Model	☒ (# Physicians: 20)	☐	☐	☐
103g. Equity Model	☐ (# Physicians: ____)	☐	☐	☒
103h. Foundation	☐ (# Physicians: ____)	☐	☐	☒
103i. Other, please specify:	☐ (# Physicians: ____)	☐	☐	☒

	Answer	Answer (History)
104. Looking across all the relationships identified in question 103, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payors or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be at the hospital, system or network level)?	20	19
105a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?	No	No
105b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that apply).		
105b. Other		
105c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that apply).		
105c. Other		
105d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	No	No
106a. Has your hospital or health care system established an accountable care organization (ACO)?	No	No
106b. If yes, please indicate the patient population that participates in the ACO. (Check all that apply):		
106b. Other		
107. Does your hospital have an established medical home program?	No	No

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
108. Does your hospital participate in a bundled payment program involving inpatient, physician, and/or post acute care services where the hospital receives a single payment from a payor for a package of services and then distributes payments to participating providers of care (such as a single fee for hospital and physician services for a specific procedure, e.g., hip replacement, CABG)?	No	No

Section C: Question Insurance Products and Capitation	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Joint Venture with Insurer	(5) Do Not Provide
109a. Health Maintenance Organization					X
109b. Preferred Provider Organization					X
109c. Indemnity Fee for Service Plan					X

	Answer
110a. Health maintenance organization (HMO)	No
110b. If YES, how many contracts?	
110c. Preferred provider organization (PPO)	No
110d. If YES, how many contracts?	
111. What percentage of the hospital's net patient revenue is paid on a capitated basis? (If the hospital does not participate in capitated arrangements, please enter 0)	0
112. What percentage of the hospital's net patient revenue is paid on a shared risk basis?	0
113. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
114. If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated payment, how many lives are covered?	
115. Does your hospital have contracts with commercial payors where payment is tied to performance on quality/safety metrics?	No
116a. Does your hospital conduct an internal survey of the hospital's quality/safety culture at least every 18 months?	No
116b. If yes, please indicate the response rate for the most recent survey.	
116c. If yes, are valid results available at the level of individual units (e.g., medical ICUs, cardiothoracic surgery)?	

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	05/12/2017	Philip J Noel

Section D: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	101	101		
c. Bassinets set up and staffed for use at the end of the reporting period	10	10		
d. Births (exclude fetal deaths)	481	475		
e. Admissions (exclude newborns, include neonatal & swing admissions)	3,142	3,165		
f. Inpatient days (exclude newborns, include neonatal & swing days)	14,792	14,850		
g. Emergency department visits	19,259	19,239		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	136,139	87,702		
i. Inpatient surgical operations	884	907		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	5,172	5,293		

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section D: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days &				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	1,694	1,701		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care?	240	144		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	9,591	10,009		
b. 2. How many Medicare inpatient days were Medicare Managed Care?	1,134	667		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	1,018	629		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care?	667	0		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	3,389	2,468		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care?	2,139	0		

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section D: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	73,685,061	71,284,032		
*b. Tax appropriations	0	0		
*c. Other operating revenue	525,539	709,402		
*d. Nonoperating revenue	6,885	10,438		
*e. TOTAL REVENUE (add 3a thru 3d)	74,217,485	72,003,872		
f. Payroll expenses (only)	21,934,359	22,429,335		
g. Employee benefits	4,708,414	5,673,044		
h. Depreciation expense (for reporting period only)	4,488,833	5,819,267		
i. Interest expense	5,323,803	5,182,431		
j. Pharmacy Expense	2,979,352			
k. Supply expense (other than pharmacy)	6,577,564	9,533,617		
l. All other expenses	26,638,773	22,760,194		
m. TOTAL EXPENSES (Add 3f thru 3l. Exclude bad debt)	72,651,098	71,397,888		
*4. Revenue By type				
a. Total gross inpatient revenue	77,656,646	76,758,622		
b. Total gross outpatient revenue	174,258,537	163,619,516		
c. Total gross patient revenue	251,915,183	240,378,138		
*5. Uncompensated Care & Provider Taxes				
a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	3,882,570	3,700,209		
b. Financial Assistance (includes Charity) (Revenue forgone at full established rates. Include in gross revenue)	538,360	672,348		
c. Is your bad debt (5a.) reported on the basis of full charges?	Yes	Yes		
d. Does your state have a provider Medicaid tax/assessment program?	Yes	Yes		
e. If yes, please report the total gross amount paid into the program	496,467	496,467		

Ottumwa Regional Health Center (6621105)

Section D: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Total Expenses.....	Yes	Yes		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Deductions from net Patient Revenue.....	No	No		

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section D: Question (continued)

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	116,372,972	113,464,844	44,407,740	35,413,702
6a1b. Managed care revenue	0	0	0	0
6a1c. Total (a + b)	116,372,972	113,464,844	44,407,740	35,413,702
Medicaid				
6a2. Medicaid:				
6a2a. Fee for service patient revenue	16,307,639	50,093,890	1,790,374	8,839,486
6a2b. Managed care revenue	32,479,800	0	4,254,026	0
6a2c. Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2d. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2e. Total (a+b+c+d)	48,787,439	50,093,890	6,044,400	8,839,486
6a3. Other Government:	0	0	0	0
6b1. Self-pay	4,523,937	3,213,409	409,408	485,576
6b2a. Managed care (includes HMO and PPO)	12,665,176	12,962,060	3,952,802	4,045,459
6b2b. Other third - party payors	69,565,659	60,643,935	18,870,711	22,499,809
6b2c. Total Third - party payors (a+b)	82,230,835	73,605,995	22,823,513	26,545,268
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	251,915,183	240,378,138	73,685,061	71,284,032

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section D: Question (continued)

	Answer	Answer (History)
6d. Are the financial data reported from your audited financial statement?	Yes	
6e. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	

	Answer	Answer (History)
7. Fixed Assets		
7a. Property, plant and equipment at cost	57,865,809	80,618,859
7b. Accumulated depreciation	4,850,294	29,158,127
7c. Net property, plant and equipment (a - b)	53,015,515	51,460,732
7d. Total gross square feet of your physical plant used for or in support of your healthcare activities	202,105	202,105
8. Total Capital Expenses		
Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.	2,746,138	2,278,319
*9. INFORMATION TECHNOLOGY		
a. IT Operating Expense	2,104,496	2,109,238
b. IT Capital Expense.	429,256	1,239,620
c. Number of Employed IT staff (in FTEs).	7	7
d. Number of outsourced IT staff (in FTEs).	0	0
Electric Health Record		
e. Does your hospital have an electronic health record (see definition)?	Yes, fully implemented	Yes, fully implemented

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.		

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section D: 10. Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	0	0	0	0	0	0	0
b. Dentists	0	0	0	0	0	0	0
c. Medical and dental residents/interns	0	0	0	0	0	0	0
d. Other trainees	0	0	0	0	0	0	0
e. Registered nurses	153	121	41	41	149.4	14	32
f. Licensed practical (vocational) nurses	3	2	4	0	5.2	4	1
g. Nursing assistive personnel	30	26	13	13	31.5	5	6
h. Radiology technicians	6	5	4	3	6.5	1	1
i. Laboratory technicians	11	10	3	6	11.1	1	3
j. Pharmacists, licensed	4	4	1	0	4.1	0	0
k. Pharmacy technicians	4	4	1	2	4.1	1	1
l. Respiratory therapists	6	4	2	3	6.2	1	1
m. All other personnel	202	208	58	69	301.6	10	31
n. Total facility personnel (add 10.a through 10.m)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 10.o and 10.p)	419	384	127	137	519.7	37	76
o. Nursing home type unit/facility Registered Nurses	0	0	0	0	0	0	0
p. Nursing home type unit/facility personnel	0	0	0	0	0	0	0

	Answer	Answer (History)
q. For your employed RNs reported above (D.10.e, column 3), please report the number of full time equivalents who are involved in direct	126.5	133

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section D: 11. Privileged Physicians	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general	0	0	20	7	27
b. Emergency medicine	0	0	9	0	9
c. Hospitalist	0	0	9	0	9
d. Intensivist	0	0	0	0	0
e. Radiologist/pathologist/anesthesiologist	0	0	54	0	54
f. Other specialist	0	0	71	36	107
g. Total (add 11a-11f)	0	0	163	43	206

12. HOSPITALISTS

	Answer	Answer (History)
12a. Do hospitalists provide care for patients in your hospital? (if yes, please report in D.11c.)	Yes	Yes
12b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	5	6

13. INTENSIVISTS

	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 14.) (if yes, please report in D.11d.)	No	No

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care				
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total				

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

14. ADVANCED PRACTICE REGISTERED NURSES / PHYSICIAN ASSISTANTS

	Answer	Answer (History)
a. Do advanced practice nurses/physician assistants provide care for patients in your hospital?(if no, please skip to 15.)	Yes	
Advanced Practice Registered Nurses Full-time	1	3
Advanced Practice Registered Nurses Part-time	15	5
Advanced Practice Registered Nurses FTE	1	3
Physician Assistants Full-time	2	2
Physician Assistants Part-time	4	0
Physician Assistants FTE	2	2
c. If yes, please indicate the type of service provided. (Please check all that apply)	Anesthesia services	Emergency department care, Other

15. FOREIGN EDUCATED NURSES

a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2016 vs. 2015?	Same	Did not hire foreign nurses
b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)		

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	05/12/2017	Philip J Noel

Section E: Supplemental Information

	Answer
1. Does your hospital provide services through one or more satellite facilities?	Yes
2. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	Yes
	HealthTrust
	Brentwood
	TN
3. Does the hospital purchase medical/surgical supplies directly through a distributor?	Yes
If yes, please provide the name(s) of the distributor.	Owens and Minor
If yes, please provide the name(s) of the distributor.	Medline
If yes, please provide the name(s) of the distributor.	
4. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	

Describe the extent of your hospital's current partnerships with the following types of organizations for community or population health improvement initiatives.	Not Involved	Collaboration	Formal Alliance
a. Health care providers outside your system	X		
b. Local or state public health organizations	X		
c. Local or state human/social service organizations	X		

d. Other local or state government	X		
e. Non-profit organizations	X		
f. Faith-based organizations	X		
g. Health insurance companies	X		
h. Schools	X		
i. Local businesses or chambers of commerce	X		
j. Other (list):	X		

	Answer
6. Use this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	
7. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	Yes
	www.ottumwaregionalhealth.com
8. Please indicate below whether or not you agree to these types of disclosure:	I do not grant AHA permission to release my confidential data.
Your Name & Title	[redacted]
Your Email Address	
Your Phone Number	
Your Fax Number	

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
2016 Iowa Department of Public Health	Completed	05/12/2017	Philip J Noel

State Supplement

	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	None
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	n/a
Bed Type Numbers - Beds and Utilization by Inpatient Service	
a. General Medical/Surgical(adult, include gynecology)	24
b. General Medical/Surgical (pediatric)	4
c. Obstetrics	17
d. Other Acute	
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	10
f. Cardiac Intensive Care	
g. Neonatal Intensive Care (exclude normal newborn)	
h. Neonatal Intermediate Care	4
i. Pediatric Intensive Care	
j. Burn Care	
k. Other Special Care (definitive observation, step down, etc.)	15
l. Other Intensive Care	
m. Rehabilitation	13
n. Chronic Disease	
o. Alzheimer's	
p. Hospice	
q. Psychiatric Care	14
r. Alcoholism/Drug Abuse or Dependency Care	

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
s. Mental Retardation	
t. Skilled Nursing Care	
u. Intermediate Care	
v. Residential Care/Elderly Housing	
w. SubAcute Care	
x. Total Facility (Add lines a thru w.)	101
a. Private	1338
b. Semi-Private	1338
c. OB	1276
d. Pediatric	1276
e. Substance Abuse Treatment	0
f. Detoxification	0
g. Rehabilitation	1107
h. Psychiatric	1527
i. Intensive Care Unit	2614
a. Amount of Charity	263421
b. Amount of Hill-Burton	0
c. Bad Debt	3882570
d. Total Non-Reimbursed	190054082
5. Data Release	Yes
[redacted]	

AHA Annual Survey - 2016

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	16307639
b. Medicaid Contractual Adjustments	14517265
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	1790374
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	13529432
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	-11739058
a. Charity Care Charge-level (should equal D.5b)	538360
b. Charity Care Cost-level	66484
9. a. How many total Auxiliary members and Volunteers (both adult and teen) did you have in your hospital?	139
9. b. How many total hours of service did the auxilians and volunteers give to the hospital?	9987
9. c. Total funds contributed to the hospital by the auxiliary and volunteer department?	

AHA Annual Survey - 2017

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status
Submitted

Date Started	Date Last Edited	Date Submitted
MAY-02-18	MAY-03-18	MAY-03-18

Survey Administrators
Philip Noel

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	05/03/2018	Philip J Noel

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	01/01/2017
	To (mm/dd/yyyy)	12/31/2017
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		365
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2018

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	05/03/2018	Philip J Noel

Section B: Question	Description	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. SELECT ONLY ONE:		33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:		10 General medical and surgical
	Other-specify treatment area:	
OTHER		
3a. Does your hospital restrict admissions primarily to children?		No
3b. Does the hospital itself operate subsidiary corporations?		No
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:		No
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
3d. Is the hospital a participant in a network? If yes, please provide the name, city, state, and telephone number of your network(s).		No
	Name	
	City	

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
	State	
	Phone	
	Name	
	City	
	State	
	Phone	
	Name	
	City	
	State	
	Phone	
3e. Is your hospital owned in whole or in part by physicians or a physician group?		No
3f. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH		
If you are arranged in a general acute care hospital, what is your host hospital's name, city and state?		

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	05/03/2018	Philip J Noel

Section C: Facilities and Services

	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
1. General medical - surgical care	[X] (#Beds: 39)	[ ]	[ ]	[ ]
2. Pediatric medical - surgical care	[X] (#Beds: 4)	[ ]	[ ]	[ ]
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	[X] (#Beds: 17) Level: 2	[ ]	[ ]	[ ]
4. Medical-surgical intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
5. Cardiac intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
6. Neonatal intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
7. Neonatal intermediate care	[X] (#Beds: 4)	[ ]	[ ]	[ ]
8. Pediatric intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
9. Burn care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	[ ] (#Beds: ____) (Specify: ____)	[ ]	[ ]	[X]
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	[X] (#Beds: 10) Desc: Med/Surg Cardiac Intensive Care	[ ]	[ ]	[ ]
12. Physical rehabilitation	[X] (#Beds: 13)	[ ]	[ ]	[ ]
13. Alcoholism-chemical dependency care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
14. Psychiatric care	[X] (#Beds: 14)	[ ]	[ ]	[ ]
15. Skilled nursing care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
16. Intermediate nursing care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
17. Acute long-term care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
18. Other long-term care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	[ ] (#Beds: ____) (Specify: ____)	[ ]	[ ]	[X]
20. Adult day care program	[ ]	[ ]	[ ]	[X]
21. Airborne infection isolation room (Please specify the number of rooms)	[X] # Rooms: 5	[ ]	[ ]	[ ]

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
22. Alcoholism-chemical dependency care Services				
22a. Alcoholism-chemical dependency pediatric services	☐ (#Beds: ____)	☐	☐	☒
22b. Alcoholism-chemical dependency outpatient services	☐	☐	☐	☒
22c. Alcoholism-chemical dependency partial hospitalization services	☐	☐	☐	☒
23. Alzheimer Center	☐	☐	☐	☒
24. Ambulance services	☒	☐	☐	☐
25. Ambulatory surgery center	☐	☐	☐	☒
26. Arthritis treatment center	☐	☐	☐	☒
27. Assisted living	☐	☐	☐	☒
28. Auxiliary	☒	☐	☐	☐
29. Bariatric/weight control services	☐	☐	☐	☒
30. Birthing room - LDR room - LDRP room	☒	☐	☐	☐
31. Blood Donor Center	☐	☐	☒	☐
32. Breast cancer screening / mammograms	☒	☐	☐	☐
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services	☒	☐	☐	☐
33b. Pediatric cardiology services	☐	☐	☐	☒
33c. Adult diagnostic catheterization	☒	☐	☐	☐
33d. Pediatric diagnostic catheterization	☐	☐	☐	☒
33e. Adult interventional cardiac catheterization	☒	☐	☐	☐
33f. Pediatric interventional cardiac catheterization	☐	☐	☐	☒
33g. Adult cardiac surgery	☐	☐	☐	☒
33h. Pediatric cardiac surgery	☐	☐	☐	☒
33i. Adult cardiac electrophysiology	☒	☐	☐	☐
33j. Pediatric cardiac electrophysiology	☐	☐	☐	☒
33k. Cardiac rehabilitation	☒	☐	☐	☐
34. Case management	☒	☐	☐	☐
35. Chaplaincy/pastoral care services	☒	☐	☐	☐

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
36. Chemotherapy	☐	☐	☐	☒
37. Children's wellness program	☐	☐	☐	☒
38. Chiropractic services	☐	☐	☐	☒
39. Community outreach	☒	☐	☐	☐
40. Complementary and alternative medicine services	☐	☐	☐	☒
41. Computer assisted orthopedic surgery (CAOS)	☐	☐	☐	☒
42. Crisis prevention	☐	☐	☐	☒
43. Dental services	☐	☐	☐	☒
44. Emergency services: 44a. Emergency department	☒	☐	☐	☐
44b. Pediatric emergency department	☒	☐	☐	☐
44c. Trauma center (certified) [Level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	☒ 3	☐	☐	☐
45. Enabling services	☐	☐	☐	☒
46. Endoscopic services: 46a.Optical colonoscopy	☒	☐	☐	☐
46b. Endoscopic ultrasound	☒	☐	☐	☐
46c. Ablation of Barrett's esophagus	☒	☐	☐	☐
46d. Esophageal impedance study	☒	☐	☐	☐
46e. Endoscopic retrograde cholangiopancreatography (ERCP)	☐	☐	☐	☒
47. Enrollment (insurance) assistance services	☒	☐	☐	☐
48. Extracorporeal shock wave lithotripter (ESWL)	☒	☐	☐	☐
49. Fertility clinic	☐	☐	☐	☒
50. Fitness center	☒	☐	☐	☐
51. Freestanding outpatient care center	☒	☐	☐	☐
52. Geriatric services	☒	☐	☐	☐
53. Health fair	☒	☐	☐	☐
54. Community health education	☒	☐	☐	☐
55. Genetic testing/counseling	☐	☐	☐	☒

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
56. Health screenings	X			
57. Health research				X
58. Hemodialysis	X			
59. HIV - AIDS services				X
60. Home health services	X			
61. Hospice program			X	
62. Hospital - based outpatient care center - services	X			
63. Immunization program				X
64. Indigent care clinic				X
65. Linguistic/translation services			X	
66. Meals on wheels				X
67. Mobile health services				X
68. Neurological services	X			
69. Nutrition programs	X			
70. Occupational health services	X			
71. Oncology services				X
72. Orthopedic services	X			
73. Outpatient surgery	X			
74. Pain management program	X			
75. Palliative care program				X
76. Palliative care inpatient unit				X
77. Patient Controlled Analgesia (PCA)	X			
78. Patient education center				X
79. Patient representative services	X			
80. Physical rehabilitation services:				
80a. Assistive technology center				X
80b. Electrodiagnostic services				X
80c. Physical rehabilitation outpatient services	X			
80d. Prosthetic and orthotic services				X

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
80e. Robot-assisted walking therapy	☐	☐	☐	☒
80f. Simulated rehabilitation environment	☒	☐	☐	☐
81. Primary care department	☐	☐	☐	☒
82. Psychiatric services: 82a.Psychiatric consultation - liaison services	☐	☐	☐	☒
82b. Psychiatric pediatric care	☐ (#Beds: ____)	☐	☐	☒
82c. Psychiatric geriatric services	☒ (#Beds: 14)	☐	☐	☐
82d. Psychiatric education services	☐	☐	☐	☒
82e. Psychiatric emergency services	☒	☐	☐	☐
82f. Psychiatric outpatient services	☐	☐	☐	☒
82g. Psychiatric intensive outpatient services	☐	☐	☐	☒
82h. Psychiatric partial hospitalization services - adult	☐	☐	☐	☒
82i. Psychiatric partial hospitalization services - pediatric	☐	☐	☐	☒
82j. Psychiatric residential treatment - adult	☐	☐	☐	☒
82k. Psychiatric residential treatment - pediatric	☐	☐	☐	☒
83. Radiology, diagnostic: 83a. CT scanner	☒	☐	☐	☐
83b. Diagnostic radioisotope facility	☒	☐	☐	☐
83c. Electron beam computed tomography (EBCT)	☐	☐	☐	☒
83d. Full-field digital mammography(FFDM)	☒	☐	☐	☐
83e. Magnetic resonance imaging (MRI)	☒	☐	☐	☐
83f. Intraoperative magnetic resonance imaging	☐	☐	☐	☒
83g. Magnetoencephalography (MEG)	☐	☐	☐	☒
83h. Multi-slice spiral computed tomography(<64 + slice CT)	☒	☐	☐	☐
83i. Multi-slice spiral computed tomography (64+ slice)	☒	☐	☐	☐
83j. Positron emission tomography (PET)	☒	☐	☐	☐
83k. Positron emission tomography/CT (PET/CT)	☒	☐	☐	☐

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
83l. Single photon emission computerized tomography (SPECT)	X			
83m. Ultrasound	X			
84. Radiology therapeutic: 84a. Image-guided Radiation Therapy(IGRT)	X			
84b. Intensity-Modulated Radiation Therapy (IMRT)	X			
84c. Proton beam therapy				X
84d. Shaped Beam Radiation System	X			
84e. Stereotactic radiosurgery				X
85. Retirement housing				X
86. Robotic surgery	X			
87. Rural health clinic				X
88. Sleep center	X			
89. Social work services	X			
90. Sports medicine	X			
91. Support groups	X			
92. Swing bed services				X
93. Teen outreach services				X
94. Tobacco treatment / cessation program	X			
95. Telehealth 95a. Consultation and office visits	X			
95b. eICU	X			
95c. Stroke care	X			
95d. Psychiatric and Addiction treatment	X			
95e. Remote patient monitoring: 1. Post-discharge.				X
2. Ongoing chronic care management				X
96. Transplant services: 96a. Bone marrow				X
96b. Heart				X
96c. Kidney				X
96d. Liver				X

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
96e. Lung	☐	☐	☐	☒
96f. Tissue	☐	☐	☐	☒
96g. Other	☐	☐	☐	☒
97. Transportation to health facilities	☐	☐	☐	☒
98. Urgent care center	☐	☐	☐	☒
99. Violence Prevention Programs: 99a. For the workplace	☐	☐	☐	☒
99b. For the community	☐	☐	☐	☒
100. Virtual Colonoscopy	☐	☐	☐	☒
101. Volunteer services department	☒	☐	☐	☐
102. Women's health center / services	☒	☐	☐	☐
103. Wound management services	☒	☐	☐	☐

Section C: Physician Arrangements	Answer	Answer (History)
104. Does your organization routinely integrate behavioral health services in the following care areas?		
a. Emergency Services	Yes	
b. Primary Care Services	No	
c. Acute inpatient care	Yes	
d. Extended care	No	

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

105. In which of the following physician arrangements does your hospital or system/network participate? Column 3 refers to the networks that were identified in section B, question 3d. For hospital level physician arrangements that are reported in column 1, please report the number of physicians involved.

	(1) My Hospital	(2) My Health System	(3) My Health Network	(4) Do Not Provide
105a. Independent Practice Association	☐ (# Physicians: ____)	☐	☐	☒
105b. Group practice without walls	☐ (# Physicians: ____)	☐	☐	☒
105c. Open Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	☒
105d. Closed Physician - Hospital Organization (PHO)	☐ (# Physicians: ____)	☐	☐	☒
105e. Management Service Organization (MSO)	☐ (# Physicians: ____)	☐	☐	☒
105f. Integrated Salary Model	☒ (# Physicians: 20)	☐	☐	☐
105g. Equity Model	☐ (# Physicians: ____)	☐	☐	☒
105h. Foundation	☐ (# Physicians: ____)	☐	☐	☒
105i. Other, please specify:	☐ (# Physicians: ____)	☐	☐	☒

	Answer	Answer (History)
106. Looking across all the relationships identified in question 105, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payors or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be at the hospital, system or network level)?	20	20
107a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?	No	No
107b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that apply).		
107b. Other		
107c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that apply).		
107c. Other		
107d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	No	No

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Insurance and Alternative Payment Models	Completed	05/03/2018	Philip J Noel

Section D: Question	Answer
1. Does your hospital/system have a health plan license?	No
1a. In what states? (Select all that applies)	
1b. Does your hospital/system partner with an insurer to offer insurance products?	No
1c. Does your hospital/system offer the following insurance products (either via ownership or joint venture)?	No

1d. What is the total medical enrollment for each product you offer?

Insurance Product	Hospital	System	JV	Medical Enrollment	No	Do Not Know
1. Medicare Advantage	☐	☐	☐		X	☐
2. Medicaid Managed Care	☐	☐	☐		X	☐
3. Health Insurance Marketplace	☐	☐	☐		X	☐
4. Other Individual Market	☐	☐	☐		X	☐
5. Small Group	☐	☐	☐		X	☐
6. Large Group	☐	☐	☐		X	☐

Does your health plan make capitated payments to physicians either within or outside of your network for specific groups or enrollees?

	Answer
a. Physicians within your network	No
b. Physicians outside your network	No

Does your health plan make bundled payments to providers in your network or to outside providers?

	Answer
a. Providers within your network	No
b. Providers outside your network	No

Does your health plan offer shared risk contracts either to providers in your network or to outside providers? (i.e., other than capitation or bundled payment)

	Answer
a. Providers within your network	No
b. Providers outside your network	No

Ottumwa Regional Health Center (6621105)

	Answer
5. What percentage of the hospital's net patient revenue is paid on a capitated basis?	0
5a. In total, how many enrollees do you serve under capitated contracts?	
6. Does your hospital participate in a bundled payment program involving care settings outside of the hospital (e.g. physician, outpatient, post acute, etc.)?	No
6a. If yes, does your hospital share upside or downside risk with any of those outside providers?	
6b. If yes, what percentage of the hospital's patient revenue is paid through bundled payment arrangements	
7. What percentage of your hospital's patient revenue is paid on a shared risk basis (other than capitated or bundled payment)?	0
8. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
9. Does your hospital have contracts with commercial payors where payment is tied to performance on quality/safety metrics?	No
10. Has your hospital or health care system established an accountable care organization (ACO)?	No
10a. If yes, please indicate the patient population that participates in the ACO. (Check all that apply):	
10a. If yes, please indicate the patient population that participates in the ACO. (Check all that apply):	

11. Do any hospitals and/or physician groups within your system or the system itself, plan to participate in any of the following risk arrangements in the next three years? (Check all that apply)

- [X] a. Shared Savings/Losses
- [ ] b. Bundled payment
- [ ] c. Capitation
- [ ] d. ACO (Ownership)
- [ ] e. ACO (Joint Venture)
- [ ] f. Health Plan (Ownership)
- [ ] g. Health Plan (Joint Venture)
- [ ] h. Other, please specify:
- [ ] i. None

	Answer
12. Does your hospital have an established medical home program?	
13. Has your hospital/system established a clinically integrated network?	

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	05/03/2018	Philip J Noel

Section E: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	101	101		
c. Bassinets set up and staffed for use at the end of the reporting period	10	10		
d. Births (exclude fetal deaths)	451	481		
e. Admissions (exclude newborns, include neonatal & swing admissions)	3,312	3,142		
f. Inpatient days (exclude newborns, include neonatal & swing days)	15,840	14,792		
g. Emergency department visits	19,920	19,259		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	143,949	136,139		
i. Inpatient surgical operations	987	884		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	5,052	5,172		

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days &				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	1,683	1,694		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care?	280	240		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	9,327	9,591		
b. 2. How many Medicare inpatient days were Medicare Managed Care?	1,313	1,134		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	1,104	1,018		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care?	969	667		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	4,441	3,389		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care?	3,796	2,139		

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	77,338,493	73,685,061		
*b. Tax appropriations	0	0		
*c. Other operating revenue	402,065	525,539		
*d. Nonoperating revenue	3,698	6,885		
*e. TOTAL REVENUE (add 3a thru 3d)	77,744,256	74,217,485		
f. Payroll expenses (only)	23,316,566	21,934,359		
g. Employee benefits	6,322,052	4,708,414		
h. Depreciation expense (for reporting period only)	4,668,514	4,488,833		
i. Interest expense	5,731,896	5,323,803		
j. Pharmacy Expense	3,296,671	2,979,352		
k. Supply expense (other than pharmacy)	7,049,050	6,577,564		
l. All other expenses	27,787,867	26,638,773		
m. TOTAL EXPENSES (Add 3f thru 3l. Exclude bad debt)	78,172,616	72,651,098		
*4. Revenue By type				
a. Total gross inpatient revenue	90,050,201	77,656,646		
b. Total gross outpatient revenue	200,461,188	174,258,537		
c. Total gross patient revenue	290,511,389	251,915,183		
*5. Uncompensated Care & Provider Taxes				
a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	5,589,127	3,882,570		
b. Financial Assistance (includes Charity) (Revenue forgone at full established rates. Include in gross revenue)	411,010	538,360		
c. Is your bad debt (5a.) reported on the basis of full charges?	Yes	Yes		
d. Does your state have a provider Medicaid tax/assessment program?	Yes	Yes		
e. If yes, please report the total gross amount paid into the program	496,467	496,467		

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Total Expenses.....	Yes	Yes		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Deductions from net Patient Revenue.....	No	No		

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	141,045,502	116,372,972	32,070,087	44,407,740
6a1b. Managed care revenue	0	0	0	0
6a1c. Total (a + b)	141,045,502	116,372,972	32,070,087	44,407,740
Medicaid				
6a2. Medicaid:				
6a2a. Fee for service patient revenue	9,441,879	16,307,639	1,475,360	1,790,374
6a2b. Managed care revenue	55,568,017	32,479,800	8,682,892	4,254,026
6a2c. Medicaid Graduate Medical Education (GME) payments			0	
6a2d. Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2e. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2f. Other Medicaid			0	
6a2g. Total (a+b+c+d+e+f)	65,009,896	48,787,439	10,158,252	6,044,400
6a3. Other Government:	0	0	0	0
6b1. Self-pay	5,237,964	4,523,937	472,189	409,408
6b2a. Managed care (includes HMO and PPO)	12,072,898	12,665,176	5,086,193	3,952,802
6b2b. Other third - party payors	67,145,129	69,565,659	29,551,772	18,870,711
6b2c. Total Third - party payors (a+b)	79,218,027	82,230,835	34,637,965	22,823,513
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	290,511,389	251,915,183	77,338,493	73,685,061

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Inpatient	Inpatient (History)	Outpatient	Outpatient (History)
If you reported receiving Medicaid Supplemental Payments on line 6.a(2)e, please break the payment total into inpatient and outpatient care.				
Medicaid supplemental payments				

	Answer	Answer (History)
6e. If you are a government owned facility, does your facility participate in the Medicaid intergovernmental transfer or certified public expenditure program.	No	

	Gross	Gross (History)	Net	Net (History)
*6f. If yes, please report gross and net revenue.				

	Answer	Answer (History)
6g. Are the financial data reported from your audited financial statement?	Yes	
6h. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	
7. Fixed Assets		
7a. Property, plant and equipment at cost	60,531,414	57,865,809
7b. Accumulated depreciation	9,518,808	4,850,294
7c. Net property, plant and equipment (a - b)	51,012,606	53,015,515
7d. Total gross square feet of your physical plant used for or in support of your healthcare activities	202,105	202,105
8. Total Capital Expenses		
Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.	2,665,604	2,746,138
9. INFORMATION TECHNOLOGY AND CYBERSECURITY		
a. IT Operating Expense	2,015,949	2,104,496
b. IT Capital Expense.	1,105,662	429,256
c. Number of Employed IT staff (in FTEs).	8	7
d. Number of outsourced IT staff (in FTEs).	0	0
*e. What percentage of your IT budget is spent on security?		

f. Which of the following cybersecurity measures does your hospital or health system currently deploy?*

- [X] a. Annual risk assessment
- [X] b. Incident response plan
- [X] c. Intrusion detection systems
- [X] d. Mobile device encryption
- [X] e. Mobile device data wiping
- [ ] f. Penetration testing to identify security vulnerabilities
- [X] g. Strong password requirements
- [ ] h. Two-factor authentication

	Answer	Answer (History)
CYBERSECURITY		
g. Does your hospital or health system board oversight of risk management and reduction specifically include consideration of cybersecurity risk?*	Unsure	
h. Does your hospital or health system have cybersecurity insurance?*	Yes	
i. Is your hospital or health system participating in cybersecurity information-sharing activities with an outside information Sharing and Analysis Organization to identify threats and vulnerabilities?*	Yes	
*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.		
*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.		

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section E: 10. Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	0	0	0	0	0	0	0
b. Dentists	0	0	0	0	0	0	0
c. Medical and dental residents/interns	0	0	0	0	0	0	0
d. Other trainees	0	0	0	0	0	0	0
e. Registered nurses	146	153	53	41	147.7	24	14
f. Licensed practical (vocational) nurses	5	3	4	4	6.1	3	4
g. Nursing assistive personnel	26	30	17	13	28.9	8	5
h. Radiology technicians	5	6	3	4	5	3	1
i. Laboratory technicians	11	11	4	3	11	3	1
j. Pharmacists, licensed	3	4	1	1	3.1	0	0
k. Pharmacy technicians	4	4	0	1	4	2	1
l. Respiratory therapists	6	6	3	2	6.3	0	1
m. All other personnel	219	202	77	58	234.4	21	10
n. Total facility personnel (add 10.a through 10.m)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 10.o and 10.p)	425	419	162	127	446.5	64	37
o. Nursing home type unit/facility Registered Nurses	0	0	0	0	0	0	0
p. Nursing home type unit/facility personnel	0	0	0	0	0	0	0

	Answer	Answer (History)
q. For your employed RNs reported above (E.10.e, column 3), please report the number of full time equivalents who are involved in direct	113.5	127

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section E: 11. Privileged Physicians	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general	0	0	19	9	28
b. Emergency medicine	0	0	7	0	7
c. Hospitalist	0	0	10	0	10
d. Intensivist	0	0	29	0	29
e. Radiologist/pathologist/anesthesiologist	0	0	39	0	39
f. Other specialist	0	0	68	29	97
g. Total (add 11a-11f)	0	0	172	38	210

12. HOSPITALISTS

	Answer	Answer (History)
12a. Do hospitalists provide care for patients in your hospital? (if yes, please report in E.11c.)	Yes	Yes
12b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	6	5

13. INTENSIVISTS

	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 14.) (if yes, please report in E.11d.)	Yes	No

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care	4.2			
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total	4.2			

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

14. ADVANCED PRACTICE REGISTERED NURSES / PHYSICIAN ASSISTANTS

	Answer	Answer (History)
a. Do advanced practice nurses/physician assistants provide care for patients in your hospital?(if no, please skip to 15.)	Yes	Yes
Advanced Practice Registered Nurses Full-time	5	1
Advanced Practice Registered Nurses Part-time	12	15
Advanced Practice Registered Nurses FTE	5	1
Physician Assistants Full-time	2	2
Physician Assistants Part-time	5	4
Physician Assistants FTE	2	2
c. If yes, please indicate the type of service provided. (Please check all that apply)	Anesthesia services, Emergency department care, Other specialty care, Other	Anesthesia services

15. FOREIGN EDUCATED NURSES

a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2017 vs. 2016?	Did not hire foreign nurses	Same
b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)		

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	05/03/2018	Philip J Noel

Section F: Supplemental Information

	Answer
1. Does your hospital provide services through one or more satellite facilities?	Yes

1a. If yes, please indicate the type of service offered along with the number of satellite facilities providing that service.

Facilities	Check all that apply	Number of Facilities
Primary Care Clinic		
Specialty Clinic	X	2
Urgent Care		
Ambulatory Surgery		
Rehabilitation		
Psychiatric Care		
Substance Abuse/Chemical Dependency		
Skilled Nursing		
Residential Care		
Other Extended Care		
Laboratory		
Diagnostic Imaging Center		
Other		

	Answer
2. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	Yes
	HealthTrust
	Brentwood
	TN
3. Does the hospital purchase medical/surgical supplies directly through a distributor?	Yes
If yes, please provide the name(s) of the distributor.	Owens & Minor
If yes, please provide the name(s) of the distributor.	Medline
If yes, please provide the name(s) of the distributor.	Cardinal

Ottumwa Regional Health Center (6621105)

4. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	

5. Describe the extent of your hospital's current partnerships with the following types of organizations for community or population health improvement initiatives.	Not Involved	Collaboration	Formal Alliance
a. Health care providers outside your system	X		
b. Local or state public health organizations	X		
c. Local or state human/social service organizations	X		
d. Other local or state government	X		
e. Non-profit organizations	X		
f. Faith-based organizations	X		
g. Health insurance companies	X		
h. Schools	X		
i. Local businesses or chambers of commerce	X		
j. Other (list):	X		

	Answer
6. Does your hospital have an established patient and family advisory council that meets regularly to actively engage the perspectives of patients and families?	No
7. Does your hospital have a policy or guidelines that facilitate unrestricted access, 24 hours a day, to hospitalized patients	b. Exists across some units
8. Use this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	
9. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	Yes
	www.ottumwaregionalhealth.com
10. Please indicate below whether or not you agree to these types of disclosure:	I do not grant AHA permission to release my confidential data.
Your Name & Title	[redacted]
Your Email Address	
Your Phone Number	
Your Fax Number	

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
2017 Iowa Department of Public Health	Completed	05/03/2018	Philip J Noel

State Supplement

	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	None
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	n/a
Bed Type Numbers - Beds and Utilization by Inpatient Service	
a. General Medical/Surgical(adult, include gynecology)	
b. General Medical/Surgical (pediatric)	
c. Obstetrics	
d. Other Acute	
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	
f. Cardiac Intensive Care	
g. Neonatal Intensive Care (exclude normal newborn)	
h. Neonatal Intermediate Care	
i. Pediatric Intensive Care	
j. Burn Care	
k. Other Special Care (definitive observation, step down, etc.)	
l. Other Intensive Care	
m. Rehabilitation	
n. Chronic Disease	
o. Alzheimer's	
p. Hospice	
q. Psychiatric Care	
r. Alcoholism/Drug Abuse or Dependency Care	

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
s. Mental Retardation	
t. Skilled Nursing Care	
u. Intermediate Care	
v. Residential Care/Elderly Housing	
w. SubAcute Care	
x. Total Facility (Add lines a thru w.)	
a. Private	1471
b. Semi-Private	1471
c. OB	1402
d. Pediatric	1402
e. Substance Abuse Treatment	0
f. Detoxification	0
g. Rehabilitation	1217
h. Psychiatric	1679
i. Intensive Care Unit	2874
a. Amount of Charity	411010
b. Amount of Hill-Burton	0
c. Bad Debt	5589127
d. Total Non-Reimbursed	6000137
5. Data Release	
[redacted]	

AHA Annual Survey - 2017

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	65009895
b. Medicaid Contractual Adjustments	54851643
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	10158252
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	19502968
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	-9344716
a. Charity Care Charge-level (should equal D.5b)	411010
b. Charity Care Cost-level	123303
9. a. How many total Auxiliary members and Volunteers (both adult and teen) did you have in your hospital?	112
9. b. How many total hours of service did the auxilians and volunteers give to the hospital?	10029
9. c. Total funds contributed to the hospital by the auxiliary and volunteer department?	13850

Tuesday, May 7, 2019

AHA Annual Survey - 2018

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status
Submitted

Date Started	Date Last Edited	Date Submitted
APR-15-19	MAY-07-19	MAY-07-19

Survey Administrators
Philip Noel

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	05/03/2019	Philip J Noel

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	01/01/2018
	To (mm/dd/yyyy)	12/31/2018
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		365
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2019

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	05/03/2019	Philip J Noel

Section B: Question	Description	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. SELECT ONLY ONE:		33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:		10 General medical and surgical
	Other-specify treatment area:	
OTHER		
3a. Does your hospital restrict admissions primarily to children?		No
3b. Does the hospital itself operate subsidiary corporations?		No
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:		No
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
3d. Is your hospital owned in whole or in part by physicians or a physician group?		No
3e. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH		
If you are arranged in a general acute care hospital, what is your host hospital's name, city and state?		

Section B: Question	Description	Answer
3f. Are any other types of hospitals co-located in your hospital?		No

3g. What type of hospital is co-located? (Check all that apply)

1. Cancer ☐
2. Cardiac ☐
3. Orthopedic ☐
4. Pediactric ☐
5. Psychiatric ☐
6. Surgical ☐
7. Other ☐

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	05/03/2019	Philip J Noel

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
1. General medical - surgical care	[X] (#Beds: 39)	[ ]	[ ]	[ ]
2. Pediatric medical - surgical care	[X] (#Beds: 4)	[ ]	[ ]	[ ]
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	[X] (#Beds: 17) Level: 2	[ ]	[ ]	[ ]
4. Medical-surgical intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
5. Cardiac intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
6. Neonatal intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
7. Neonatal intermediate care	[X] (#Beds: 4)	[ ]	[ ]	[ ]
8. Pediatric intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
9. Burn care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	[ ] (#Beds: ____) (Specify: ____)	[ ]	[ ]	[X]
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	[X] (#Beds: 10) Desc: Med/Surg Cardiac Intensive Care	[ ]	[ ]	[ ]
12. Physical rehabilitation	[X] (#Beds: 13)	[ ]	[ ]	[ ]
13. Alcoholism-chemical dependency care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
14. Psychiatric care	[X] (#Beds: 14)	[ ]	[ ]	[ ]
15. Skilled nursing care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
16. Intermediate nursing care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
17. Acute long-term care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
18. Other long-term care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	[ ] (#Beds: ____) (Specify: ____)	[ ]	[ ]	[X]
20. Adult day care program	[ ]	[ ]	[ ]	[X]
21. Airborne infection isolation room (Please specify the number of rooms)	[X] # Rooms: 5	[ ]	[ ]	[ ]

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
22. Alcoholism-chemical dependency care Services				
22a. Alcoholism-chemical dependency pediatric services	☐ (#Beds: ____)	☐	☐	☒
22b. Alcoholism-chemical dependency outpatient services	☐	☐	☐	☒
22c. Alcoholism-chemical dependency partial hospitalization services	☐	☐	☐	☒
23. Alzheimer Center	☐	☐	☐	☒
24. Ambulance services	☒	☐	☐	☐
25. Air Ambulance services	☐	☐	☐	☒
26. Ambulatory surgery center	☐	☐	☐	☒
27. Arthritis treatment center	☐	☐	☐	☒
28. Auxiliary	☒	☐	☐	☐
29. Bariatric/weight control services	☐	☐	☐	☒
30. Birthing room - LDR room - LDRP room	☒	☐	☐	☐
31. Blood Donor Center	☐	☐	☒	☐
32. Breast cancer screening / mammograms	☒	☐	☐	☐
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services	☒	☐	☐	☐
33b. Pediatric cardiology services	☐	☐	☐	☒
33c. Adult diagnostic catheterization	☒	☐	☐	☐
33d. Pediatric diagnostic catheterization	☐	☐	☐	☒
33e. Adult interventional cardiac catheterization	☒	☐	☐	☐
33f. Pediatric interventional cardiac catheterization	☐	☐	☐	☒
33g. Adult cardiac surgery	☐	☐	☐	☒
33h. Pediatric cardiac surgery	☐	☐	☐	☒
33i. Adult cardiac electrophysiology	☒	☐	☐	☐
33j. Pediatric cardiac electrophysiology	☐	☐	☐	☒
33k. Cardiac rehabilitation	☒	☐	☐	☐
34. Case management	☒	☐	☐	☐
35. Chaplaincy/pastoral care services	☒	☐	☐	☐

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
36. Chemotherapy	☐	☐	☐	☒
37. Children's wellness program	☐	☐	☐	☒
38. Chiropractic services	☐	☐	☐	☒
39. Community outreach	☒	☐	☐	☐
40. Complementary and alternative medicine services	☐	☐	☐	☒
41. Computer assisted orthopedic surgery (CAOS)	☐	☐	☐	☒
42. Crisis prevention	☐	☐	☐	☒
43. Dental services	☐	☐	☐	☒
44. Diabetes prevention program	☐	☐	☐	☒
45. Emergency services: 45a. On-campus emergency department	☒	☐	☐	☐
45b. Off-campus emergency department	☐ (24 hours: ____)	☐	☐	☒
45c. Pediatric emergency department	☒	☐	☐	☐
45d. Trauma center (certified) [Level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	☒ 3	☐	☐	☐
46. Enabling services	☐	☐	☐	☒
47. Endoscopic services: 47a.Optical colonoscopy	☒	☐	☐	☐
47b. Endoscopic ultrasound	☒	☐	☐	☐
47c. Ablation of Barrett's esophagus	☒	☐	☐	☐
47d. Esophageal impedance study	☒	☐	☐	☐
47e. Endoscopic retrograde cholangiopancreatography (ERCP)	☐	☐	☐	☒
48. Enrollment (insurance) assistance services	☒	☐	☐	☐
49. Employment support services	☐	☐	☐	☒
50. Extracorporeal shock wave lithotripter (ESWL)	☒	☐	☐	☐
51. Fertility clinic	☐	☐	☐	☒
52. Fitness center	☒	☐	☐	☐
53. Freestanding outpatient care center	☒	☐	☐	☐
54. Geriatric services	☒	☐	☐	☐

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
55. Health fair	X			
56. Community health education	X			
57. Genetic testing/counseling				X
58. Health screenings	X			
59. Health research				X
60. Hemodialysis	X			
61. HIV - AIDS services				X
62. Home health services	X			
63. Hospice program			X	
64. Hospital - based outpatient care center - services	X			
65. Housing services: 65a. Assisted living				X
65b. Retirement housing				X
65c. Supportive housing services				X
66. Immunization program				X
67. Indigent care clinic				X
68. Linguistic/translation services			X	
69. Meal delivery services				X
70. Mobile health services				X
71. Neurological services				X
72. Nutrition programs	X			
73. Occupational health services	X			
74. Oncology services				X
75. Orthopedic services	X			
76. Outpatient surgery	X			
77. Pain management program	X			
78. Palliative care program				X
79. Palliative care inpatient unit				X
80. Patient Controlled Analgesia (PCA)	X			

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
81. Patient education center	☐	☐	☐	☒
82. Patient representative services	☒	☐	☐	☐
83. Physical rehabilitation services:				
83a. Assistive technology center	☐	☐	☐	☒
83b. Electrodiagnostic services	☐	☐	☐	☒
83c. Physical rehabilitation outpatient services	☒	☐	☐	☐
83d. Prosthetic and orthotic services	☐	☐	☐	☒
83e. Robot-assisted walking therapy	☐	☐	☐	☒
83f. Simulated rehabilitation environment	☒	☐	☐	☐
84. Primary care department	☐	☐	☐	☒
85. Psychiatric services: 85a.Psychiatric consultation - liaison services	☐	☐	☐	☒
85b. Psychiatric pediatric care	☐ (#Beds: ____)	☐	☐	☒
85c. Psychiatric geriatric services	☒ (#Beds: 14)	☐	☐	☐
85d. Psychiatric education services	☐	☐	☐	☒
85e. Psychiatric emergency services	☒	☐	☐	☐
85f. Psychiatric outpatient services	☐	☐	☐	☒
85g. Psychiatric intensive outpatient services	☐	☐	☐	☒
85h. Psychiatric partial hospitalization services - adult	☐	☐	☐	☒
85i. Psychiatric partial hospitalization services - pediatric	☐	☐	☐	☒
82j. Psychiatric residential treatment - adult	☐	☐	☐	☒
85k. Psychiatric residential treatment - pediatric	☐	☐	☐	☒
86. Radiology, diagnostic: 86a. CT scanner	☒	☐	☐	☐
86b. Diagnostic radioisotope facility	☒	☐	☐	☐
86c. Electron beam computed tomography (EBCT)	☐	☐	☐	☒
86d. Full-field digital mammography(FFDM)	☒	☐	☐	☐
86e. Magnetic resonance imaging (MRI)	☒	☐	☐	☐
86f. Intraoperative magnetic resonance imaging	☐	☐	☐	☒

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
86g. Magnetoencephalography (MEG)				X
86h. Multi-slice spiral computed tomography(<64 + slice CT)	X			
86i. Multi-slice spiral computed tomography (64+ slice)	X			
86j. Positron emission tomography (PET)	X			
86k. Positron emission tomography/CT (PET/ CT)	X			
86l. Single photon emission computerized tomography (SPECT)	X			
86m. Ultrasound	X			
87. Radiology therapeutic: 87a. Image-guided Radiation Therapy(IGRT)	X			
87b. Intensity-Modulated Radiation Therapy (IMRT)	X			
87c. Proton beam therapy				X
87d. Shaped Beam Radiation System	X			
87e. Stereotactic radiosurgery				X
88. Robotic surgery	X			
89. Rural health clinic				X
90. Sleep center	X			
91. Social work services	X			
92. Sports medicine	X			
93. Support groups	X			
94. Swing bed services				X
95. Teen outreach services				X
96. Tobacco treatment / cessation program	X			
97. Telehealth 97a. Consultation and office visits	X			
97b. eICU	X			
97c. Stroke care	X			
97d. Psychiatric and Addiction treatment	X			
97e. Remote patient monitoring: 1. Post-discharge.				X

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
2. Ongoing chronic care management	☐	☐	☐	☒
3. Other remote patient monitoring	☐	☐	☐	☒
97f. Other telehealth	☒	☐	☐	☐
98. Transplant services: 98a. Bone marrow	☐	☐	☐	☒
98b. Heart	☐	☐	☐	☒
98c. Kidney	☐	☐	☐	☒
98d. Liver	☐	☐	☐	☒
98e. Lung	☐	☐	☐	☒
98f. Tissue	☐	☐	☐	☒
98g. Other	☐	☐	☐	☒
99. Transportation to health facilities (non-emergency)	☐	☐	☐	☒
100. Urgent care center	☐	☐	☐	☒
101. Violence Prevention Programs: 101a. For the workplace	☐	☐	☐	☒
101b. For the community	☐	☐	☐	☒
102. Virtual Colonoscopy	☐	☐	☐	☒
103. Volunteer services department	☒	☐	☐	☐
104. Women's health center / services	☒	☐	☐	☐
105. Wound management services	☒	☐	☐	☐

Section C: Physician Arrangements	Answer	Answer (History)
106. Does your organization routinely integrate behavioral health services in the following care areas?		
a. Emergency Services	Yes	Yes
b. Primary Care Services	No	No
c. Acute inpatient care	Yes	Yes
d. Extended care	No	No

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

107a. For each of the physician-organization arrangements, please report the number of physicians and the approximate ownership share.

	Number of Physicians	Hospital ownership share %	Physician ownership share %	Parent corporation ownership share %	Insurance ownership share %
107a.1 Independent Practice Association (IPA)					
107a.2 Group practice without walls					
107a.3 Open Physician-Hospital Organization (PHO)					
107a.4 Closed Physician-Hospital Organization (PHO)					
107a.5 Management Service Organization (MSO)					
107a.6 Integrated Salary Model					
107a.7 Equity Model					
107a.8 Foundation					
107a.9 Other, please specify: 0					

107b. If the hospital owns physician practices, how are they organized?

	Percent %	Number of Physicians
107b.1 Solo practice		
107b.2 Single specialty group		
107b.3 Multi-specialty group		

	Answer	Answer (History)
107c. Of the physician practices owned by the hospital, what percentage are primary care?		
107d. Of the physician practices owned by the hospital, what percentage are specialty care?		
108. Looking across all the relationships identified in question 107a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payors or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be any type of ownership)?	0	20
109a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?	No	No
109b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that apply).		
109b. Other		
109c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that apply).		
109c. Other		
109d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	No	No

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Insurance and Alternative Payment Models	Completed	05/03/2019	Philip J Noel

Section D: Question	Answer
1. Does your hospital own or jointly own a health plan?	No
1a. In what states? (Select all that applies)	
2. Does your system own or jointly own a health plan?	No
2a. In what states? (Select all that applies)	
3. Does your hospital/system have a significant partnership with an insurer on an insurance company/health plan?	No
3a. In what states? (Select all that applies)	

4. If yes, to 1, 2 and/or 3, please indicate the insurance products and the total medical enrollment (check all that apply)

4. Insurance

Insurance Product	Hospital	System	JV	Medical Enrollment	New Product	No	Do Not Know
a. Medicare Advantage	☐	☐	☐		☐	☐	☐
b. Medicaid Managed Care	☐	☐	☐		☐	☐	☐
c. Health Insurance Marketplace ("exchange")	☐	☐	☐		☐	☐	☐
d. Other Individual Market	☐	☐	☐		☐	☐	☐
e. Small Group	☐	☐	☐		☐	☐	☐
f. Large Group	☐	☐	☐		☐	☐	☐
g. Other	☐	☐	☐		☐	☐	☐

	Answer
If yes, to 4.g. Other Please specify:	

5. Does your health plan make capitated payments to physicians either within or outside of your network for specific groups or enrollees?

	Answer
a. Physicians within your network	No
b. Physicians outside your network	No

Ottumwa Regional Health Center (6621105)

6. Does your health plan make bundled payments to providers in your network or to outside providers?

	Answer
a. Providers within your network	No
b. Providers outside your network	No

7. Does your health plan offer shared risk contracts either to providers in your network or to outside providers? (i.e., other than capitation or bundled payment)

	Answer
a. Providers within your network	No
b. Providers outside your network	No

	Answer
8. Does your hospital or system offer a self-administered health plan for your employees?	No

	Answer
9. What percentage of the hospital's net patient revenue is paid on a capitated basis?	0
9a. In total, how many enrollees do you serve under capitated contracts?	
10. Does your hospital participate in any bundled payment arrangements?	No

10a. If yes, with which of the following types of payers does your hospital have a bundled payment arrangement? (Select all that apply)

- ☐ 1. Traditional Medicare
- ☐ 2. A Medicare Advantage plan
- ☐ 3. A commercial insurance plan including ACA participants, individual, group or employer markets
- ☐ 4. Medicaid

10b. For which of the following medical/surgical conditions does your hospital have a bundled payment arrangement? (Select all that apply)

- ☐ 1. Cardiovascular
- ☐ 2. Orthopedic
- ☐ 3. Oncologic
- ☐ 4. Neurology
- ☐ 5. Hematology
- ☐ 6. Gastrointestinal
- ☐ 7. Pulmonary
- ☐ 8. Infectious disease
- ☐ 9. Other (please specify

	Answer
10c. what percentage of the hospital's patient revenue is paid through bundled payment arrangements	
11. Does your hospital participate in a bundled payment program involving care settings outside of the hospital (e.g. physician, outpatient, post acute)?	No

Ottumwa Regional Health Center (6621105)

	Answer
11a. If yes, does your hospital share upside or downside risk with any of those outside providers?	
12. What percentage of your hospital's patient revenue is paid on a shared risk basis (other than capitated or bundled payment)?	0
13. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
14. Does your hospital have contracts with commercial payers where payment is tied to performance on quality/safety metrics?	No

	Answer
15a. Has your hospital or health care system established an accountable care organization (ACO)?	4. My hospital/system has never participated or led an ACO
15b. With which of the following types of payers does your hospital/system have an accountable care contract? (Select all that apply)	

15c. If you selected Traditional Medicare, in which of the following Medicare programs is your hospital/system participating? (Select all that apply)

- ☐ 1. MSSP Track 1
- ☐ 2. MSSP Track 2
- ☐ 3. MSSP Track 3
- ☐ 4. MSSP Track 1+
- ☐ 5. NextGen
- ☐ 6. Comprehensive ESRD Care

	Answer
15d. What percentage of your hospital's/system patients are covered by accountable care contracts?	
15e. What percentage of your hospital's/system patient revenue came from ACO contracts in 2018?	
16a. In what year did your hospital's/system last ACO contract end?	

16b. Which of the following types of payers did your hospital's/system have an accountable care contract with? (Select all that apply)

- 1. Traditional Medicare (MSSP and NextGen) ☐
- 2. A Medicare Advantage plan ☐
- 3. A commercial insurance plan (including ACA participants, individual, group, and employer markets) ☐
- 4. Medicaid ☐

16c. In which of the following Medicare programs did your hospital's/system participate? (Select all that apply)

- 1. MSSP Track 1 ☐
- 2. MSSP Track 2 ☐
- 3. MSSP Track 3 ☐
- 4. MSSP Track 1+ ☐
- 5. NextGen ☐
- 6. Pioneer ☐

16c. In which of the following Medicare programs did your hospital's/system participate? (Select all that apply)

7. Comprehensive ESRD Care ☐

	Answer
16d. How many commercial accountable care contracts has your hospital's/system previously been a part of?	
17. Has your hospital's/system ever considered participating in an ACO?	b. Yes, but we are not planning to join one

18. Do any hospitals and/or physician groups within your system or the system itself, plan to participate in any of the following risk arrangements in the next three years? (Check all that apply)

a. Shared Savings/Losses ☐

b. Bundled payment ☐

c. Capitation ☐

d. ACO (Ownership) ☐

e. ACO (Joint Venture) ☐

f. Health Plan (Ownership) ☐

g. Health Plan (Joint Venture) ☐

h. Other, please specify ☐

i. None ☐

19. Does your hospital/system have an established medical home program?

	Answer
a. Hospital	No
b. System	

20. Has your hospital/system established a clinically integrated network?

	Answer
a. Hospital	No
b. System	

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	05/03/2019	Philip J Noel

Section E: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	101	101		
c. Bassinets set up and staffed for use at the end of the reporting period	10	10		
d. Births (exclude fetal deaths)	418	451		
e. Admissions (exclude newborns, include neonatal & swing admissions)	3,098	3,312		
f. Inpatient days (exclude newborns, include neonatal & swing days)	15,162	15,840		
g. Emergency department visits	19,469	19,920		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	134,655	143,949		
i. Inpatient surgical operations	841	987		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	5,363	5,052		

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days &				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	1,665	1,683		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care?	340	280		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	9,366	9,327		
b. 2. How many Medicare inpatient days were Medicare Managed Care?	1,698	1,313		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	1,061	1,104		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care?	893	969		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	4,117	4,441		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care?	3,419	3,796		

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	78,248,884	77,338,493		
*b. Tax appropriations	0	0		
*c. Other operating revenue	306,451	402,065		
*d. Nonoperating revenue	0	3,698		
*e. TOTAL REVENUE (add 3a thru 3d)	78,555,335	77,744,256		
f. Payroll expenses (only)	22,596,529	23,316,566		
g. Employee benefits	6,562,076	6,322,052		
h. Depreciation expense (for reporting period only)	4,528,743	4,668,514		
i. Interest expense	160,247	5,731,896		
j. Pharmacy Expense	3,282,026	3,296,671		
k. Supply expense (other than pharmacy)	7,602,280	7,049,050		
l. All other expenses	29,484,223	27,787,867		
m. TOTAL EXPENSES (Add 3f thru 3l. Exclude bad debt)	74,216,124	78,172,616		
Standalone Question 7				
n. Do your total expenses (E3.m) reflect full allocation from your corporate office?	Yes			
*4. Revenue By type				
a. Total gross inpatient revenue	92,869,459	90,050,201		
b. Total gross outpatient revenue	210,600,723	200,461,188		
c. Total gross patient revenue	303,470,182	290,511,389		
*5. Uncompensated Care & Provider Taxes				
a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	6,061,298	5,589,127		
b. Financial Assistance (includes Charity) (Revenue forgone at full established rates. Include in gross revenue)	801,317	411,010		
c. Is your bad debt (5a.) reported on the basis of full charges?	Yes	Yes		
d. Does your state have a provider Medicaid tax/assessment program?	Yes	Yes		

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
e. If yes, please report the total gross amount paid into the program	496,467	496,467		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Total Expenses.....	Yes	Yes		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Deductions from net Patient Revenue.....	No	No		

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	150,772,925	141,045,502	34,030,475	32,070,087
6a1b. Managed care revenue	0	0	0	0
6a1c. Total (a + b)	150,772,925	141,045,502	34,030,475	32,070,087
Medicaid				
6a2. Medicaid:				
6a2a. Fee for service patient revenue	6,949,775	9,441,879	1,076,663	1,475,360
6a2b. Managed care revenue	56,615,258	55,568,017	8,710,163	8,682,892
6a2c. Medicaid Graduate Medical Education (GME) payments			0	0
6a2d. Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2e. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments)			0	0
6a2f. Other Medicaid			0	0
6a2g. Total (a+b+c+d+e+f)	63,565,033	65,009,896	9,786,826	10,158,252
6a3. Other Government:	0	0	0	0
6b1. Self-pay	6,791,959	5,237,964	83,190	472,189
6b2a. Managed care (includes HMO and PPO)	12,150,447	12,072,898	2,742,438	5,086,193
6b2b. Other third - party payers	70,189,818	67,145,129	31,605,955	29,551,772
6b2c. Total Third - party payers (a+b)	82,340,265	79,218,027	34,348,393	34,637,965
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	303,470,182	290,511,389	78,248,884	77,338,493

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Inpatient	Inpatient (History)	Outpatient	Outpatient (History)
If you reported receiving Medicaid Supplemental Payments on line 6.a(2)e, please break the payment total into inpatient and outpatient care.				
Medicaid supplemental payments				

	Answer	Answer (History)
*6e. If you are a government owned facility, does your facility participate in the Medicaid intergovernmental transfer or certified public expenditure program.	No	No

*6f. If yes, please report gross and net revenue.	Gross	Net

	Answer	Answer (History)
*6g. Are the financial data reported from your audited financial statement?	Yes	Yes
6h. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

	Answer	Answer (History)
*7. FINANCIAL PERFORMANCE - MARGIN		
</br>*a. </br>Total Margin	9	
*b. Operating Margin	9	
*c. EBITDA Margin	15	
*d. Medicare Margin	-8	
*e. Medicaid Margin	-58	
8. Fixed Assets		
8a. Property, plant and equipment at cost	62,028,060	60,531,414
8b. Accumulated depreciation	13,997,090	9,518,808
8c. Net property, plant and equipment (a - b)	48,030,970	51,012,606
8d. Total gross square feet of your physical plant used for or in support of your healthcare activities	202,105	202,105
9. Total Capital Expenses		
Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.	1,920,101	2,665,604
10. INFORMATION TECHNOLOGY AND CYBERSECURITY		
a. IT Operating Expense	2,028,405	2,015,949
b. IT Capital Expense.	429,319	1,105,662

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
c. Number of Employed IT staff (in FTEs).	6	8
d. Number of outsourced IT staff (in FTEs).	0	0
*e. What percentage of your IT budget is spent on security?		
f. Which of the following cybersecurity measures does your hospital or health system currently deploy?*	a. Annual risk assessment, c. Intrusion detection systems, d. Mobile device encryption, e. Mobile device data wiping, g. Strong password requirements	a. Annual risk assessment, b. Incident response plan, c. Intrusion detection systems, d. Mobile device encryption, e. Mobile device data wiping, g. Strong password requirements
CYBERSECURITY		
g. Does your hospital or health system board oversight of risk management and reduction specifically include consideration of cybersecurity risk?*	Unsure	Unsure
h. Does your hospital or health system have cybersecurity insurance?*	Unsure	
i. Is your hospital or health system participating in cybersecurity information-sharing activities with an outside information Sharing and Analysis Organization to identify threats and vulnerabilities?*	Unsure	
*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.		
*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.		

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section E: 11. Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	0	0	0	0	0	0	0
b. Dentists	0	0	0	0	0	0	0
c. Medical and dental residents/interns	0	0	0	0	0	0	0
d. Other trainees	0	0	0	0	0	0	0
e. Registered nurses	132	146	82	53	142	35	24
f. Licensed practical (vocational) nurses	13	5	5	4	11.88	2	3
g. Nursing assistive personnel	23	26	18	17	25.4	7	8
h. Radiology technicians	5	5	5	3	6.24	1	3
i. Laboratory technicians	8	11	6	4	8.86	1	3
j. Pharmacists, licensed	4	3	0	1	3.04	0	0
k. Pharmacy technicians	4	4	1	0	3.87	1	2
l. Respiratory therapists	8	6	2	3	7.89	1	0
m. All other personnel	225	219	102	77	238.14	19	21
n. Total facility personnel (add 11.a through 11.m)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 11.o and 11.p)	422	425	221	162	447.32	67	64
o. Nursing home type unit/facility Registered Nurses	0	0	0	0	0	0	0
p. Nursing home type unit/facility personnel	0	0	0	0	0	0	0

	Answer	Answer (History)
q. For your employed RNs reported above (E.11.e, column 3), please report the number of full time equivalents who are involved in direct	123.93	114

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section E: 12. Privileged Physicians	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general	0	0	7	10	17
b. Emergency medicine	0	0	8	0	8
c. Hospitalist	0	0	14	0	14
d. Intensivist	0	0	33	0	33
e. Radiologist/pathologist/anesthesiologist	0	0	40	3	43
f. Other specialist	0	0	75	21	96
g. Total (add 12a-12f)	0	0	177	34	211

13. HOSPITALISTS

	Answer	Answer (History)
13a. Do hospitalists provide care for patients in your hospital? (if yes, please report in E.12c.)	Yes	Yes
13b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	5	6

14. INTENSIVISTS

	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 15.) (if yes, please report in E.12d.)	Yes	Yes

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care			4	
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total			4	

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

15. ADVANCED PRACTICE REGISTERED NURSES / PHYSICIAN ASSISTANTS

	Answer	Answer (History)
a. Do advanced practice nurses/physician assistants provide care for patients in your hospital?(if no, please skip to 16.)	Yes	Yes
Advanced Practice Registered Nurses Full-time	3	5
Advanced Practice Registered Nurses Part-time	17	12
Advanced Practice Registered Nurses FTE	3	5
Physician Assistants Full-time	2	2
Physician Assistants Part-time	2	5
Physician Assistants FTE	2	2
c. If yes, please indicate the type of service provided. (Please check all that apply)	Anesthesia services, Emergency department care, Other specialty care, Other	Anesthesia services, Emergency department care, Other specialty care, Other

16. FOREIGN EDUCATED NURSES

a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2018 vs. 2017?	Same	Did not hire foreign nurses
b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)		

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	05/03/2019	Philip J Noel

Section F: Supplemental Information

	Answer
1. Does your hospital provide services through satellite outpatient departments?	Yes

1b. Please indicate the clinical families of outpatient services offered along with the number of hospital outpatient sites by location.

Facilities	Check all that apply	Number of On-Campus Sites	Number of Off-Campus Sites
Airway endoscopy			
Ambulatory surgery	X	1	
Blood product exchange	X	1	
Cardiac/pulmonary rehabilitation	X	1	
Diagnostic/screening test and related procedures	X	1	
Drug administration and clinical oncology	X	1	
Ear, nose throat (ENT)	X	1	
General surgery and related procedures	X	1	
Gastrointestinal (GI)	X	1	
Gynecology	X	1	
Laboratory	X	1	
Major imaging	X	1	
Minor imaging	X	1	
Musculoskeletal surgery	X	1	
Nervous system procedures	X	1	
Ophthalmology	X	1	
Pathology	X	1	
Primary care	X	1	3
Psychiatric care	X	1	
Radiation oncology	X	1	
Rehabilitation	X	1	
Skilled nursing			

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

1b. Please indicate the clinical families of outpatient services offered along with the number of hospital outpatient sites by location.

Facilities	Check all that apply	Number of On-Campus Sites	Number of Off-Campus Sites
Substance abuse/chemical dependency			
Urgent care			
Urology	X	1	
Vascular/endovascular/cardiovascular	X	1	
Visits and related services			
Other, please specify: Wound Care	X	1	2

	Answer
2. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	Yes
	HealthTrust
	Brentwood
	TN
3. Does the hospital purchase medical/surgical supplies directly through a distributor?	Yes
If yes, please provide the name(s) of the distributor.	Cardinal Health
If yes, please provide the name(s) of the distributor.	Medline
If yes, please provide the name(s) of the distributor.	Owens & Minor
4. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	1

5. Describe the extent of your hospital's current partnerships with the following types of organizations for community or population health improvement initiatives.	Not Involved	Collaboration	Formal Alliance
a. Health care providers outside your system		X	
b. Local or state public health organizations		X	
c. Local or state human/social service organizations		X	
d. Other local or state government		X	
e. Non-profit organizations		X	
f. Faith-based organizations		X	

g. Health insurance companies		X	
h. Schools		X	
i. Local businesses or chambers of commerce		X	
j. National businesses	X		
k. Other (list):	X		

	Answer
6. Does your hospital have an established patient and family advisory council that meets regularly to actively engage the perspectives of patients and families?	No
7. Does your hospital have a policy or guidelines that facilitate unrestricted access, 24 hours a day, to hospitalized patients	b. Exists across some units
8. Use this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	
9. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	Yes
	www.ottumwaregionalhealth.com
10. Please indicate below whether or not you agree to these types of disclosure:	I do not grant AHA permission to release my confidential data.
Your Name & Title	[redacted]
Your Email Address	
Your Phone Number	
Your Fax Number	

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
2018 Iowa Department of Public Health	Completed	05/03/2019	Philip J Noel

State Supplement

	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	None
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	n/a
Bed Type Numbers - Beds and Utilization by Inpatient Service	
a. General Medical/Surgical(adult, include gynecology)	39
b. General Medical/Surgical (pediatric)	4
c. Obstetrics	17
d. Other Acute	0
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	0
f. Cardiac Intensive Care	0
g. Neonatal Intensive Care (exclude normal newborn)	0
h. Neonatal Intermediate Care	4
i. Pediatric Intensive Care	0
j. Burn Care	0
k. Other Special Care (definitive observation, step down, etc.)	0
l. Other Intensive Care	10
m. Rehabilitation	13
n. Chronic Disease	0
o. Alzheimer's	0
p. Hospice	0
q. Psychiatric Care	14
r. Alcoholism/Drug Abuse or Dependency Care	0

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
s. Mental Retardation	0
t. Skilled Nursing Care	0
u. Intermediate Care	0
v. Residential Care/Elderly Housing	0
w. SubAcute Care	0
x. Total Facility (Add lines a thru w.)	101
a. Private	1530
b. Semi-Private	1530
c. OB	1458
d. Pediatric	1458
e. Substance Abuse Treatment	0
f. Detoxification	0
g. Rehabilitation	1266
h. Psychiatric	1746
i. Intensive Care Unit	2989
a. Amount of Charity	801317
b. Amount of Hill-Burton	0
c. Bad Debt	6061298
d. Total Non-Reimbursed	6862615
5. Data Release	Yes
[redacted]	

AHA Annual Survey - 2018

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	63565033
b. Medicaid Contractual Adjustments	53609380
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	9955653
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	15729931
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	-5774279
a. Charity Care Charge-level (should equal E.5b)	801317
b. Charity Care Cost-level	200329
9. a. How many total Auxiliary members and Volunteers (both adult and teen) did you have in your hospital?	70
9. b. How many total hours of service did the auxilians and volunteers give to the hospital?	8427
9. c. Total funds contributed to the hospital by the auxiliary and volunteer department?	15964

Monday, July 27, 2020

AHA Annual Survey - 2019

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status
Submitted

Date Started	Date Last Edited	Date Submitted
APR-20-20	JUL-27-20	JUL-27-20

Survey Administrators
Philip Noel

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	07/27/2020	Philip J Noel

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	01/01/2019
	To (mm/dd/yyyy)	12/31/2019
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		365
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2020

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	07/27/2020	Philip J Noel

Section B: Question	Description	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. SELECT ONLY ONE:		33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:		10 General medical and surgical
	Other-specify treatment area:	
OTHER		
3a. Does your hospital restrict admissions primarily to children?		No
3b. Does the hospital itself operate subsidiary corporations?		No
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:		No
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
	Name	
	City	
	State	
3d. Is your hospital owned in whole or in part by physicians or a physician group?		No
3e. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH		
If you are arranged in a general acute care hospital, what is your host hospital's name, city and state?		

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section B: Question	Description	Answer
3f. Are any other types of hospitals co-located in your hospital?		No
3g. What type of hospital is co-located? (Check all that apply)		
3g. What type of hospital is co-located? (Check all that apply)		

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	07/27/2020	Philip J Noel

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
1. General medical - surgical care	X (#Beds: 24)			
2. Pediatric medical - surgical care	X (#Beds: 4)			
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	X (#Beds: 17) Level: 2			
4. Medical-surgical intensive care	(#Beds: ____)			X
5. Cardiac intensive care	(#Beds: ____)			X
6. Neonatal intensive care	(#Beds: ____)			X
7. Neonatal intermediate care	X (#Beds: 4)			
8. Pediatric intensive care	(#Beds: ____)			X
9. Burn care	(#Beds: ____)			X
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	(#Beds: ____) (Specify: ____)			X
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	X (#Beds: 10) Desc: Med/Surg Cardiac Intensive Care			
12. Physical rehabilitation	X (#Beds: 13)			
13. Alcoholism-chemical dependency care	(#Beds: ____)			X
14. Psychiatric care	X (#Beds: 14)			
15. Skilled nursing care	(#Beds: ____)			X
16. Intermediate nursing care	(#Beds: ____)			X
17. Acute long-term care	(#Beds: ____)			X
18. Other long-term care	(#Beds: ____)			X
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	(#Beds: ____) (Specify: ____)			X
20. Adult day care program				X
21. Airborne infection isolation room (Please specify the number of rooms)	X # Rooms: 5			

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
22. Alcoholism-chemical dependency care Services				
22a. Alcoholism-chemical dependency pediatric services	☐ (#Beds: ____)	☐	☐	☒
22b. Alcoholism-chemical dependency outpatient services	☐	☐	☐	☒
22c. Alcoholism-chemical dependency partial hospitalization services	☐	☐	☐	☒
23. Alzheimer Center	☐	☐	☐	☒
24. Ambulance services	☒	☐	☐	☐
25. Air Ambulance services	☐	☐	☐	☒
26. Ambulatory surgery center	☐	☐	☐	☒
27. Arthritis treatment center	☐	☐	☐	☒
28. Auxiliary	☒	☐	☐	☐
29. Bariatric/weight control services	☐	☐	☐	☒
30. Birthing room - LDR room - LDRP room	☒	☐	☐	☐
31. Blood Donor Center	☐	☐	☒	☐
32. Breast cancer screening / mammograms	☒	☐	☐	☐
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services	☒	☐	☐	☐
33b. Pediatric cardiology services	☐	☐	☐	☒
33c. Adult diagnostic catheterization	☒	☐	☐	☐
33d. Pediatric diagnostic catheterization	☐	☐	☐	☒
33e. Adult interventional cardiac catheterization	☒	☐	☐	☐
33f. Pediatric interventional cardiac catheterization	☐	☐	☐	☒
33g. Adult cardiac surgery	☐	☐	☐	☒
33h. Pediatric cardiac surgery	☐	☐	☐	☒
33i. Adult cardiac electrophysiology	☒	☐	☐	☐
33j. Pediatric cardiac electrophysiology	☐	☐	☐	☒
33k. Cardiac rehabilitation	☒	☐	☐	☐
34. Case management	☒	☐	☐	☐
35. Chaplaincy/pastoral care services	☒	☐	☐	☐

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
36. Chemotherapy	☐	☐	☐	☒
37. Children's wellness program	☐	☐	☐	☒
38. Chiropractic services	☐	☐	☐	☒
39. Community outreach	☒	☐	☐	☐
40. Complementary and alternative medicine services	☐	☐	☐	☒
41. Computer assisted orthopedic surgery (CAOS)	☐	☐	☐	☒
42. Crisis prevention	☐	☐	☐	☒
43. Dental services	☐	☐	☐	☒
44. Diabetes prevention program	☐	☐	☐	☒
45. Emergency services: 45a. On-campus emergency department	☒	☐	☐	☐
45b. Off-campus emergency department	☐ (24 hours: ____)	☐	☐	☒
45c. Pediatric emergency department	☒	☐	☐	☐
45d. Trauma center (certified) [Level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	☒ 3	☐	☐	☐
46. Enabling services	☐	☐	☐	☒
47. Endoscopic services: 47a.Optical colonoscopy	☒	☐	☐	☐
47b. Endoscopic ultrasound	☒	☐	☐	☐
47c. Ablation of Barrett's esophagus	☒	☐	☐	☐
47d. Esophageal impedance study	☒	☐	☐	☐
47e. Endoscopic retrograde cholangiopancreatography (ERCP)	☐	☐	☐	☒
48. Enrollment (insurance) assistance services	☒	☐	☐	☐
49. Employment support services	☐	☐	☐	☒
50. Extracorporeal shock wave lithotripter (ESWL)	☒	☐	☐	☐
51. Fertility clinic	☐	☐	☐	☒
52. Fitness center	☒	☐	☐	☐
53. Freestanding outpatient care center	☒	☐	☐	☐
54. Geriatric services	☒	☐	☐	☐

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
55. Health fair	X			
56. Community health education	X			
57. Genetic testing/counseling				X
58. Health screenings	X			
59. Health research				X
60. Hemodialysis	X			
61. HIV - AIDS services				X
62. Home health services				X
63. Hospice program			X	
64. Hospital - based outpatient care center - services	X			
65. Housing services: 65a. Assisted living				X
65b. Retirement housing				X
65c. Supportive housing services				X
66. Immunization program				X
67. Indigent care clinic				X
68. Linguistic/translation services			X	
69. Meal delivery services				X
70. Mobile health services				X
71. Neurological services				X
72. Nutrition programs	X			
73. Occupational health services	X			
74. Oncology services				X
75. Orthopedic services	X			
76. Outpatient surgery	X			
77. Pain management program	X			
78. Palliative care program				X
79. Palliative care inpatient unit				X
80. Patient Controlled Analgesia (PCA)	X			

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
81. Patient education center	☐	☐	☐	☒
82. Patient representative services	☒	☐	☐	☐
83. Physical rehabilitation services:				
83a. Assistive technology center	☐	☐	☐	☒
83b. Electrodiagnostic services	☐	☐	☐	☒
83c. Physical rehabilitation outpatient services	☒	☐	☐	☐
83d. Prosthetic and orthotic services	☐	☐	☐	☒
83e. Robot-assisted walking therapy	☐	☐	☐	☒
83f. Simulated rehabilitation environment	☒	☐	☐	☐
84. Primary care department	☐	☐	☐	☒
85. Psychiatric services: 85a.Psychiatric consultation - liaison services	☐	☐	☐	☒
85b. Psychiatric pediatric care	☐ (#Beds: ____)	☐	☐	☒
85c. Psychiatric geriatric services	☒ (#Beds: 14)	☐	☐	☐
85d. Psychiatric education services	☐	☐	☐	☒
85e. Psychiatric emergency services	☒	☐	☐	☐
85f. Psychiatric outpatient services	☐	☐	☐	☒
85g. Psychiatric intensive outpatient services	☐	☐	☐	☒
85h. Psychiatric partial hospitalization services - adult	☐	☐	☐	☒
85i. Psychiatric partial hospitalization services - pediatric	☐	☐	☐	☒
82j. Psychiatric residential treatment - adult	☐	☐	☐	☒
85k. Psychiatric residential treatment - pediatric	☐	☐	☐	☒
86. Radiology, diagnostic: 86a. CT scanner	☒	☐	☐	☐
86b. Diagnostic radioisotope facility	☒	☐	☐	☐
86c. Electron beam computed tomography (EBCT)	☐	☐	☐	☒
86d. Full-field digital mammography(FFDM)	☒	☐	☐	☐
86e. Magnetic resonance imaging (MRI)	☒	☐	☐	☐
86f. Intraoperative magnetic resonance imaging	☐	☐	☐	☒

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
86g. Magnetoencephalography (MEG)	☐	☐	☐	☒
86h. Multi-slice spiral computed tomography(<64 + slice CT)	☒	☐	☐	☐
86i. Multi-slice spiral computed tomography (64+ slice CT)	☒	☐	☐	☐
86j. Positron emission tomography (PET)	☒	☐	☐	☐
86k. Positron emission tomography/CT (PET/ CT)	☒	☐	☐	☐
86l. Single photon emission computerized tomography (SPECT)	☒	☐	☐	☐
86m. Ultrasound	☒	☐	☐	☐
87. Radiology therapeutic: 87a. Image-guided Radiation Therapy(IGRT)	☒	☐	☐	☐
87b. Intensity-Modulated Radiation Therapy (IMRT)	☒	☐	☐	☐
87c. Proton beam therapy	☐	☐	☐	☒
87d. Shaped Beam Radiation System	☒	☐	☐	☐
87e. Stereotactic radiosurgery	☐	☐	☐	☒
88. Robotic surgery	☒	☐	☐	☐
89. Rural health clinic	☐	☐	☐	☒
90. Sleep center	☒	☐	☐	☐
91. Social work services	☒	☐	☐	☐
92. Sports medicine	☒	☐	☐	☐
93. Support groups	☒	☐	☐	☐
94. Swing bed services	☐	☐	☐	☒
95. Teen outreach services	☐	☐	☐	☒
96. Tobacco treatment / cessation program	☒	☐	☐	☐
97. Telehealth 97a. Consultation and office visits	☐	☐	☐	☒
97b. eICU	☒	☐	☐	☐
97c. Stroke care	☒	☐	☐	☐
97d. Psychiatric and addiction treatment	☒	☐	☐	☐
97e. Remote patient monitoring: 1. Post-discharge.	☐	☐	☐	☒

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
2. Ongoing chronic care management	☐	☐	☐	☒
3. Other remote patient monitoring	☐	☐	☐	☒
97f. Other telehealth	☐	☐	☐	☒
98. Transplant services: 98a. Bone marrow	☐	☐	☐	☒
98b. Heart	☐	☐	☐	☒
98c. Kidney	☐	☐	☐	☒
98d. Liver	☐	☐	☐	☒
98e. Lung	☐	☐	☐	☒
98f. Tissue	☐	☐	☐	☒
98g. Other	☐	☐	☐	☒
99. Transportation to health facilities (non-emergency)	☐	☐	☐	☒
100. Urgent care center	☐	☐	☐	☒
101. Violence Prevention Programs: 101a. For the workplace	☐	☐	☐	☒
101b. For the community	☐	☐	☐	☒
102. Virtual Colonoscopy	☐	☐	☐	☒
103. Volunteer services department	☒	☐	☐	☐
104. Women's health center / services	☒	☐	☐	☐
105. Wound management services	☒	☐	☐	☐

Section C: Physician Arrangements	Answer	Answer (History)
106. Does your organization routinely integrate behavioral health services in the following care areas?		
a. Emergency Services	Yes	Yes
b. Primary Care Services	No	No
c. Acute inpatient care	Yes	Yes
d. Extended care	No	No

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

107a. For each of the physician-organization arrangements, please report the number of involved physicians in these arrangements.

	Number of Physicians	My Hospital	My Health System	Do Not Provide
1. Independent Practice Association				X
2. Group practice without walls				X
3. Open Physician - Hospital Organization (PHO)				X
4. Closed Physician - Hospital Organization (PHO)				X
5. Management Service Organization (MSO)				X
6. Integrated Salary Model				X
7. Equity Model				X
8. Foundation				X
9. Other, please specify:				

107b. For those arrangements reported in 107a., please report the approximate ownership share.

	Hospital ownership share %	Physician ownership share %	Parent corporation ownership share %	Insurance ownership share %
1. Independent Practice Association (IPA)				
2. Group practice without walls				
3. Open Physician-Hospital Organization (PHO)				
4. Closed Physician-Hospital Organization (PHO)				
5. Management Service Organization (MSO)				
6. Integrated Salary Model				
7. Equity Model				
8. Foundation				
9. Other, please specify				

107c. If the hospital owns physician practices, how are they organized?

	Percent %	Number of Physicians
107.1 Solo practice		
107.2 Single specialty group		
107.3 Multi-specialty group		

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
107d. Of the physician practices owned by the hospital, what percentage are primary care?		
107e. Of the physician practices owned by the hospital, what percentage are specialty care?		
108. Looking across all the relationships identified in question 107a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payors or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be any type of ownership)?	0	0
109a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?	No	No
109b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that apply).		
109b. Other		
109c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that apply).		
109c. Other		
109d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	No	No

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Insurance and Alternative Payment Models	Completed	07/27/2020	Philip J Noel

Section D: Question	Answer
1. Does your hospital own or jointly own a health plan?	No
1a. In what states? (Select all that applies)	
2. Does your system own or jointly own a health plan?	No
2a. In what states? (Select all that applies)	
3. Does your hospital/system have a significant partnership with an insurer on an insurance company/health plan?	No
3a. In what states? (Select all that applies)	

4. If yes, to 1, 2 and/or 3, please indicate the insurance products and the total medical enrollment (check all that apply)

4. Insurance

Insurance Product	Hospital	System	JV	Medical Enrollment	New Product	No	Do Not Know
a. Medicare Advantage	☐	☐	☐		☐	☐	☐
b. Medicaid Managed Care	☐	☐	☐		☐	☐	☐
c. Health Insurance Marketplace ("exchange")	☐	☐	☐		☐	☐	☐
d. Other Individual Market	☐	☐	☐		☐	☐	☐
e. Small Group	☐	☐	☐		☐	☐	☐
f. Large Group	☐	☐	☐		☐	☐	☐
g. Other	☐	☐	☐		☐	☐	☐

	Answer
If yes, to 4.g. Other Please specify:	

5. Does your health plan make capitated payments to physicians either within or outside of your network for specific groups or enrollees?

	Answer
a. Physicians within your network	No
b. Physicians outside your network	No

Ottumwa Regional Health Center (6621105)

6. Does your health plan make bundled payments to providers in your network or to outside providers?

	Answer
a. Providers within your network	No
b. Providers outside your network	No

7. Does your health plan offer shared risk contracts either to providers in your network or to outside providers? (i.e., other than capitation or bundled payment)

	Answer
a. Providers within your network	No
b. Providers outside your network	No

	Answer
8. Does your hospital or system offer a self-administered health plan for your employees?	No

	Answer
9. What percentage of the hospital's net patient revenue is paid on a capitated basis?	0
9a. In total, how many enrollees do you serve under capitated contracts?	
10. Does your hospital participate in any bundled payment arrangement?	No

10a. If yes, with which of the following types of payers does your hospital have a bundled payment arrangement? (Select all that apply)

1. Traditional Medicare ☐
2. A Medicare Advantage plan ☐
3. A commercial insurance plan including ACA participants, individual, group or employer markets ☐
4. Medicaid ☐

	Answer
10b. For which of the following medical/surgical conditions does your hospital have a bundled payment arrangement? (Select all that apply)	
Other (please specify)	
10c. what percentage of the hospital's patient revenue is paid through bundled payment arrangements	
11. Does your hospital participate in a bundled payment program involving care settings outside of the hospital (e.g. physician, outpatient, post acute)?	No
11a. If yes, does your hospital share upside or downside risk with any of those outside providers?	

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

	Answer
12. What percentage of your hospital's patient revenue is paid on a shared risk basis (other than capitated or bundled payment)?	0
13. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
14. Does your hospital have contracts with commercial payers where payment is tied to performance on quality/safety metrics?	No

	Answer
15a. Has your hospital or health care system established an accountable care organization (ACO)?	4. My hospital/system has never participated or led an ACO
15b. With which of the following types of payers does your hospital/system have an accountable care contract? (Select all that apply)	

15c. If you selected Traditional Medicare, in which of the following Medicare programs is your hospital/system participating? (Select all that apply)

- ☐ 1. MSSP Track 1
- ☐ 2. MSSP Track 2
- ☐ 3. MSSP Track 3
- ☐ 4. MSSP Track 1+
- ☐ 5. NextGen
- ☐ 6. Comprehensive ESRD Care

	Answer
15d. What percentage of your hospital's/system patients are covered by accountable care contracts?	
15e. What percentage of your hospital's/system patient revenue came from ACO contracts in 2019?	
16a. In what year did your hospital's/system last ACO contract end?	
16b. Which of the following types of payers did your hospital's/system have an accountable care contract with? (Select all that apply)	
16c. In which of the following Medicare programs did your hospital's/system participate? (Select all that apply)	
16d. How many commercial accountable care contracts has your hospital's/system previously been a part of?	

17. Has your hospital/system ever considered participating in an ACO?

- a. Yes, and we are planning to join one ☐
- b. Yes, but we are not planning to join one ☐
- c. No, we have not even considered it ☐

	Answer
18. Do any hospitals and/or physician groups within your system or the system itself, plan to participate in any of the following risk arrangements in the next three years? (Check all that apply)	i. None
18. Other, please specify	

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

19. Does your hospital/system have an established medical home program?

	Answer
a. Hospital	No
b. System	

20. Has your hospital/system established a clinically integrated network?

	Answer
a. Hospital	No
b. System	

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	07/27/2020	Philip J Noel

Section E: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	86	101		
c. Bassinets set up and staffed for use at the end of the reporting period	10	10		
d. Births (exclude fetal deaths)	445	418		
e. Admissions (exclude newborns, include neonatal & swing admissions)	2,890	3,098		
f. Inpatient days (exclude newborns, include neonatal & swing days)	14,405	15,162		
g. Emergency department visits	18,635	19,469		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	129,816	134,655		
i. Inpatient surgical operations	805	841		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	5,557	5,363		

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days &				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	1,536	1,665		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care?	460	340		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	8,739	9,366		
b. 2. How many Medicare inpatient days were Medicare Managed Care?	2,427	1,698		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	948	1,061		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care?	799	893		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	3,856	4,117		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care?	3,231	3,419		

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	80,182,498	78,248,884		
*b. Tax appropriations	0	0		
*c. Other operating revenue	364,815	306,451		
*d. Nonoperating revenue	20,031	38,712		
*e. TOTAL REVENUE (add 3a thru 3d)	80,567,344	78,594,047		
f. Payroll expenses (only)	22,549,905	22,596,529		
g. Employee benefits	7,413,006	6,562,076		
h. Depreciation expense (for reporting period only)	4,728,540	4,528,743		
i. Interest expense	138,818	160,247		
j. Pharmacy Expense	3,313,802	3,282,026		
k. Supply expense (other than pharmacy)	7,256,979	7,602,280		
l. All other expenses	28,455,363	29,484,223		
m. TOTAL EXPENSES (Add 3f thru 3l. Exclude bad debt)	73,856,413	74,216,124		
n. Do your total expenses (E3.m) reflect full allocation from your corporate office?	Yes	Yes		
*4. Revenue By type				
a. Total gross inpatient revenue	92,315,831	92,869,459		
b. Total gross outpatient revenue	223,553,917	210,600,723		
c. Total gross patient revenue	315,869,748	303,470,182		
*5. Uncompensated Care & Provider Taxes				
a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	5,156,420	6,061,298		
b. Financial Assistance (includes Charity) (Revenue forgone at full established rates. Include in gross revenue)	452,966	801,317		
c. Is your bad debt (5a.) reported on the basis of full charges?	Yes	Yes		
d. Does your state have a provider Medicaid tax/assessment program?	Yes	Yes		

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
e. If yes, please report the total gross amount paid into the program	496,467	496,467		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Total Expenses.....	Yes	Yes		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Deductions from net Patient Revenue.....	No	No		

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	154,719,146	150,772,925	33,765,749	34,030,475
6a1b. Managed care revenue	0	0	0	0
6a1c. Total (a + b)	154,719,146	150,772,925	33,765,749	34,030,475
Medicaid				
6a2. Medicaid:				
6a2a. Fee for service patient revenue	5,813,388	6,949,775	1,028,339	1,076,663
6a2b. Managed care revenue	61,353,698	56,615,258	10,518,483	8,710,163
6a2c. Medicaid Graduate Medical Education (GME) payments			0	0
6a2d. Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2e. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments)			0	0
6a2f. Other Medicaid			0	0
6a2g. Total (a+b+c+d+e+f)	67,167,086	63,565,033	11,546,822	9,786,826
6a3. Other Government:	0	0	0	0
6b1. Self-pay	6,158,583	6,791,959	79,659	83,190
6b2a. Managed care (includes HMO and PPO)	11,918,491	12,150,447	2,601,079	2,742,438
6b2b. Other third - party payers	75,906,442	70,189,818	32,189,189	31,605,955
6b2c. Total Third - party payers (a+b)	87,824,933	82,340,265	34,790,268	34,348,393
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	315,869,748	303,470,182	80,182,498	78,248,884

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Inpatient	Inpatient (History)	Outpatient	Outpatient (History)
If you reported receiving Medicaid Supplemental Payments on line 6.a(2)e, please break the payment total into inpatient and outpatient care.				
Medicaid supplemental payments				

	Answer	Answer (History)
*6e. If you are a government owned facility, does your facility participate in the Medicaid intergovernmental transfer or certified public expenditure program.	No	No

*6f. If yes, please report gross and net revenue.	Gross	Net

	Answer	Answer (History)
*6g. Are the financial data reported from your audited financial statement?	Yes	Yes
6h. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

	Answer	Answer (History)
*7. FINANCIAL PERFORMANCE - MARGIN		
*a. Total Margin	8.31	9
*b. Operating Margin	8.48	9
*c. EBITDA Margin	14.35	15
*d. Medicare Margin	-9.12	-8
*e. Medicaid Margin	-36.30	-58
8. Fixed Assets		
8a. Property, plant and equipment at cost	63,707,264	62,028,060
8b. Accumulated depreciation	18,554,146	13,997,090
8c. Net property, plant and equipment (a - b)	45,153,118	48,030,970
8d. Total gross square feet of your physical plant used for or in support of your healthcare activities	202,105	202,105
9. Total Capital Expenses		
Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.	2,024,984	1,920,101
10. INFORMATION TECHNOLOGY AND CYBERSECURITY		
a. IT Operating Expense	2,096,698	2,028,405
b. IT Capital Expense.	169,732	429,319

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
c. Number of Employed IT staff (in FTEs).	6	6
d. Number of outsourced IT staff (in FTEs).	0	0
*e. What percentage of your IT budget is spent on security?		
f. Which of the following cybersecurity measures does your hospital or health system currently deploy?*	a. Annual risk assessment, c. Intrusion detection systems, d. Mobile device encryption, e. Mobile device data wiping, g. Strong password requirements	a. Annual risk assessment, c. Intrusion detection systems, d. Mobile device encryption, e. Mobile device data wiping, g. Strong password requirements
CYBERSECURITY		
g. Does your hospital or health system board oversight of risk management and reduction specifically include consideration of cybersecurity risk?*	Unsure	Unsure
h. Does your hospital or health system have cybersecurity insurance?*	Unsure	
i. Is your hospital or health system participating in cybersecurity information-sharing activities with an outside information Sharing and Analysis Organization to identify threats and vulnerabilities?*	Unsure	

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.		

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section E: 11. Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	0	0	0	0	0	0	0
b. Dentists	0	0	0	0	0	0	0
c. Medical residents/interns	0		0		0	0	
d. Dental residents/interns	0		0		0	0	
e. Other trainees	0	0	0	0	0	0	0
f. Registered nurses	119	132	65	82	138	30	35
g. Licensed practical (vocational) nurses	10	13	5	5	15	1	2
h. Nursing assistive personnel	32	23	13	18	28	4	7
i. Radiology technicians	6	5	8	5	14	0	1
j. Laboratory technicians	9	8	2	6	9.8	0	1
k. Pharmacists, licensed	3	4	1	0	3.1	0	0
l. Pharmacy technicians	4	4	0	1	4	0	1
m. Respiratory therapists	7	8	4	2	7.4	2	1
n. All other personnel	192	225	110	102	220	16	19
o. Total facility personnel (add 11.a through 11.n)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 11.p and 11.q)	382	422	208	221	439.3	53	67
p. Nursing home type unit/facility Registered Nurses	0	0	0	0	0	0	0
q. Nursing home type unit/facility personnel	0	0	0	0	0	0	0

	Answer	Answer (History)
r. For your employed RNs reported above (F.11.f, column 3), please report the number of full time equivalents who are involved in direct patient care.	65	124

	Answer	Answer (History)
s. For your medical residents/interns reported above (E.11c. column 1) please indicate the number of full-time on payroll.		
1. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics)	0	
2. Other Specialties	0	

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section E: 12. Privileged Physicians	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general	0	0	3	5	8
b. Obstetrics/gynecology	0	0	4	0	4
c. Emergency medicine	0	0	14	0	14
d. Hospitalist	0	0	12	0	12
e. Intensivist	0	0	30	0	30
f. Radiologist/pathologist/anesthesiologist	0	0	38	3	41
g. Other specialist	0	0	61	21	82
h. Total (add 12a-12g)	0	0	162	29	191

13. HOSPITALISTS

	Answer	Answer (History)
13a. Do hospitalists provide care for patients in your hospital? (if yes, please report in E.12c.)	Yes	Yes
13b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	4	5

14. INTENSIVISTS

	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 15.) (if yes, please report in E.12e.)	Yes	Yes

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care				
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total				

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

15. ADVANCED PRACTICE REGISTERED NURSES / PHYSICIAN ASSISTANTS

	Answer	Answer (History)
a. Do advanced practice nurses/physician assistants provide care for patients in your hospital?(if no, please skip to 16.)	Yes	Yes
Advanced Practice Registered Nurses Full-time	3	3
Advanced Practice Registered Nurses Part-time	27	17
Advanced Practice Registered Nurses FTE	3	3
Physician Assistants Full-time	2	2
Physician Assistants Part-time	0	2
Physician Assistants FTE	2	2
c. If yes, please indicate the type of service provided. (Please check all that apply)	Anesthesia services, Emergency department care, Other specialty care, Other	Anesthesia services, Emergency department care, Other specialty care, Other

16. FOREIGN EDUCATED NURSES

a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2019 vs. 2018?	Did not hire foreign nurses	Same
b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)		

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	07/27/2020	Philip J Noel

Section F: Supplemental Information

	Answer
1. Does your hospital provide services through satellite outpatient departments?	Yes

1b. Please indicate the clinical families of outpatient services offered along with the number of hospital outpatient sites by location.

Facilities	Check all that apply	Number of On-Campus Sites	Number of Off-Campus Sites
Airway endoscopy			
Ambulatory surgery	X	1	
Blood product exchange	X	1	
Cardiac/pulmonary rehabilitation	X	1	
Diagnostic/screening test and related procedures	X	1	
Drug administration and clinical oncology			
Ear, nose throat (ENT)			
General surgery and related procedures	X	1	
Gastrointestinal (GI)	X	1	
Gynecology			
Laboratory	X	1	
Major imaging	X	1	
Minor imaging	X	1	
Musculoskeletal surgery	X	1	
Nervous system procedures			
Ophthalmology			
Pathology	X	1	
Primary care			
Psychiatric care			
Radiation oncology	X		1
Rehabilitation	X	1	
Skilled nursing			

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

1b. Please indicate the clinical families of outpatient services offered along with the number of hospital outpatient sites by location.

Facilities	Check all that apply	Number of On-Campus Sites	Number of Off-Campus Sites
Substance abuse/chemical dependency			
Urgent care			
Urology			
Vascular/endovascular/cardiovascular			
Visits and related services			
Other, please specify: Wound Care, Sleep Lab, Pain	X	2	3

	Answer
2. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of the group purchasing organization(s):	Yes
	HealthTrust
	Brentwood
	TN
3. Does the hospital purchase medical/surgical supplies directly through a distributor?	Yes
If yes, please provide the name(s) of the distributor.	Cardinal Health
If yes, please provide the name(s) of the distributor.	Medline
If yes, please provide the name(s) of the distributor.	Owens & Minor
4. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	5

5. Describe the extent of your hospital's current partnerships with the following types of organizations for community or population health improvement initiatives.	Not Involved	Collaboration	Formal Alliance
a. Health care providers outside your system		X	
b. Local or state public health organizations		X	
c. Local or state human/social service organizations		X	
d. Other local or state government		X	
e. Non-profit organizations		X	
f. Faith-based organizations		X	

g. Health insurance companies		X	
h. Schools		X	
i. Local businesses or chambers of commerce			X
j. National businesses	X		
k. Other (list):	X		

	Answer
6. Does your hospital have an established patient and family advisory council that meets regularly to actively engage the perspectives of patients and families?	No
7. Does your hospital have a policy or guidelines that facilitate unrestricted access, 24 hours a day, to hospitalized patients	b. Exists across some units
8. Use this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	
9. Does your hospital or health system have an Internet or Homepage address? If yes, please provide the address.	Yes
	www.ottumwaregionalhealth.com
10. Please indicate below whether or not you agree to these types of disclosure:	I do not grant AHA permission to release my confidential data.
Your Name & Title	[redacted]
Your Email Address	
Your Phone Number	
Your Fax Number	

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
2019 Iowa Department of Public Health	Completed	07/27/2020	Philip J Noel

State Supplement

	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	None
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	n/a
Bed Type Numbers - Beds and Utilization by Inpatient Service	
a. General Medical/Surgical(adult, include gynecology)	39
b. General Medical/Surgical (pediatric)	4
c. Obstetrics	17
d. Other Acute	0
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	0
f. Cardiac Intensive Care	0
g. Neonatal Intensive Care (exclude normal newborn)	0
h. Neonatal Intermediate Care	4
i. Pediatric Intensive Care	0
j. Burn Care	0
k. Other Special Care (definitive observation, step down, etc.)	0
l. Other Intensive Care	10
m. Rehabilitation	13
n. Chronic Disease	0
o. Alzheimer's	0
p. Hospice	0
q. Psychiatric Care	14
r. Alcoholism/Drug Abuse or Dependency Care	0

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
s. Mental Retardation	0
t. Skilled Nursing Care	0
u. Intermediate Care	0
v. Residential Care/Elderly Housing	0
w. SubAcute Care	0
x. Total Facility (Add lines a thru w.)	101
a. Private	1609
b. Semi-Private	1609
c. OB	1458
d. Pediatric	1458
e. Substance Abuse Treatment	0
f. Detoxification	0
g. Rehabilitation	1266
h. Psychiatric	1746
i. Intensive Care Unit	2989
a. Amount of Charity	452966
b. Amount of Hill-Burton	0
c. Bad Debt	5156420
d. Total Non-Reimbursed	5609386
5. Data Release	Yes
[redacted]	

AHA Annual Survey - 2019

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	67167086
b. Medicaid Contractual Adjustments	55418974
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	11748111
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	15977431
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	-4229320
a. Charity Care Charge-level (should equal E.5b)	452966
b. Charity Care Cost-level	99653
9. a. How many total Auxiliary members and Volunteers (both adult and teen) did you have in your hospital?	98
9. b. How many total hours of service did the auxilians and volunteers give to the hospital?	8274
9. c. Total funds contributed to the hospital by the auxiliary and volunteer department?	0

Wednesday, May 26, 2021

AHA Annual Survey - 2020

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status
Submitted

Date Started	Date Last Edited	Date Submitted
APR-07-21	MAY-26-21	MAY-26-21

Survey Administrators
Dennis Hunger

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	05/26/2021	Philip J Noel

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	01/01/2020
	To (mm/dd/yyyy)	12/31/2020
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		366
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2021

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	05/26/2021	Philip J Noel

Section B: Question	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. SELECT ONLY ONE:	33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:	10 General medical and surgical
Other-specify treatment area:	

OTHER

3a. Does your hospital restrict admissions primarily to children?	No
3b. Does the hospital itself operate subsidiary corporations?	No
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization that manages the hospital:	No

Name	City	State

3d. Is your hospital owned in whole or in part by physicians or a physician group?	No
3e. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH or a LTCH arranged within a general acute care hospital.	

If you are arranged in a general acute care hospital, what is your host hospital's name, city and state?

Name	City	State

3f. Are any other types of hospitals co-located in your hospital?	No

3g. What type of hospital is co-located? (Check all that apply)

- ☐ 1. Cancer
- ☐ 2. Cardiac
- ☐ 3. Orthopedic
- ☐ 4. Pediatric
- ☐ 5. Psychiatric
- ☐ 6. Surgical
- ☐ 7. Other

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	05/26/2021	Philip J Noel

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
1. General medical - surgical care	X (#Beds: 24)			
2. Pediatric medical - surgical care	X (#Beds: 4)			
3. Obstetrics (Please specify the level of unit provided by the hospital if applicable.)	X (#Beds: 17) Level: 2			
4. Medical-surgical intensive care	(#Beds: ____)			X
5. Cardiac intensive care	(#Beds: ____)			X
6. Neonatal intensive care	(#Beds: ____)			X
7. Neonatal intermediate care	X (#Beds: 4)			
8. Pediatric intensive care	(#Beds: ____)			X
9. Burn care	(#Beds: ____)			X
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	(#Beds: ____) (Specify: ____)			X
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	X (#Beds: 10) Desc: Med/Surg Cardiac Intensive Care			
12. Physical rehabilitation	X (#Beds: 13)			
13. Substance use disorder	(#Beds: ____)			X
14. Psychiatric care	X (#Beds: 14)			
15. Skilled nursing care	(#Beds: ____)			X
16. Intermediate nursing care	(#Beds: ____)			X
17. Acute long-term care	(#Beds: ____)			X
18. Other long-term care	(#Beds: ____)			X
19. Other care (Please specify the type of other care provided by the hospital if applicable.)	(#Beds: ____) (Specify: ____)			X
20. Adult day care program				X
21. Airborne infection isolation room (Please specify the number of rooms)	X # Rooms: 5			
22. Alzheimer Center				X
23. Ambulance services	X			

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
24. Air Ambulance services				X
25. Ambulatory surgery center				X
26. Arthritis treatment center				X
27. Auxiliary	X			
28. Bariatric/weight control services				X
29. Birthing room - LDR room - LDRP room	X			
30. Blood Donor Center			X	
31. Breast cancer screening / mammograms	X			
32. Cardiology and cardiac surgery services: 32a. Adult cardiology services	X			
32b. Pediatric cardiology services				X
32c. Adult diagnostic catheterization	X			
32d. Pediatric diagnostic catheterization				X
32e. Adult interventional cardiac catheterization	X			
32f. Pediatric interventional cardiac catheterization				X
32g. Adult cardiac surgery				X
32h. Pediatric cardiac surgery				X
32i. Adult cardiac electrophysiology	X			
32j. Pediatric cardiac electrophysiology				X
32k. Cardiac rehabilitation	X			
33. Case management	X			
34. Chaplaincy/pastoral care services	X			
35. Chemotherapy				X
36. Children's wellness program				X
37. Chiropractic services				X
38. Community outreach	X			
39. Complementary and alternative medicine services				X
40. Computer assisted orthopedic surgery (CAOS)				X

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
41. Crisis prevention	☐	☐	☐	☒
42. Dental services	☐	☐	☐	☒
43. Diabetes prevention program	☐	☐	☐	☒
44. Emergency services: 44a. On-campus emergency department	☒	☐	☐	☐
44b. Off-campus emergency department	☐	☐	☐	☒
44c. Pediatric emergency department	☒	☐	☐	☐
44d. Trauma center (certified) [Level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	☒ 3	☐	☐	☐
45. Enabling services	☐	☐	☐	☒
46. Endoscopic services: 46a.Optical colonoscopy	☒	☐	☐	☐
46b. Endoscopic ultrasound	☒	☐	☐	☐
46c. Ablation of Barrett's esophagus	☐	☐	☐	☒
46d. Esophageal impedance study	☐	☐	☐	☒
46e. Endoscopic retrograde cholangiopancreatography (ERCP)	☐	☐	☐	☒
47. Enrollment (insurance) assistance services	☒	☐	☐	☐
48. Employment support services	☐	☐	☐	☒
49. Extracorporeal shock wave lithotripter (ESWL)	☒	☐	☐	☐
50. Fertility clinic	☐	☐	☐	☒
51. Fitness center	☐	☐	☐	☒
52. Freestanding outpatient care center	☐	☐	☐	☒
53. Geriatric services	☒	☐	☐	☐
54. Health fair	☒	☐	☐	☐
55. Community health education	☒	☐	☐	☐
56. Genetic testing/counseling	☐	☐	☐	☒
57. Health screenings	☒	☐	☐	☐
58. Health research	☐	☐	☐	☒
59. Hemodialysis	☒	☐	☐	☐
60. HIV - AIDS services	☐	☐	☐	☒

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
61. Home health services	☐	☐	☐	☒
62. Hospice program	☐	☐	☒	☐
63. Hospital - based outpatient care center - services	☒	☐	☐	☐
64. Housing services:				
64a. Assisted living	☐	☐	☐	☒
64b. Retirement housing	☐	☐	☐	☒
64c. Supportive housing services	☐	☐	☐	☒
65. Immunization program	☐	☐	☐	☒
66. Indigent care clinic	☐	☐	☐	☒
67. Linguistic/translation services	☐	☐	☒	☐
68. Meal delivery services	☐	☐	☐	☒
69. Mobile health services	☐	☐	☐	☒
70. Neurological services	☐	☐	☐	☒
71. Nutrition programs	☒	☐	☐	☐
72. Occupational health services	☒	☐	☐	☐
73. Oncology services	☐	☐	☐	☒
74. Orthopedic services	☒	☐	☐	☐
75. Outpatient surgery	☒	☐	☐	☐
76. Pain management program	☒	☐	☐	☐
77. Palliative care program	☐	☐	☐	☒
78. Palliative care inpatient unit	☐	☐	☐	☒
79. Patient Controlled Analgesia (PCA)	☒	☐	☐	☐
80. Patient education center	☐	☐	☐	☒
81. Patient representative services	☒	☐	☐	☐
82. Physical rehabilitation services:				
82a. Assistive technology center	☐	☐	☐	☒
82b. Electrodiagnostic services	☐	☐	☐	☒
82c. Physical rehabilitation outpatient services	☒	☐	☐	☐
82d. Prosthetic and orthotic services	☐	☐	☐	☒

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
82e. Robot-assisted walking therapy	☐	☐	☐	☒
82f. Simulated rehabilitation environment	☒	☐	☐	☐
83. Primary care department	☐	☐	☐	☒
84. Psychiatric services: 84a.Psychiatric consultation - liaison services	☐	☐	☐	☒
84b. Psychiatric pediatric care	☐ (#Beds: ____)	☐	☐	☒
84c. Psychiatric geriatric services	☒ (#Beds: 14)	☐	☐	☐
84d. Psychiatric education services	☐	☐	☐	☒
84e. Psychiatric emergency services	☒	☐	☐	☐
84f. Psychiatric outpatient services	☐	☐	☐	☒
84g. Psychiatric intensive outpatient services	☐	☐	☐	☒
84h. Social and Community psychiatry	☐	☐	☐	☒
84i. Forensic psychiatry	☐	☐	☐	☒
84j. Prenatal psychiatry and Postpartum psychiatry	☐	☐	☐	☒
84k. Psychiatric partial hospitalization services - adult	☐	☐	☐	☒
84l. Psychiatric partial hospitalization services - pediatric	☐	☐	☐	☒
84m. Psychiatric residential treatment - adult	☐	☐	☐	☒
84n. Psychiatric residential treatment - pediatric	☐	☐	☐	☒
84o. Suicide prevention services	☒	☐	☐	☐
85. Radiology, diagnostic: 85a. CT scanner	☒	☐	☐	☐
85b. Diagnostic radioisotope facility	☒	☐	☐	☐
85c. Electron beam computed tomography (EBCT)	☐	☐	☐	☒
85d. Full-field digital mammography(FFDM)	☒	☐	☐	☐
85e. Magnetic resonance imaging (MRI)	☒	☐	☐	☐
85f. Intraoperative magnetic resonance imaging	☐	☐	☐	☒
85g. Magnetoencephalography (MEG)	☐	☐	☐	☒
85h. Multi-slice spiral computed tomography(<64 + slice CT)	☒	☐	☐	☐

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
85i. Multi-slice spiral computed tomography (64+ slice CT)	X			
85j. Positron emission tomography (PET)	X			
85k. Positron emission tomography/CT (PET/CT)	X			
85l. Single photon emission computerized tomography (SPECT)	X			
85m. Ultrasound	X			
86. Radiology therapeutic: 86a. Image-guided Radiation Therapy(IGRT)	X			
86b. Intensity-Modulated Radiation Therapy (IMRT)	X			
86c. Proton beam therapy				X
86d. Shaped Beam Radiation System	X			
86e. Stereotactic radiosurgery				X
86f. Basic interventional radiology				X
87. Robotic surgery	X			
88. Rural health clinic				X
89. Sleep center	X			
90. Social work services	X			
91. Sports medicine				X
92. Substance use disorder care Services 92a. Substance use disorder pediatric services	(#Beds: ____)			X
92b. Substance use disorder outpatient services				X
92c. Substance use disorder partial hospitalization services				X
92d. Medication Assisted Treatment for Opioid Use Disorder				X
92e. Medication Assisted Treatment for other substance use disorders				X
93. Support groups				X
94. Swing bed services				X
95. Teen outreach services				X
96. Tobacco treatment / cessation program	X			
97. Telehealth 97a. Consultation and office visits				X

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
97b. eICU	X			
97c. Stroke care	X			
97d. Psychiatric and addiction treatment	X			
97e. Remote patient monitoring: 1. Post-discharge.				X
2. Ongoing chronic care management				X
3. Other remote patient monitoring				X
97f. Other telehealth				X
98. Transplant services: 98a. Bone marrow				X
98b. Heart				X
98c. Kidney				X
98d. Liver				X
98e. Lung				X
98f. Tissue				X
98g. Other				X
99. Transportation to health facilities (non-emergency)				X
100. Urgent care center				X
101. Violence Prevention Programs: 101a. For the workplace				X
101b. For the community				X
102. Virtual Colonoscopy				X
103. Volunteer services department	X			
104. Women's health center / services	X			
105. Wound management services	X			

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section C: Physician Arrangements	Answer	Answer (History)
106a. Does your organization routinely offer psychiatric consultation & liaison services in the following care areas?		
1. Emergency Services	Yes	
2. Primary Care Services	No	
3. Acute inpatient care	Yes	
4. Extended care	No	
106b. Does your organization routinely offer addiction/substance use disorder consultation & liaison services in the following care areas?		
1. Emergency Services	No	
2. Primary Care Services	No	
3. Acute inpatient care	No	
4. Extended care	No	
106c. Does your organization routinely integrate behavioral health services in the following care areas?		
1. Emergency Services	Yes	Yes
2. Primary Care Services	No	No
3. Acute inpatient care	Yes	Yes
4. Extended care	No	No

107a. For each of the physician-organization arrangements, please report the number of involved physicians in these arrangements.

	Number of Physicians	My Hospital	My Health System	Do Not Provide
1. Independent Practice Association				X
2. Group practice without walls				X
3. Open Physician - Hospital Organization (PHO)				X
4. Closed Physician - Hospital Organization (PHO)				X
5. Management Service Organization (MSO)				X
6. Integrated Salary Model				X
7. Equity Model				X
8. Foundation				X
9. Other, please specify:				

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

107b. For those arrangements reported in 107a., please report the approximate ownership share.

	Hospital ownership share %	Physician ownership share %	Parent corporation ownership share %	Insurance ownership share %
1. Independent Practice Association (IPA)				
2. Group practice without walls				
3. Open Physician-Hospital Organization (PHO)				
4. Closed Physician-Hospital Organization (PHO)				
5. Management Service Organization (MSO)				
6. Integrated Salary Model				
7. Equity Model				
8. Foundation				
9. Other, specified above:				

107c. If the hospital owns physician practices, how are they organized?

	Percent %	Number of Physicians
107c.1 Solo practice		
107c.2 Single specialty group		
107c.3 Multi-specialty group		

	Answer	Answer (History)
107d. Of the physician practices owned by the hospital, what percentage are primary care?		
107e. Of the physician practices owned by the hospital, what percentage are specialty care?		
108. Looking across all the relationships identified in question 107a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payors or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be any type of ownership)?	0	0
109a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?	No	No
109b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that apply).		
109b. Other		
109c. If you selected 'a'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that apply).		
109c. Other		
109d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	No	No

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
110a. Bed changes: a. Was there a permanent or significant change in the total number of beds set up and staffed for use during the reporting period?	No	

Change 1 Date | Number of beds added | Number of beds removed

Change 2 Date | Number of beds added | Number of beds removed

	Answer	Answer (History)
110b. Was there a permanent or significant change in the total number of ICU beds set up and staffed for use during the reporting period?	No	

Change 1 Date | Number of beds added | Number of beds removed

Change 2 Date | Number of beds added | Number of beds removed

111. Airborne isolation room:

	Answer	Answer (History)
a. Please indicate the total number of airborne isolation rooms set up at the start of the reporting period?	5	
b. Please indicate the total number of airborne isolation rooms set up at the end of the reporting period?	5	
c. Please indicate how many rooms not set-up as airborne isolation rooms at the end of the reporting period can be converted to airborne isolation rooms?		
112. Temporary spaces: a.Please indicate if any temporary spaces such as tents or other spaces not typically used for clinical purposes were set up for using in triage, testing or treatment during the reporting period.	No	

113. Ventilators:

	Answer	Answer (History)
a. How many adult (in use and not in use) mechanical ventilators were there in your facility at the start of the reporting period?	5	
b. How many adult (in use and not in use) mechanical ventilators were there in your facility at the end of the reporting period?	5	
c. How many pediatric/NICU (in use and not in use) mechanical ventilators were there in your facility at the start of the reporting period??	1	
d. How many pediatric/NICU (in use and not in use) mechanical ventilators were there in your facility at the end of the reporting period?	1	

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

114. Emergency Departments:

	Answer	Answer (History)
a. Please indicate the number of emergency department beds set up and staffed at the start of the reporting period.	17	
b. Please indicate the number of emergency department beds set up and staffed at the end of the reporting period.	17	
c. Was there a permanent or significant change in the total number of emergency department beds set up and staffed for use during the reporting period?	No	

Change 1 Date | Number of beds added | Number of beds removed

Change 2 Date | Number of beds added | Number of beds removed

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Insurance and Alternative Payment Models	Completed	05/26/2021	Philip J Noel

Section D: Question	Answer
1. Does your hospital own or jointly own a health plan?	No
1a. In what states? (Select all that apply)	
2. Does your system own or jointly own a health plan?	No
2a. In what states? (Select all that apply)	
3. Does your hospital/system have a significant partnership with an insurer on an insurance company/health plan?	No
3a. In what states? (Select all that apply)	

4. Insurance
If yes, to 1, 2 and/or 3, please indicate the insurance products and the total medical enrollment (check all that apply)

Insurance Product	Hospital	System	JV	Medical Enrollment	New Product	No	Do Not Know
a. Medicare Advantage	☐	☐	☐		☐	☐	☐
b. Medicaid Managed Care	☐	☐	☐		☐	☐	☐
c. Health Insurance Marketplace ("exchange")	☐	☐	☐		☐	☐	☐
d. Other Individual Market	☐	☐	☐		☐	☐	☐
e. Small Group	☐	☐	☐		☐	☐	☐
f. Large Group	☐	☐	☐		☐	☐	☐
g. Other	☐	☐	☐		☐	☐	☐

	Answer
If yes, to 4.g. Other Please specify:	

5. Does your health plan make capitated payments to physicians either within or outside of your network for specific groups or enrollees?

a. Physicians within your network	
b. Physicians outside your network	
c. If yes, which specialties?	

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

6. Does your health plan make bundled payments to providers in your network or to outside providers?

	Answer
a. Providers within your network	
b. Providers outside your network	
c. If yes, which specialties?	

7. Does your health plan offer shared risk contracts either to providers in your network or to outside providers? (i.e., other than capitation or bundled payment)

a. Providers within your network	
b. Providers outside your network	
c. If yes, which specialties?	

8. Does your hospital or health system fund the health benefits for your employees?	Yes
a. If yes, does the hospital or health system also administer the benefits (as opposed to contracting with a third party administrator)?	No
9. What percentage of the hospital's net patient revenue is paid on a capitated basis?	0
9a. In total, how many enrollees do you serve under capitated contracts?	
10. Does your hospital participate in any bundled payment arrangement?	No

10a. If yes, with which of the following types of payers does your hospital have a bundled payment arrangement? (Select all that apply)

- ☐ 1. Traditional Medicare
- ☐ 2. A Medicare Advantage plan
- ☐ 3. A commercial insurance plan including ACA participants, individual, group or employer markets
- ☐ 4. Medicaid

10b. For which of the following medical/surgical conditions does your hospital have a bundled payment arrangement? (Select all that apply)

- ☐ 1. Cardiovascular
- ☐ 2. Orthopedic
- ☐ 3. Oncologic
- ☐ 4. Neurology
- ☐ 5. Hematology
- ☐ 6. Gastrointestinal
- ☐ 7. Pulmonary
- ☐ 8. Infectious disease
- ☐ 9. Other (please specify):

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

	Answer
10c.what percentage of the hospital's patient revenue is paid through bundled payment arrangements	
11.Does your hospital participate in a bundled payment program involving care settings outside of the hospital (e.g. physician, outpatient, post acute)?	No
11a.If yes, does your hospital share upside or downside risk with any of those outside providers?	
12. What percentage of your hospital's patient revenue is paid on a shared risk basis (other than capitated or bundled payment)?	0
13. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
14.Does your hospital have contracts with commercial payers where payment is tied to performance on quality/safety metrics?	No
15a. Has your hospital or health care system established an accountable care organization (ACO)?	4. My hospital/system has never participated or led an ACO
15b. With which of the following types of payers does your hospital/system have an accountable care contract? (Select all that apply)	

15c. If you selected Traditional Medicare, in which of the following Medicare programs is your hospital/system participating? (Select all that apply)

- ☐ 1. MSSP Track 1
- ☐ 2. MSSP Track 2
- ☐ 3. MSSP Track 3
- ☐ 4. MSSP Track 1+
- ☐ 5. NextGen
- ☐ 6. Comprehensive ESRD Care

15d. What percentage of your hospital's/system patients are covered by accountable care contracts?	
15e. What percentage of your hospital's/system patient revenue came from ACO contracts in 2020?	
16. Has your hospital/system ever considered participating in an ACO?	b. Yes, but we are not planning to join one

Ottumwa Regional Health Center (6621105)

17. Do any hospitals and/or physician groups within your system or the system itself, plan to participate in any of the following risk arrangements in the next three years? (Check all that apply)

- [ ] a. Shared Savings/Losses
- [ ] b. Bundled payment
- [ ] c. Capitation
- [ ] d. ACO (Ownership)
- [ ] e. ACO (Joint Venture)
- [ ] f. Health Plan (Ownership)
- [ ] g. Health Plan (Joint Venture)
- [ ] h. Primary care transformation, including direct contracting
- [ ] i. Other, please specify:
- [X] j. None

18. Does your hospital/system have an established medical home program?

	Answer
a. Hospital	No
b. System	No

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	05/26/2021	Philip J Noel

Section E: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	86	86		
c. Bassinets set up and staffed for use at the end of the reporting period	10	10		
d. Births (exclude fetal deaths)	455	445		
e. Admissions (exclude newborns, include neonatal & swing admissions)	2,700	2,890		
f. Inpatient days (exclude newborns, include neonatal & swing days)	13,537	14,405		
g. Emergency department visits	15,580	18,635		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	110,621	129,816		
i. Inpatient surgical operations	800	805		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	4,601	5,557		

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days &				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	1,401	1,536		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care?	406	460		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	7,975	8,739		
b. 2. How many Medicare inpatient days were Medicare Managed Care?	2,185	2,427		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	722	948		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care?	668	799		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	2,996	3,856		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care?	2,734	3,231		

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	71,684,985	80,182,498		
*b. Tax appropriations	0	0		
*c. Other operating revenue	506,936	364,815		
*d. Nonoperating revenue	619	20,031		
*e. TOTAL REVENUE (add 3a thru 3d)	72,192,540	80,567,344		
f. Payroll expenses (only)	21,749,810	22,549,905		
g. Employee benefits	7,357,289	7,413,006		
h. Depreciation expense (for reporting period only)	4,762,609	4,728,540		
i. Interest expense	146,005	138,818		
j. Pharmacy Expense	2,524,766	3,313,802		
k. Supply expense (other than pharmacy)	7,024,457	7,256,979		
l. All other expenses	19,269,521	28,455,363		
m. TOTAL EXPENSES (Add 3f thru 3l. Exclude bad debt)	62,834,457	73,856,413		
n. Do your total expenses (E3.m) reflect full allocation from your corporate office?	Yes	Yes		
*4. Revenue By type				
a. Total gross inpatient revenue	84,618,322	92,315,831		
b. Total gross outpatient revenue	206,947,418	223,553,917		
c. Total gross patient revenue	291,565,740	315,869,748		
*5. Uncompensated Care & Provider Taxes				
a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	4,416,950	5,156,420		
1. Are you able to distinguish bad debt derived from patients with or without insurance?	Yes			
2. If yes, how much is from patients with insurance?	1,987,628			
b. Financial assistance (Includes charity care) (Revenue forgone at full-established rates. Include in gross revenue.)	480,776	452,966		
c. Is your bad debt (5a.) reported on the basis of full charges?	Yes	Yes		

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
d. Does your state have a provider Medicaid tax/assessment program?	Yes	Yes		
e. If yes, please report the total gross amount paid into the program	496,467	496,467		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Total Expenses.....	Yes	Yes		
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in: Deductions from net Patient Revenue.....	No	No		

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	138,153,316	154,719,146	32,738,517	33,765,749
6a1b. Managed care revenue	0	0	0	0
6a1c. Total (a + b)	138,153,316	154,719,146	32,738,517	33,765,749
6a2. Medicaid:				
6a2a. Fee for service patient revenue	2,392,227	5,813,388	388,717	1,028,339
6a2b. Managed care revenue	60,133,249	61,353,698	9,771,150	10,518,483
6a2c. Medicaid Graduate Medical Education (GME) payments			0	0
6a2d. Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2e. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments			0	0
6a2f. Other Medicaid			0	0
6a2g. Total (a+b+c+d+e+f)	62,525,476	67,167,086	10,159,867	11,546,822
6a3. Other Government:	0	0	0	0
*6b. NONGOVERNMENT				
6b1. Self-pay	7,558,018	6,158,583	102,033	79,659
6b2. Third-party payers:				
6b2a. Managed care (includes HMO and PPO)	10,490,901	11,918,491	2,486,053	2,601,079
6b2b. Other third - party payers	72,838,029	75,906,442	26,198,515	32,189,189
6b2c. Total Third - party payers (a+b)	83,328,930	87,824,933	28,684,568	34,790,268
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	291,565,740	315,869,748	71,684,985	80,182,498

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Inpatient	Inpatient (History)	Outpatient	Outpatient (History)
*6d. If you reported receiving Medicaid Supplemental Payments on line 6.a(2)e, please break the payment total into inpatient and outpatient care.				
Medicaid supplemental payments				

	Answer	Answer (History)
*6e. If you are a government owned facility(control codes 12-16 section b), does your facility participate in the Medicaid intergovernmental transfer or certified public expenditure program.	No	No

*6f. If yes, please report gross and net revenue.	Gross	Net

	Answer	Answer (History)
*6g. Are the financial data reported from your audited financial statement?	Yes	Yes
6h. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

	Answer	Answer (History)
*7. FINANCIAL PERFORMANCE - MARGIN		
*a. Total Margin	12.67	8
*b. Operating Margin	12.88	8
*c. EBITDA Margin	19.50	14
*d. Medicare Margin	5	-9
*e. Medicaid Margin	-38	-36
8. Fixed Assets		
8a. Property, plant and equipment at cost	68,767,355	63,707,264
8b. Accumulated depreciation	23,332,132	18,554,146
8c. Net property, plant and equipment (a - b)	45,435,223	45,153,118
8d. Total gross square feet of your physical plant used for or in support of your healthcare activities	270,499	202,105
9. Total Capital Expenses		
Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.	492,147	2,024,984
10. INFORMATION TECHNOLOGY AND CYBERSECURITY		
a. IT Operating Expense	2,350,419	2,096,698
b. IT Capital Expense.	63,608	169,732

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
c. Number of Employed IT staff (in FTEs).	5	6
d. Number of outsourced IT staff (in FTEs).	0	0
*e. What percentage of your IT budget is spent on security?		
*f. Which of the following cybersecurity measures does your hospital or health system currently deploy?	a. Annual risk assessment, c. Intrusion detection systems, d. Mobile device encryption, e. Mobile device data wiping, f. Penetration testing to identify security vulnerabilities , g. Strong password requirements, h. Two-factor authentication	a. Annual risk assessment, c. Intrusion detection systems, d. Mobile device encryption, e. Mobile device data wiping, g. Strong password requirements

CYBERSECURITY

*g. Does your hospital or health system board oversight of risk management and reduction specifically include consideration of cybersecurity risk?	Yes	Unsure
*h. Does your hospital or health system have cybersecurity insurance?	Yes	
*i. Is your hospital or health system participating in cybersecurity information-sharing activities with an outside information Sharing and Analysis Organization to identify threats and vulnerabilities?	Yes	

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.		

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section E: 11. Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	0	0	0	0	0	0	0
b. Dentists	0	0	0	0	0	0	0
c. Medical residents/interns	0	0	0	0	0	0	0
d. Dental residents/interns	0	0	0	0	0	0	0
e. Other trainees	0	0	0	0	0	0	0
f. Registered nurses	99	119	65	65	118	35	30
g. Licensed practical (vocational) nurses	6	10	3	5	7.2	2	1
h. Nursing assistive personnel	20	32	21	13	24	6	4
i. Radiology technicians	11	6	4	8	11.2	1	0
j. Laboratory technicians	8	9	1	2	7.8	1	0
k. Pharmacists, licensed	3	3	1	1	3.1	0	0
l. Pharmacy technicians	3	4	0	0	3	2	0
m. Respiratory therapists	7	7	4	4	7.4	3	2
n. All other personnel	202	192	44	110	190.5	20	16
o. Total facility personnel (add 11.a through 11.n)(Total facility personnel should include hospital plus nursing home type unit/facility personnel reported in 11.p and 11.q)	359	382	143	208	372.2	70	53
p. Nursing home type unit/facility Registered Nurses	0	0	0	0	0	0	0
q. Nursing home type unit/facility personnel	0	0	0	0	0	0	0

	Answer	Answer (History)
r. For your employed RNs reported above (E.11.f, column 3), please report the number of full time equivalents who are involved in direct patient care.	54	65

s. For your medical residents/interns reported above (E.11c. column 1) please indicate the number of full-time on payroll.

	Answer	Answer (History)
1. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics)	0	0
2. Other Specialties	0	0

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section E: 12. Privileged Physicians	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general	0	0	4	3	7
b. Obstetrics/gynecology	0	0	4	0	4
c. Emergency medicine	0	0	12	0	12
d. Hospitalist	0	0	13	0	13
e. Intensivist	0	0	32	0	32
f. Radiologist/pathologist/anesthesiologist	0	0	35	3	38
g. Other specialist	0	0	67	21	88
h. Total (add 12a-12g)	0	0	167	27	194

13. HOSPITALISTS

	Answer	Answer (History)
13a. Do hospitalists provide care for patients in your hospital? (if yes, please report in E.12d.)	Yes	Yes
13b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	4	4

14. INTENSIVISTS

	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 15.) (if yes, please report in E.12e.)	Yes	Yes

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care	4			
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total	4			

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

15. ADVANCED PRACTICE REGISTERED NURSES / PHYSICIAN ASSISTANTS

	Answer	Answer (History)
a. Do advanced practice nurses/physician assistants provide care for patients in your hospital?(if no, please skip to 16.)	Yes	Yes
Advanced Practice Registered Nurses Full-time	2	3
Advanced Practice Registered Nurses Part-time	26	27
Advanced Practice Registered Nurses FTE	2	3
Physician Assistants Full-time	2	2
Physician Assistants Part-time	0	0
Physician Assistants FTE	2	2
c. If yes, please indicate the type of service provided. (Please check all that apply)	Anesthesia services, Emergency department care, Other specialty care, Other	Anesthesia services, Emergency department care, Other specialty care, Other

16. FOREIGN EDUCATED NURSES

a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2020 vs. 2019?	More	Did not hire foreign nurses
b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)	Africa	

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Addressing Patient Social Needs and Community Social Determinants of Health	Completed	05/26/2021	Philip J Noel

Section F: Addressing Patient Social Needs and Community Social Determinants of Health

1. Which social needs of patients/social determinants of health in communities does your hospital or health system have programs or strategies to address? (Check all that apply)

- [X] a. Housing (instability, quality, financing)
- [X] b. Food insecurity or hunger
- [X] c. Utility needs
- [X] d. Interpersonal violence
- [X] e. Transportation
- [X] f. Employment and income
- [X] g. Education
- [X] h. Social isolation (lack of family and social support)
- [X] i. Health behaviors
- [ ] j. Other, please describe

	Answer
2. Does your hospital or health system screen patients for social needs?	a. Yes for all patients

2a. If yes, please indicate which social needs are assessed. Check all that apply.

- [X] a. Housing (instability, quality, financing)
- [X] b. Food insecurity or hunger
- [X] c. Utility need
- [X] d. Interpersonal violence
- [X] e. Transportation
- [X] f. Employment and income
- [X] g. Education
- [X] h. Social isolation (lack of family and social support)
- [X] i. Health behaviors
- [ ] j. Other, please describe

	Answer
2b. If yes, does your hospital or health system record the social needs screening results in your electronic health record?	Yes
3. Does your hospital or health system utilize outcome metrics (for example, cost of care or readmission rates) to assess the effectiveness of interventions to address the patients' social needs?	No

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

4. Has your hospital or health system been able to gather data indicating that activities used to address the social determinants of health and patient social needs have resulted in any of the following (check all that apply):

- [ ] a. Better health outcomes for patients
- [ ] b. Decreased utilization of hospital or health system services
- [ ] c. Decreased health care costs
- [ ] d. Improved community health status

5. Please indicate the extent of your hospital's current partnerships with external partners for population and/or community health initiatives. Which types of organizations do you currently partner with in each of the following activities? (Check all that apply)

	Not involved	Work together to meet patient social needs	Participates in our Community	Work together to implement community-level initiatives
a. Health care providers outside of your systems	☐	☐	☐	☒
b. Health insurance providers outside of your own system	☐	☒	☐	☐
c. Local or state public health departments/organizations	☐	☐	☐	☒
d. Other local or state government agencies or social service oganizations	☐	☐	☐	☒
e. Faith based organizations	☐	☒	☐	☐
f. Local organizations addressing food insecurity	☐	☐	☒	☐
g. Local organizations addressing transportation needs	☐	☐	☒	☐
h. Local organizations addressing housing insecurity	☒	☐	☐	☐
i. Local organizations providing legal assistance for individuals	☒	☐	☐	☐
j. Other community non-profit organizations	☐	☐	☐	☒
k. K - 12 Schools	☐	☐	☐	☒
l. Colleges or universities	☐	☐	☐	☒
m. Local businesses or chambers of commerce	☐	☐	☒	☐
n. Law enforcement/safety forces	☐	☐	☒	☐

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	05/26/2021	Philip J Noel

Section G: Supplemental Information

	Answer
1a. Does your hospital provide services through satellite outpatient departments?	Yes

1b. Please indicate the clinical families of outpatient services offered along with the number of hospital outpatient sites by location.

Facilities	Check all that apply	Number of On-Campus Sites	Number of Off-Campus Sites
Airway endoscopy			
Ambulatory surgery	X	1	
Blood product exchange	X	1	
Cardiac/pulmonary rehabilitation	X	1	
Diagnostic/screening test and related procedures	X	1	
Drug administration and clinical oncology			
Ear, nose throat (ENT)	X	1	
General surgery and related procedures	X	1	
Gastrointestinal (GI)	X	1	
Gynecology	X	1	
Laboratory	X	1	
Major imaging	X	1	
Minor imaging	X	1	
Musculoskeletal surgery	X	1	
Nervous system procedures			
Ophthalmology	X	1	
Pathology	X	1	
Primary care	X	1	
Psychiatric care			
Radiation oncology	X		1
Rehabilitation	X	1	
Skilled nursing			

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

1b. Please indicate the clinical families of outpatient services offered along with the number of hospital outpatient sites by location.

Facilities	Check all that apply	Number of On-Campus Sites	Number of Off-Campus Sites
Substance use disorder care			
Urgent care			
Urology	X	1	
Vascular/endovascular/cardiovascular	X	1	
Visits and related services			
Other, please specify: Wound Care, Sleep Lab, Pain	X	3	1

	Answer
2. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of your primary group purchasing organization(s):	Yes

Name	City	State
HealthTrust	Brentwood	TN

	Answer
3. Does the hospital purchase medical/surgical supplies directly through a distributor?	Yes

If yes, please provide the name(s) of the primary distributor.

Name: Cardinal Health

Name: Medline

Name: Owens & Minor

4. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	5
5. Does your hospital have an established patient and family advisory council that meets regularly to actively engage the perspectives of patients and families?	No

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

6. Utilization of telehealth/virtual care

	Answer
a. Number of video visits: Synchronous visits between patient and provider that are not co-located, through the use of two-way, interactive, real-time audio and video communication.	0
b. Number of audio visits: Synchronous visits between a patient and a provider that are not co-located, through the use of two-way, interactive, real-time audio-only communication.	0
c. Number of patients being monitored through remote patient monitoring (RPM): Asynchronous or synchronous interactions between and patient and a provider that are not co-located involving the collection, transmission, evaluation, and communication of physiological data.	0
d. Number of patients receiving other virtual services: All other synchronous or asynchronous interactions between a provider and patient or provider and provider delivered remotely including messages, eConsults, and virtual check-ins.	0
7. Please indicate below whether or not you agree to these types of disclosure:	I do not grant AHA permission to release my confidential data.
Use this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.	

Thank you for your cooperation in completing this survey. If there are any questions about your responses to this survey, who should be contacted

Your Name & Title	Dennis Hunger
Your Name & Title	CEO
Your Email Address	[redacted]
Your Phone Number	[redacted]
Your Fax Number	[redacted]

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
2020 Iowa Department of Public Health	Completed	05/14/2021	Philip J Noel

State Supplement

	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	None
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	n/a
Bed Type Numbers - Beds and Utilization by Inpatient Service	
a. General Medical/Surgical(adult, include gynecology)	39
b. General Medical/Surgical (pediatric)	4
c. Obstetrics	17
d. Other Acute	0
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	0
f. Cardiac Intensive Care	0
g. Neonatal Intensive Care (exclude normal newborn)	0
h. Neonatal Intermediate Care	4
i. Pediatric Intensive Care	0
j. Burn Care	0
k. Other Special Care (definitive observation, step down, etc.)	0
l. Other Intensive Care	10
m. Rehabilitation	13
n. Chronic Disease	0
o. Alzheimer's or other Dementia Diagnosis	0
p. Hospice	0
q. Psychiatric Care	14
r. Substance Use Disorder	0

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
s. Developmental Disability	0
t. Skilled Nursing Care	0
u. Intermediate Care	0
v. Residential Care/Senior Housing	0
w. SubAcute Care	0
x. Total Facility (Add lines a thru w.)	101
a. Private	1687
b. Semi-Private	1687
c. OB	1608
d. Pediatric	1608
e. Substance Use Disorder Treatment	0
f. Detoxification	0
g. Rehabilitation	1395
h. Psychiatric	1925
i. Intensive Care Unit	3295
a. Amount of Charity	480776
b. Amount of Hill-Burton	0
c. Bad Debt	4416950
d. Total Non-Reimbursed	4897726
5. Data Release	Yes
[redacted]	

AHA Annual Survey - 2020

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	62525476
b. Medicaid Contractual Adjustments	52365609
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	10159866
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	14020616
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	-3860749
a. Charity Care Charge-level (should equal E.5b)	480776
b. Charity Care Cost-level	101424
9. a. How many total Auxiliary members and Volunteers (both adult and teen) did you have in your hospital?	31
9. b. How many total hours of service did the auxilians and volunteers give to the hospital?	1513
9. c. Total funds contributed to the hospital by the auxiliary and volunteer department?	0

Tuesday, May 31, 2022

AHA Annual Survey - 2021

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status
Submitted

Date Started	Date Last Edited	Date Submitted
MAY-06-22	MAY-31-22	MAY-31-22

Survey Administrators
Dennis Hunger

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	05/31/2022	Dennis Hunger

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	01/01/2021
	To (mm/dd/yyyy)	12/31/2021
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		365
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2022

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	05/31/2022	Dennis Hunger

Section B: Question	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. SELECT ONLY ONE:	33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:	10 General medical and surgical
Other-specify treatment area:	

OTHER

3a. Does your hospital restrict admissions primarily to children?	No
3b. Does the hospital itself operate subsidiary corporations?	No
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization	No

Name	City	State

3d. Is your hospital owned in whole or in part by physicians or a physician group?	No
3e. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH or a LTCH arranged within a general acute care hospital.	

If you are arranged in a general acute care hospital, what is your host hospital's name, city and state?

Name	City	State

3f. Are any other types of hospitals co-located in your hospital?	No

3g. If you checked yes for 3f, what type of hospital is co-located? (Check all that apply)

- ☐ 1. Cancer
- ☐ 2. Cardiac
- ☐ 3. Orthopedic
- ☐ 4. Pediatric
- ☐ 5. Psychiatric
- ☐ 6. Surgical
- ☐ 7. Other

3h. Is your hospital designated as a state, jurisdiction, or federal Ebola or other Special Pathogens facility? (Check all that apply.)

- ☐ 1. Federal designation: Regional Emerging Special Pathogen Treatment Center
- ☐ 2. State/Jurisdiction designation: Special Pathogen Treatment Center
- ☐ 3. State/Jurisdiction designation: Special Pathogen Assessment Hospital
- ☐ 4. Frontline facility

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	05/31/2022	Dennis Hunger

Section C: Facilities and Services

	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
1. General medical - surgical care	[X] (#Beds: 24)	[ ]	[ ]	[ ]
2. Pediatric medical - surgical care	[X] (#Beds: 4)	[ ]	[ ]	[ ]
3. Obstetrics [Hospital level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	[X] (#Beds: 17) Level: 2	[ ]	[ ]	[ ]
4. Medical-surgical intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
5. Cardiac intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
6. Neonatal intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
7. Neonatal intermediate care	[X] (#Beds: 4)	[ ]	[ ]	[ ]
8. Pediatric intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
9. Burn care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	[ ] (#Beds: ____) (Specify: ____)	[ ]	[ ]	[X]
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	[X] (#Beds: 10) Desc: Med/Surg Cardiac Intensive Care	[ ]	[ ]	[ ]
12. Physical rehabilitation	[X] (#Beds: 13)	[ ]	[ ]	[ ]
13. Substance use disorder	[ ] (#Beds: ____)	[ ]	[ ]	[X]
14. Psychiatric care	[X] (#Beds: 14)	[ ]	[ ]	[ ]
15. Skilled nursing care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
16. Intermediate nursing care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
17. Acute long-term care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
18. Other long-term care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
19. Biocontainment patient care unit	[ ] (#Beds: ____)	[ ]	[ ]	[X]
20. Other care (Please specify the type of other care provided by the hospital if applicable.)	[ ] (#Beds: ____) (Specify: ____)	[ ]	[ ]	[X]
21. Adult day care program	[ ]	[ ]	[ ]	[X]
22. Airborne infection isolation room (Please specify the number of rooms)	[X] # Rooms: 5	[ ]	[ ]	[ ]

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
23. Alzheimer Center	☐	☐	☐	☒
24. Ambulance services	☒	☐	☐	☐
25. Air Ambulance services	☐	☐	☐	☒
26. Ambulatory surgery center	☐	☐	☐	☒
27. Arthritis treatment center	☐	☐	☐	☒
28. Auxiliary	☒	☐	☐	☐
29. Bariatric/weight control services	☐	☐	☐	☒
30. Birthing room - LDR room - LDRP room	☒	☐	☐	☐
31. Blood Donor Center	☐	☐	☒	☐
32. Breast cancer screening / mammograms	☒	☐	☐	☐
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services	☒	☐	☐	☐
33b. Pediatric cardiology services	☐	☐	☐	☒
33c. Adult diagnostic catheterization	☒	☐	☐	☐
33d. Pediatric diagnostic catheterization	☐	☐	☐	☒
33e. Adult interventional cardiac catheterization	☒	☐	☐	☐
33f. Pediatric interventional cardiac catheterization	☐	☐	☐	☒
33g. Adult cardiac surgery	☐	☐	☐	☒
33h. Pediatric cardiac surgery	☐	☐	☐	☒
33i. Adult cardiac electrophysiology	☒	☐	☐	☐
33j. Pediatric cardiac electrophysiology	☐	☐	☐	☒
33k. Cardiac rehabilitation	☒	☐	☐	☐
34. Case management	☒	☐	☐	☐
35. Chaplaincy/pastoral care services	☒	☐	☐	☐
36. Chemotherapy	☐	☐	☐	☒
37. Children's wellness program	☐	☐	☐	☒
38. Chiropractic services	☐	☐	☐	☒
39. Community outreach	☒	☐	☐	☐
40. Complementary and alternative medicine services	☐	☐	☐	☒

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
41. Computer assisted orthopedic surgery (CAOS)	☐	☐	☐	☒
42. Crisis prevention	☐	☐	☐	☒
43. Dental services	☐	☐	☐	☒
44. Diabetes prevention program	☐	☐	☐	☒
45. Emergency services: 45a. On-campus emergency department	☒	☐	☐	☐
45b. Off-campus emergency department	☐	☐	☐	☒
45c. Pediatric emergency department	☒	☐	☐	☐
45d. Trauma center (certified) [Hospital Level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	☒ 3	☐	☐	☐
46. Enabling services	☐	☐	☐	☒
47. Endoscopic services: 47a.Optical colonoscopy	☒	☐	☐	☐
47b. Endoscopic ultrasound	☒	☐	☐	☐
47c. Ablation of Barrett's esophagus	☐	☐	☐	☒
47d. Esophageal impedance study	☐	☐	☐	☒
47e. Endoscopic retrograde cholangiopancreatography (ERCP)	☐	☐	☐	☒
48. Enrollment (insurance) assistance services	☒	☐	☐	☐
49. Employment support services	☐	☐	☐	☒
50. Extracorporeal shock wave lithotripter (ESWL)	☒	☐	☐	☐
51. Fertility clinic	☐	☐	☐	☒
52. Fitness center	☐	☐	☐	☒
53. Freestanding outpatient care center	☐	☐	☐	☒
54. Geriatric services	☒	☐	☐	☐
55. Health fair	☒	☐	☐	☐
56. Community health education	☒	☐	☐	☐
57. Genetic testing/counseling	☐	☐	☐	☒
58. Health screenings	☒	☐	☐	☐
59. Health research	☐	☐	☐	☒

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
60. Hemodialysis	X			
61. HIV - AIDS services				X
62. Home health services				X
63. Hospice program			X	
64. Hospital - based outpatient care center - services	X			
65. Housing services:				
65a. Assisted living				X
65b. Retirement housing				X
65c. Supportive housing services				X
66. Immunization program				X
67. Indigent care clinic				X
68. Linguistic/translation services			X	
69. Meal delivery services				X
70. Mobile health services				X
71. Neurological services				X
72. Nutrition programs	X			
73. Occupational health services	X			
74. Oncology services				X
75. Orthopedic services	X			
76. Outpatient surgery	X			
77. Pain management program	X			
78. Palliative care program				X
79. Palliative care inpatient unit				X
80. Patient Controlled Analgesia (PCA)	X			
81. Patient education center				X
82. Patient representative services	X			
83. Physical rehabilitation services:				
83a. Assistive technology center				X
83b. Electrodiagnostic services				X

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
83c. Physical rehabilitation outpatient services	X			
83d. Prosthetic and orthotic services				X
83e. Robot-assisted walking therapy				X
83f. Simulated rehabilitation environment	X			
84. Primary care department				X
85. Psychiatric services: 85a.Psychiatric consultation - liaison services				X
85b. Psychiatric pediatric care	(#Beds: ____)			X
85c. Psychiatric geriatric services	X (#Beds: 14)			
85d. Psychiatric education services				X
85e. Psychiatric emergency services	X			
85f. Psychiatric outpatient services				X
85g. Psychiatric intensive outpatient services				X
85h. Social and Community psychiatry				X
85i. Forensic psychiatry				X
85j. Prenatal psychiatry and Postpartum psychiatry				X
85k. Psychiatric partial hospitalization services - adult				X
85l. Psychiatric partial hospitalization services - pediatric				X
85m. Psychiatric residential treatment - adult				X
85n. Psychiatric residential treatment - pediatric				X
85o. Suicide prevention services	X			
86. Radiology, diagnostic: 86a. CT scanner	X			
86b. Diagnostic radioisotope facility	X			
86c. Electron beam computed tomography (EBCT)				X
86d. Full-field digital mammography(FFDM)	X			
86e. Magnetic resonance imaging (MRI)	X			
86f. Intraoperative magnetic resonance imaging				X

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
86g. Magnetoencephalography (MEG)	☐	☐	☐	☒
86h. Multi-slice spiral computed tomography(<64 + slice CT)	☒	☐	☐	☐
86i. Multi-slice spiral computed tomography (64+ slice CT)	☒	☐	☐	☐
86j. Positron emission tomography (PET)	☒	☐	☐	☐
86k. Positron emission tomography/CT (PET/ CT)	☒	☐	☐	☐
86l. Single photon emission computerized tomography (SPECT)	☒	☐	☐	☐
86m. Ultrasound	☒	☐	☐	☐
87. Radiology therapeutic: 87a. Image-guided Radiation Therapy(IGRT)	☒	☐	☐	☐
87b. Intensity-Modulated Radiation Therapy (IMRT)	☒	☐	☐	☐
87c. Proton beam therapy	☐	☐	☐	☒
87d. Shaped Beam Radiation System	☒	☐	☐	☐
87e. Stereotactic radiosurgery	☐	☐	☐	☒
87f. Basic interventional radiology	☐	☐	☐	☒
88. Robotic surgery	☒	☐	☐	☐
89. Rural health clinic	☐	☐	☐	☒
90. Sleep center	☒	☐	☐	☐
91. Social work services	☒	☐	☐	☐
92. Sports medicine	☐	☐	☐	☒
93. Substance use disorder care Services 93a. Substance use disorder pediatric services	☐ (#Beds: ____)	☐	☐	☒
93b. Substance use disorder outpatient services	☐	☐	☐	☒
93c. Substance use disorder partial hospitalization services	☐	☐	☐	☒
93d. Medication Assisted Treatment for Opioid Use Disorder	☐	☐	☐	☒
93e. Medication Assisted Treatment for other substance use disorders	☐	☐	☐	☒
94. Support groups	☐	☐	☐	☒
95. Swing bed services	☐	☐	☐	☒
96. Teen outreach services	☐	☐	☐	☒

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
97. Tobacco treatment / cessation program	X			
98. Telehealth 98a. Consultation and office visits				X
98b. eICU	X			
98c. Stroke care	X			
98d. Psychiatric and addiction treatment	X			
98e. Remote patient monitoring: 1. Post-discharge.				X
2. Ongoing chronic care management				X
3. Other remote patient monitoring				X
98f. Other telehealth				X
99. Transplant services: 99a. Bone marrow				X
99b. Heart				X
99c. Kidney				X
99d. Liver				X
99e. Lung				X
99f. Tissue				X
99g. Other				X
100. Transportation to health facilities (non-emergency)				X
101. Urgent care center				X
102. Violence Prevention Programs: 102a. For the workplace				X
102b. For the community				X
103. Virtual Colonoscopy				X
104. Volunteer services department	X			
105. Women's health center / services	X			
106. Wound management services	X			

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section C: Physician Arrangements	Answer	Answer (History)
107a. Does your organization routinely offer psychiatric consultation & liaison services in the following care areas?		
1. Emergency Services	Yes	Yes
2. Primary Care Services	No	No
3. Acute inpatient care	Yes	Yes
4. Extended care	No	No
107b. Does your organization routinely offer addiction/substance use disorder consultation & liaison services in the following care areas?		
1. Emergency Services	No	No
2. Primary Care Services	No	No
3. Acute inpatient care	No	No
4. Extended care	No	No
107c. Does your organization routinely screen for psychiatric disorders in the following care areas?		
1. Emergency Services	Yes	
2. Primary Care Services	No	
3. Acute inpatient care	Yes	
4. Extended care	No	
107d. Does your organization routinely screen for substance use disorders in the following care areas?		
1. Emergency Services	No	
2. Primary Care Services	No	
3. Acute inpatient care	No	
4. Extended care	No	

108a. For each of the physician-organization arrangements, please report the number of involved physicians in these arrangements.

	Number of Physicians	My Hospital	My Health System	Do Not Provide
1. Independent Practice Association (IPA)				X
2. Group practice without walls				X
3. Open Physician - Hospital Organization (PHO)				X
4. Closed Physician - Hospital Organization (PHO)				X
5. Management Service Organization (MSO)				X
6. Integrated Salary Model				X
7. Equity Model				X
8. Foundation				X
9. Other, please specify:				X

108b. For those arrangements reported in 108a., please report the approximate ownership share.

	Hospital ownership share %	Physician ownership share %	Parent corporation ownership share %	Insurance ownership share %
1. Independent Practice Association (IPA)				
2. Group practice without walls				
3. Open Physician-Hospital Organization (PHO)				
4. Closed Physician-Hospital Organization (PHO)				
5. Management Service Organization (MSO)				
6. Integrated Salary Model				
7. Equity Model				
8. Foundation				
9. Other, specified above:				

108c. If the hospital owns physician practices, how are they organized?

	Percent %	Number of Physicians
108c.1 Solo practice		
108c.2 Single specialty group		
108c.3 Multi-specialty group		

	Answer	Answer (History)
108d. Of the physician practices owned by the hospital, what percentage are primary care?		
108e. Of the physician practices owned by the hospital, what percentage are specialty care?		
109. Looking across all the relationships identified in question 108a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payors or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be any type of ownership)?	0	0
110a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?	No	No

110b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that apply).

- ☐ 1. Limited Service Hospital
- ☐ 2. Ambulatory surgical centers
- ☐ 3. Imaging Centers
- ☐ 4. Other

110c. If you selected '1'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that apply).

- ☐ 1. Cardiac
- ☐ 2. Orthopedic
- ☐ 3. Surgical
- ☐ 4. Other

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
110d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	No	No
110d. Other	No	No
Other	No	No
111a. Bed changes: a. Was there a temporary increase in the total number of beds set up and staffed for use during the reporting period?	No	No
111b. Bed changes: b. Was there a temporary increase in the total number of ICU beds set up and staffed for use during the reporting period?	No	No

112. Airborne infection isolation rooms:

	Answer	Answer (History)
a. Please indicate the total number of airborne infection isolation rooms set up at the start of the reporting period?	5	5
b. Please indicate the total number of airborne infection isolation rooms set up at the end of the reporting period?	5	5
c. Please indicate how many rooms not set up as airborne infection isolation rooms at the end of the reporting period can be converted to airborne isolation rooms?	0	
113. Temporary spaces: Please indicate if any temporary spaces such as tents or other spaces not typically used for clinical purposes were set up for using in triage, testing or treatment during the reporting period.	No	No

114. Ventilators:

a. How many adult (in use and not in use) mechanical ventilators were there in your facility at the start of the reporting period?	5	5
b. How many adult (in use and not in use) mechanical ventilators were there in your facility at the end of the reporting period?	10	5
c. How many pediatric/NICU (in use and not in use) mechanical ventilators were there in your facility at the start of the reporting period??	1	1
d. How many pediatric/NICU (in use and not in use) mechanical ventilators were there in your facility at the end of the reporting period?	1	1

	Answer	Answer (History)
115. Was there a temporary increase in the total number of emergency department beds set up and staffed for use during the reporting period?	No	No

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Insurance and Alternative Payment Models	Completed	05/31/2022	Dennis Hunger

Section D: Question	Answer
1. Does your hospital own or jointly own a health plan?	No
1a. In what states? (Select all that apply)	
2. Does your system own or jointly own a health plan?	No
2a. In what states? (Select all that apply)	
3. Does your hospital/system have a significant partnership with an insurer on an insurance company/health plan?	No
3a. In what states? (Select all that apply)	

4. Insurance
If yes, to 1, 2 and/or 3, please indicate the insurance products and the total medical enrollment (check all that apply)

Insurance Product	Hospital	System	JV	Medical Enrollment	New Product	No	Do Not Know
a. Medicare Advantage	☐	☐	☐		☐	☐	☐
b. Medicaid Managed Care	☐	☐	☐		☐	☐	☐
c. Health Insurance Marketplace ("exchange")	☐	☐	☐		☐	☐	☐
d. Other Individual Market	☐	☐	☐		☐	☐	☐
e. Small Group	☐	☐	☐		☐	☐	☐
f. Large Group	☐	☐	☐		☐	☐	☐
g. Other	☐	☐	☐		☐	☐	☐

	Answer
If yes, to 4.g. Other Please specify:	

5. Does your health plan make capitated payments to physicians either within or outside of your network for specific groups or enrollees?

a. Physicians within your network	
b. Physicians outside your network	
c. If yes, which specialties?	

Ottumwa Regional Health Center (6621105)

6. Does your health plan make bundled payments to providers in your network or to outside providers?

	Answer
a. Providers within your network	
b. Providers outside your network	
c. If yes, which specialties?	

7. Does your health plan offer shared risk contracts either to providers in your network or to outside providers? (i.e., other than capitation or bundled payment)

a. Providers within your network	
b. Providers outside your network	
c. If yes, which specialties?	

8. Does your hospital or health system fund the health benefits for your employees?	Yes
a. If yes, does the hospital or health system also administer the benefits (as opposed to contracting with a third party administrator)?	No
9. What percentage of the hospital's net patient revenue is paid on a capitated basis?	0
9a. In total, how many enrollees do you serve under capitated contracts?	
10. Does your hospital participate in any bundled payment arrangement?	No

10a. If yes, with which of the following types of payers does your hospital have a bundled payment arrangement? (Select all that apply)

- ☐ 1. Traditional Medicare
- ☐ 2. A Medicare Advantage plan
- ☐ 3. A commercial insurance plan including ACA participants, individual, group or employer markets
- ☐ 4. Medicaid

10b. For which of the following medical/surgical conditions does your hospital have a bundled payment arrangement? (Select all that apply)

- ☐ 1. Cardiovascular
- ☐ 2. Orthopedic
- ☐ 3. Oncologic
- ☐ 4. Neurology
- ☐ 5. Hematology
- ☐ 6. Gastrointestinal
- ☐ 7. Pulmonary
- ☐ 8. Infectious disease
- ☐ 9. Other please specify:

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

	Answer
10c.what percentage of the hospital's patient revenue is paid through bundled payment arrangements	
11.Does your hospital participate in a bundled payment program involving care settings outside of the hospital (e.g. physician, outpatient, post acute)?	No
11a.If yes, does your hospital share upside or downside risk with any of those outside providers?	
12. What percentage of your hospital's patient revenue is paid on a shared risk basis (other than capitated or bundled payment)?	0
13. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
14.Does your hospital have contracts with commercial payers where payment is tied to performance on quality/safety metrics?	No
15a. Has your hospital or health care system established an accountable care organization (ACO)?	4. My hospital/system has never participated or led an ACO

15b. With which of the following types of payers does your hospital/system have an accountable care contract? (Select all that apply)

- ☐ 1. Traditional Medicare (MSSP and NextGen)
- ☐ 2. A Medicare Advantage plan
- ☐ 3. A commercial insurance plan (including ACA participants, individual, group, and employer markets)
- ☐ 4. Medicaid

15c. If you selected Traditional Medicare, in which of the following Medicare programs is your hospital/system participating? (Select all that apply)

- ☐ 1. MSSP BASIC Track, Level A
- ☐ 2. MSSP BASIC Track, Level B
- ☐ 3. MSSP BASIC Track, Level C
- ☐ 4. MSSP BASIC Track, Level D
- ☐ 5. MSSP BASIC Track, Level E
- ☐ 6. MSSP ENHANCED Track
- ☐ 7. Original MSSP program, Tracks 1, 1+, 2 or 3
- ☐ 8. Comprehensive ESRD Care

15d. What percentage of your hospital's/system patients are covered by accountable care contracts?	
15e. What percentage of your hospital's/system patient revenue came from ACO contracts in 2021?	
16. Has your hospital/system ever considered participating in an ACO?	b. Yes, but we are not planning to join one

17. Do any hospitals and/or physician groups within your system or the system itself, plan to participate in any of the following risk arrangements in the next three years? (Check all that apply)

- [ ] a. Shared Savings/Losses
- [ ] b. Bundled payment
- [ ] c. Capitation
- [ ] d. ACO (Ownership)
- [ ] e. ACO (Joint Venture)
- [ ] f. Health Plan (Ownership)
- [ ] g. Health Plan (Joint Venture)
- [ ] h. Primary care transformation, including direct contracting
- [ ] i. Other, please specify:
- [X] j. None

18. Does your hospital/system have an established medical home program?

	Answer
a. Hospital	No
b. System	No

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	05/31/2022	Dennis Hunger

Section E: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	86	86		
c. Bassinets set up and staffed for use at the end of the reporting period	10	10		
d. Births (exclude fetal deaths)	400	455		
e. Admissions (exclude newborns, include neonatal & swing admissions)	2,500	2,700		
f. Inpatient days (exclude newborns, include neonatal & swing days)	13,312	13,537		
g. Emergency department visits	15,736	15,580		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	115,960	110,621		
i. Inpatient surgical operations	747	800		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	5,282	4,601		

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days &				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	1,341	1,401		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care?	436	406		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	8,074	7,975		
b. 2. How many Medicare inpatient days were Medicare Managed Care?	2,497	2,185		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	791	722		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care?	745	668		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	3,507	2,996		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care?	3,367	2,734		

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	76,619,930	71,684,985		
*b. Tax appropriations	0	0		
*c. Other operating revenue	270,624	506,936		
*d. Nonoperating revenue	1,795	619		
*e. TOTAL REVENUE (add 3a thru 3d)	76,892,349	72,192,540		
f. Payroll expenses (only)	20,338,766	21,749,810		
g. Employee benefits	5,128,469	7,357,289		
h. Depreciation expense (for reporting period only)	4,756,728	4,762,609		
i. Interest expense	237,771	146,005		
j. Pharmacy Expense	3,048,147	2,524,766		
k. Supply expense (other than pharmacy)	8,530,874	7,024,457		
l. All other expenses	28,229,343	19,269,521		
m. TOTAL EXPENSES (Add 3f thru 3l. Exclude bad debt)	70,270,098	62,834,457		

	Answer	Answer (History)
n. Do your total expenses (E3.m) reflect full allocation from your corporate office?	Yes	Yes
*4. Revenue By type		
a. Total gross inpatient revenue	86971680	84618322
b. Total gross outpatient revenue	238142583	206947418
c. Total gross patient revenue	325114263	291565740

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

*5. Uncompensated Care & Provider Taxes

a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	8327128	4416950
1. Are you able to distinguish bad debt derived from patients with or without insurance?	Yes	Yes
2. If yes, how much is from patients with insurance?	3997021	1987628
b. Financial assistance (Includes charity care) (Revenue forgone at full-established rates. Include in gross revenue.)	181333	480776
c. Is your bad debt (5a.) reported on the basis of full charges?	Yes	Yes
d. Does your state have a provider Medicaid tax/assessment program?	Yes	Yes
e. If yes, please report the total gross amount paid into the program	496467	496467
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in:		
Deductions from net Patient Revenue.....	No	No
Total Expenses.....	Yes	Yes

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	100,800,458	138,153,316	22,262,258	32,738,517
6a1b. Managed care revenue	60,125,351	0	11,086,333	0
6a1c. Total (a + b)	160,925,809	138,153,316	33,348,591	32,738,517
6a2. Medicaid:				
6a2a. Fee for service patient revenue	2,233,717	2,392,227	408,613	388,717
6a2b. Managed care revenue	66,709,902	60,133,249	10,145,529	9,771,150
6a2c. Medicaid Graduate Medical Education (GME) payments			0	0
6a2d. Medicaid Disproportionate Share Hospital Payments (DSH)			0	0
6a2e. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments			0	0
6a2f. Other Medicaid			0	0
6a2g. Total (a-f)	68,943,619	62,525,476	10,554,142	10,159,867
6a3. Other Government:	6,257,136	0	1,326,039	0
*6b. NONGOVERNMENT				
6b1. Self-pay	7,121,673	7,558,018	2,343,698	102,033
6b2. Third-party payers:				
6b2a. Managed care (includes HMO and PPO)	12,673,955	10,490,901	4,800,181	2,486,053
6b2b. Other third - party payers	69,192,071	72,838,029	24,247,279	26,198,515
6b2c. Total Third - party payers (a+b)	81,866,026	83,328,930	29,047,460	28,684,568
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	325,114,263	291,565,740	76,619,930	71,684,985

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Inpatient	Inpatient (History)	Outpatient	Outpatient (History)
*6d. If you reported receiving Medicaid Supplemental Payments on line 6.a(2)e, please break the payment total into inpatient and outpatient care.				
Medicaid supplemental payments				

	Answer	Answer (History)
*6e. If you are a government owned facility(control codes 12-16 section b), does your facility participate in the Medicaid intergovernmental transfer or certified public expenditure program.	No	No

*6f. If yes, please report gross and net revenue.	Gross	Net

	Answer	Answer (History)
*6g. Are the financial data reported from your audited financial statement?	Yes	Yes
6h. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

7. COVID RELIEF FUNDS

*Include all funds received from federal and state governments for COVID relief, such as CARES Act Provider Relief Fund payments. Do not include any funds that constitute a loan and may be on the balance sheet as a liability.

	Answer	Answer (History)
*7a. Provider/COVID Relief Funds recognized as revenue in 2021	2,506	
On which survey line did you report this revenue?		
1. Net patient revenue	No	
2. Other operating revenue	Yes	
3. Nonoperating revenue	No	
*7c. Provider/COVID Relief Funds recognized as revenue in 2020 (please do not include these dollars in 7a)	0	
*7d. Did you include these funds as revenue on the 2020 survey?	No	
*7e. If yes, on which survey line did you report this revenue?		
1. Net patient revenue		
2. Other operating revenue		
3. Nonoperating revenue		

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
*8. FINANCIAL PERFORMANCE - MARGIN		
*a. Total Margin	-4.76	13
*b. Operating Margin	4.77	13
*c. EBITDA Margin	11.24	20
*d. Medicare Margin	9.09	5
*e. Medicaid Margin	-32.02	-38
9. Fixed Assets		
9a. Property, plant and equipment at cost	73,398,680	68,767,355
9b. Accumulated depreciation	28,088,860	23,332,132
9c. Net property, plant and equipment (a - b)	45,309,820	45,435,223
9d. Total gross square feet of your physical plant used for or in support of your healthcare activities	270,499	270,499
10. Total Capital Expenses		
Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.	4,714,016	492,147
11. INFORMATION TECHNOLOGY AND CYBERSECURITY		
a. IT Operating Expense	2,372,791	2,350,419
b. IT Capital Expense.	521,662	63,608
c. Number of Employed IT staff (in FTEs).	5.30	5
d. Number of outsourced IT staff (in FTEs).	0	0
*e. What percentage of your IT budget is spent on security?	3	

*f. Which of the following cybersecurity measures does your hospital or health system currently deploy?

- [X] a. Annual risk assessment
- [ ] b. Incident response plan
- [X] c. Intrusion detection systems
- [X] d. Mobile device encryption
- [X] e. Mobile device data wiping
- [X] f. Penetration testing to identify security vulnerabilities
- [X] g. Strong password requirements
- [X] h. Two-factor authentication

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
CYBERSECURITY		
*g. Does your hospital or health system board oversight of risk management and reduction specifically include consideration of cybersecurity risk?	Yes	Yes
*h. Does your hospital or health system have cybersecurity insurance?	Yes	Yes
*i. Is your hospital or health system participating in cybersecurity information-sharing activities with an outside information Sharing and Analysis Organization to identify threats and vulnerabilities?	Yes	Yes

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

	Answer	Answer (History)
*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.		

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section E: 12. Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	0	0	0	0	0	0	0
b. Dentists	0	0	0	0	0	0	0
c. Medical residents/interns	0	0	0	0	0	0	0
d. Dental residents/interns	0	0	0	0	0	0	0
e. Other trainees	0	0	0	0	0	0	0
f. Registered nurses	72	99	65	65	93	42	35
g. Licensed practical (vocational) nurses	5	6	7	3	5	8	2
h. Nursing assistive personnel	11	20	23	21	16	6	6
i. Radiology technicians	12	11	9	4	16	4	1
j. Laboratory technicians	22	8	12	1	23	7	1
k. Pharmacists, licensed	4	3	1	1	3	0	0
l. Pharmacy technicians	2	3	0	0	3	0	2
m. Respiratory therapists	5	7	4	4	9	2	3
n. All other personnel	136	202	55	44	144	17	20
o.Total facility personnel (add 12a through 12n)(Total facility personnel (a-o) should include hospital plus nursing home type unit/facility personnel reported in 12p and 12q)	269	359	176	143	312	86	70
p. Nursing home type unit/facility Registered Nurses	0	0	0	0	0	0	0
q. Nursing home type unit/facility personnel	0	0	0	0	0	0	0

	Answer	Answer (History)
r. For your employed RN FTEs reported above (E.12f, column 3) please report the number of full-time equivalents who are involved in direct patient care.	87	54

s. For your medical residents/interns reported above (E.12c. column 1) please indicate the number of full-time on payroll by specialty.

	Answer	Answer (History)
1. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics)	0	0
2. Other Specialties	0	0

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section E: 13. Privileged Physicians	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general	0	0	3	2	5
b. Obstetrics/gynecology	0	0	3	3	6
c. Emergency medicine	0	0	12	0	12
d. Hospitalist	0	0	8	0	8
e. Intensivist	0	0	32	0	32
f. Radiologist/pathologist/anesthesiologist	0	0	34	2	36
g. Other specialist	0	0	65	18	83
h. Total (add 13a-13g)	0	0	157	25	182

14. HOSPITALISTS

	Answer	Answer (History)
14a. Do hospitalists provide care for patients in your hospital? (if yes, please report in E.13d.)	Yes	Yes
14b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	4	4

15. INTENSIVISTS

	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 16.) (if yes, please report in E.13e.)	Yes	Yes

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care	4		4	
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total	4		4	

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

16. ADVANCED PRACTICE REGISTERED NURSES / PHYSICIAN ASSISTANTS

	Answer	Answer (History)
a. Do advanced practice nurses/physician assistants provide care for patients in your hospital?(if no, please skip to 17.)	Yes	Yes

b. If yes, please report the number of full time, part time and FTE advanced practice nurses/physician assistants who provide care for patients in your hospital.

Advanced Practice Registered Nurses Full-time	4	2
Advanced Practice Registered Nurses Part-time	29	26
Advanced Practice Registered Nurses FTE	5	2
Physician Assistants Full-time	2	2
Physician Assistants Part-time	0	0
Physician Assistants FTE	2	2
c. If yes, please indicate the type of service(s) provided. (Please check all that apply)	2. Anesthesia services, 3. Emergency department care, 4. Other specialty care, 7. Other	Anesthesia services, Emergency department care, Other specialty care, Other
a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2021 vs. 2020?	More	More
b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)	Africa	Africa

18a. Does your hospital use artificial intelligence (AI) or machine learning in the following: (Check all that apply):

- [ ] 1. Predicting staffing needs
- [ ] 2. Predicting patient demand
- [ ] 3. Staff scheduling
- [ ] 4. Automating routine tasks
- [ ] 5. Optimizing administrative and clinical workflows

18b. How is your hospital incorporating workforce as part of the strategic planning process (Check all that apply):

- [X] 1. Conduct needs assessment
- [X] 2. Leadership succession planning
- [X] 3. Talent development plan
- [X] 4. Recruitment and retention planning
- [X] 5. Partnerships with elementary/HS to develop interest in health care careers
- [X] 6. Training program partnership with community colleges, vocational training programs

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Addressing Patient Social Needs and Community Social Determinants of Health	Completed	05/31/2022	Dennis Hunger

Section F: Addressing Patient Social Needs and Community Social Determinants of Health

1. Which social needs of patients/social determinants of health in communities does your hospital or health system have programs or strategies to address? (Check all that apply)

- [X] a. Housing (instability, quality, financing)
- [X] b. Food insecurity or hunger
- [X] c. Utility needs
- [X] d. Interpersonal violence
- [X] e. Transportation
- [X] f. Employment and income
- [X] g. Education
- [X] h. Social isolation (lack of family and social support)
- [X] i. Health behaviors
- [ ] j. Other, please describe

	Answer
2. Does your hospital or health system screen patients for social needs?	a. Yes for all patients

2a. If yes, please indicate which social needs are assessed. Check all that apply.

- [X] 1. Housing (instability, quality, financing)
- [X] 2. Food insecurity or hunger
- [X] 3. Utility need
- [X] 4. Interpersonal violence
- [X] 5. Transportation
- [X] 6. Employment and income
- [X] 7. Education
- [X] 8. Social isolation (lack of family and social support)
- [X] 9. Health behaviors
- [ ] 10. Other, please describe

	Answer
2b. If yes, does your hospital or health system record the social needs screening results in your electronic health record?	Yes
3. Does your hospital or health system utilize outcome metrics (for example, cost of care or readmission rates) to assess the effectiveness of interventions to address the patients' social needs?	No

4. Has your hospital or health system been able to gather data indicating that activities used to address the social determinants of health and patient social needs have resulted in any of the following (check all that apply):

- ☐ a. Better health outcomes for patients
- ☐ b. Decreased utilization of hospital or health system services
- ☐ c. Decreased health care costs
- ☐ d. Improved community health status

5. Who in your hospital or health care system is accountable for meeting health equity goals? (Check all that apply):

- ☐ a. CEO
- ☐ b. Designated Senior Executive (Chief Diversity Office, VP for DEI, etc.)
- ☐ c. Middle Management
- ☐ d. Committee or Task Force
- ☐ e. Division/Department Leaders
- ☐ f. Employee Resource Group

6. Who in your hospital or health care system is accountable for implementing strategies for health equity goals? (Check all that apply):

- ☐ a. CEO
- ☐ b. Designated Senior Executive (Chief Diversity Office, VP for DEI, etc.)
- ☐ c. Middle Management
- ☐ d. Committee or Task Force
- ☐ e. Division/Department Leaders
- ☐ f. Employee Resource Group

7. Does your hospital or health care system use DEI disaggregated data to inform decisions on the following? (Check all that apply):

- ☐ a. Patient outcomes
- ☐ b. Procurement
- ☐ c. Supply chain
- ☐ d. Training
- ☐ e. Professional development

8. Does your hospital or health care system have a health equity strategic plan for the following? (Check all that apply):

- ☐ a. Equitable and inclusive organizational policies
- ☐ b. Systematic and shared accountability for health equity
- ☐ c. Diverse representation in hospital and health care system leadership
- ☐ d. Diverse representation in hospital and health care system governance
- ☐ e. Community engagement
- ☐ f. Collection and use of segmented data to drive action
- ☐ g. Culturally appropriate patient care

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

9. Please indicate the extent of your hospital's current partnerships with external partners for population and/or community health initiatives. Which types of organizations do you currently partner with in each of the following activities? (Check all that apply)

	Not involved	Work together to meet patient social needs	Participates in our Community	Work together to implement community-level initiatives
a. Health care providers outside of your systems	☐	☐	☐	☒
b. Health insurance providers outside of your own system	☐	☒	☐	☐
c. Local or state public health departments/organizations	☐	☐	☐	☒
d. Other local or state government agencies or social service organizations	☐	☐	☐	☒
e. Faith based organizations	☐	☒	☐	☐
f. Local organizations addressing food insecurity	☐	☐	☒	☐
g. Local organizations addressing transportation needs	☐	☐	☒	☐
h. Local organizations addressing housing insecurity	☒	☐	☐	☐
i. Local organizations providing legal assistance for individuals	☒	☐	☐	☐
j. Other community non-profit organizations	☐	☐	☐	☒
k. K - 12 Schools	☐	☐	☐	☒
l. Colleges or universities	☐	☐	☐	☒
m. Local businesses or chambers of commerce	☐	☐	☒	☐
n. Law enforcement/safety forces	☐	☐	☒	☐
o. Area Behavioral Health Providers	☐	☐	☐	☒
p. Area Agencies on Aging (AAA)	☐	☒	☐	☐

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	05/31/2022	Dennis Hunger

Section G: Supplemental Information

	Answer
1. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of your primary group purchasing organization:	Yes

Name	City	State
HealthTrust	Brentwood	TN

	Answer
2. Does the hospital purchase medical/surgical supplies directly through a distributor?	Yes

If yes, please provide the name(s) of the primary distributor.

Name: Cardinal Health

Name: Medline

Name: Owens & Minor

	Answer
3. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	5
4. Does your hospital have an established patient and family advisory council that meets regularly to actively engage the perspectives of patients and families?	No
5. Utilization of telehealth/virtual care	
a. Number of video visits: Synchronous visits between patient and provider that are not co-located, through the use of two-way, interactive, real-time audio and video communication.	0
b. Number of audio visits: Synchronous visits between a patient and a provider that are not co-located, through the use of two-way, interactive, real-time audio-only communication.	0
c. Number of patients being monitored through remote patient monitoring (RPM): Asynchronous or synchronous interactions between and patient and a provider that are not co-located involving the collection, transmission, evaluation, and communication of physiological data.	0
d. Number of patients receiving other virtual services: All other synchronous or asynchronous interactions between a provider and patient or provider and provider delivered remotely including messages, eConsults, and virtual check-ins.	0
6. Does your hospital have a partnership with a Community Mental Health Center or a Certified Community Behavioral Health Center?	
a. Community Mental Health Center	No
b. Certified Community Behavioral Health Center	No

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Decarbonization Goals

	Answer
7. Which of the following describe(s) your organizations decarbonization efforts?	e. We have not set any decarbonization targets/goals and uncertain if any plans to within the year.
If yes to, have your hospital set a decarbonization percentage reduction.	
% Reduction goal (e.g. xxx.xx)	
Target year to meet goal	
Baseline year	
If yes to, net-zero emissions goal	
Target year to meet goal?	
Baseline year	

Please feel free to expand on your response in the box below:

8. The federal government has recently released ambitious goals for federal facilities. It includes achieving a carbon pollution-free electricity sector by 2035 and net-zero emissions economy-wide by no later than 2050 with a 65% reduction in Scope 1 and 2 GHG emissions from Federal operations by 2030 (from 2008 levels). Irrespective of the exact targets and years, would your organization, in principle, be willing to support similar types of goals for the health sector? You can read the announcement by clicking on the question mark in red.	c. Unsure

Please feel free to expand on your response in the box below:

9. Do you believe the decarbonization goals for the health sector should be similar, more ambitious, or less ambitious than the targets set by the federal government? (check one of the following)	d. Unsure

Please feel free to expand on your response in the box below:

10. Does your organization have an executive leader responsible for environmental sustainability, including climate change mitigation?	No

Please feel free to expand on your response in the box below:

Please indicate below whether or not you agree to these types of disclosure:	I do not grant AHA permission to release my confidential data.

Use this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Thank you for your cooperation in completing this survey. If there are any questions about your responses to this survey, who should be contacted

Your Name & Title	Dennis Hunger
Your Name & Title	CEO
Your Email Address	[redacted]
Your Phone Number	[redacted]
Your Fax Number	[redacted]

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
2021 Iowa Department of Public Health	Completed	05/31/2022	Dennis Hunger

State Supplement

	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	None
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	n/a
Bed Type Numbers - Beds and Utilization by Inpatient Service	
a. General Medical/Surgical(adult, include gynecology)	39
b. General Medical/Surgical (pediatric)	4
c. Obstetrics	17
d. Other Acute	0
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	0
f. Cardiac Intensive Care	0
g. Neonatal Intensive Care (exclude normal newborn)	0
h. Neonatal Intermediate Care	4
i. Pediatric Intensive Care	0
j. Burn Care	0
k. Other Special Care (definitive observation, step down, etc.)	0
l. Other Intensive Care	10
m. Rehabilitation	13
n. Chronic Disease	0
o. Alzheimer's or other Dementia Diagnosis	0
p. Hospice	0
q. Psychiatric Care	14
r. Substance Use Disorder	0

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
s. Developmental Disability	0
t. Skilled Nursing Care	0
u. Intermediate Care	0
v. Residential Care/Senior Housing	0
w. SubAcute Care	0
x. Total Facility (Add lines a thru w.)	101
a. Private	1771
b. Semi-Private	1771
c. OB	1688
d. Pediatric	1688
e. Substance Use Disorder Treatment	0
f. Detoxification	0
g. Rehabilitation	1465
h. Psychiatric	2021
i. Intensive Care Unit	3460
a. Amount of Charity	181333
b. Amount of Hill-Burton	0
c. Bad Debt	8327128
d. Total Non-Reimbursed	8508461
5. Data Release	[redacted]
[redacted]	

AHA Annual Survey - 2021

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	68943619
b. Medicaid Contractual Adjustments	58389477
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	10554142
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	13842321
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	-3288179
a. Charity Care Charge-level (should equal E.5b)	181333
b. Charity Care Cost-level	38577
9. a. How many total Auxiliary members and Volunteers (both adult and teen) did you have in your hospital?	43
9. b. How many total hours of service did the auxilians and volunteers give to the hospital?	1338
9. c. Total funds contributed to the hospital by the auxiliary and volunteer department?	0

Thursday, June 15, 2023

AHA Annual Survey - 2022

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Ottumwa Regional Health Center (6621105)

1001 Pennsylvania Avenue

Ottumwa, Iowa 52501

Wapello County

Survey Status
Submitted

Date Started	Date Last Edited	Date Submitted
MAY-15-23	JUN-15-23	JUN-15-23

Survey Administrators
William Kiefer

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	06/15/2023	William Kiefer

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	01/01/2022
	To (mm/dd/yyyy)	12/31/2022
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		365
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	01/01/2023

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	06/15/2023	William Kiefer

Section B: Question	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. SELECT ONLY ONE:	33 Corporation (Investor-owned, for-profit)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:	10 General medical and surgical
Other-specify treatment area:	

OTHER

3a. Does your hospital restrict admissions primarily to children?	No
3b. Does the hospital itself operate subsidiary corporations?	No
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization	No

Name	City	State

3d. Is your hospital owned in whole or in part by physicians or a physician group?	No
3e. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH or a LTCH arranged within a general acute care hospital.	

If you are arranged in a general acute care hospital, what is your host hospital's name, city and state?

Name	City	State

3f. Are any other types of hospitals co-located in your hospital?	No

3g. If you checked yes for 3f, what type of hospital is co-located? (Check all that apply)

- ☐ 1. Cancer
- ☐ 2. Cardiac
- ☐ 3. Orthopedic
- ☐ 4. Pediatric
- ☐ 5. Psychiatric
- ☐ 6. Surgical
- ☐ 7. Other

Ottumwa Regional Health Center (6621105)

3h. Is your hospital designated as a state, jurisdiction, or federal Ebola or other Special Pathogens facility? (Check all that apply.)

- [ ] 1. Federal designation: Regional Emerging Special Pathogen Treatment Center
- [ ] 2. State/Jurisdiction designation: Special Pathogen Treatment Center
- [ ] 3. State/Jurisdiction designation: Special Pathogen Assessment Hospital
- [ ] 4. Frontline facility
- [X] 5. None

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	06/15/2023	William Kiefer

Section C: Facilities and Services

	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
1. General medical - surgical care	X (#Beds: 20)			
2. Pediatric medical - surgical care	X (#Beds: 4)			
3. Obstetrics [Hospital level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	X (#Beds: 9) Level: 2			
4. Medical-surgical intensive care	(#Beds: ____)			X
5. Cardiac intensive care	(#Beds: ____)			X
6. Neonatal intensive care	(#Beds: ____)			X
7. Neonatal intermediate care	X (#Beds: 3)			
8. Pediatric intensive care	(#Beds: ____)			X
9. Burn care	(#Beds: ____)			X
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	(#Beds: ____) (Specify: ____)			X
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	X (#Beds: 4) Desc: Med/Surg Cardiac Intensive Care			
12. Physical rehabilitation	X (#Beds: 10)			
13. Substance use disorder	(#Beds: ____)			X
14. Psychiatric care	X (#Beds: 10)			
15. Skilled nursing care	(#Beds: ____)			X
16. Intermediate nursing care	(#Beds: ____)			X
17. Acute long-term care	(#Beds: ____)			X
18. Other long-term care	(#Beds: ____)			X
19. Biocontainment patient care unit	(#Beds: ____)			X
20. Other care (Please specify the type of other care provided by the hospital if applicable.)	(#Beds: ____) (Specify: ____)			X
21. Adult day care program				X
22. Airborne infection isolation room (Please specify the number of rooms)	X # Rooms: 5			

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
23. Alzheimer Center				X
24. Ambulance services	X			
25. Air Ambulance services				X
26. Ambulatory surgery center				X
27. Arthritis treatment center				X
28. Auxiliary	X			
29. Bariatric/weight control services				X
30. Birthing room - LDR room - LDRP room	X			
31. Blood Donor Center			X	
32. Breast cancer screening / mammograms	X			
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services	X			
33b. Pediatric cardiology services				X
33c. Adult diagnostic catheterization	X			
33d. Pediatric diagnostic catheterization				X
33e. Adult interventional cardiac catheterization	X			
33f. Pediatric interventional cardiac catheterization				X
33g. Adult cardiac surgery				X
33h. Pediatric cardiac surgery				X
33i. Adult cardiac electrophysiology	X			
33j. Pediatric cardiac electrophysiology				X
33k. Cardiac rehabilitation	X			
34. Case management	X			
35. Chaplaincy/pastoral care services	X			
36. Chemotherapy				X
37. Children's wellness program				X
38. Chiropractic services				X
39. Community outreach	X			
40. Complementary and alternative medicine services				X

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
41. Computer assisted orthopedic surgery (CAOS)	☐	☐	☐	☒
42. Crisis prevention	☐	☐	☐	☒
43. Dental services	☐	☐	☐	☒
44. Diabetes prevention program	☐	☐	☐	☒
45. Emergency services: 45a. On-campus emergency department	☒	☐	☐	☐
45b. Off-campus emergency department	☐	☐	☐	☒
45c. Pediatric emergency department	☒	☐	☐	☐
45d. Trauma center (certified) [Hospital Level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable). 45.e If column (1) is checked for 45d (Trauma center) does your hospital own the trauma certification?	☒ (Level: 3)	☐	☐	☐
46. Enabling services	☐	☐	☐	☒
47. Endoscopic services: 47a.Optical colonoscopy	☒	☐	☐	☐
47b. Endoscopic ultrasound	☒	☐	☐	☐
47c. Ablation of Barrett's esophagus	☐	☐	☐	☒
47d. Esophageal impedance study	☐	☐	☐	☒
47e. Endoscopic retrograde cholangiopancreatography (ERCP)	☐	☐	☐	☒
48. Enrollment (insurance) assistance services	☒	☐	☐	☐
49. Employment support services	☐	☐	☐	☒
50. Extracorporeal shock wave lithotripter (ESWL)	☒	☐	☐	☐
51. Fertility clinic	☐	☐	☐	☒
52. Fitness center	☐	☐	☐	☒
53. Freestanding outpatient care center	☐	☐	☐	☒
54. Geriatric services	☒	☐	☐	☐
55. Health fair	☒	☐	☐	☐
56. Community health education	☒	☐	☐	☐
57. Genetic testing/counseling	☐	☐	☐	☒

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
58. Health screenings	X			
59. Health research				X
60. Hemodialysis	X			
61. HIV - AIDS services				X
62. Home health services				X
63. Hospice program			X	
64. Hospital - based outpatient care center - services	X			
65. Housing services: 65a. Assisted living				X
65b. Retirement housing				X
65c. Supportive housing services				X
66. Immunization program				X
67. Indigent care clinic				X
68. Linguistic/translation services			X	
69. Meal delivery services				X
70. Mobile health services				X
71. Neurological services				X
72. Nutrition programs	X			
73. Occupational health services	X			
74. Oncology services				X
75. Orthopedic services	X			
76. Outpatient surgery	X			
77. Pain management program	X			
78. Palliative care program				X
79. Palliative care inpatient unit				X
80. Patient Controlled Analgesia (PCA)	X			
81. Patient education center				X
82. Patient representative services	X			

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
83. Physical rehabilitation services:				
83a. Assistive technology center	☐	☐	☐	☒
83b. Electrodiagnostic services	☐	☐	☐	☒
83c. Physical rehabilitation outpatient services	☒	☐	☐	☐
83d. Prosthetic and orthotic services	☐	☐	☐	☒
83e. Robot-assisted walking therapy	☐	☐	☐	☒
83f. Simulated rehabilitation environment	☒	☐	☐	☐
84. Primary care department	☐	☐	☐	☒
85. Psychiatric services: 85a.Psychiatric consultation - liaison services	☐	☐	☐	☒
85b. Psychiatric pediatric care	☐ (#Beds: ____)	☐	☐	☒
85c. Psychiatric geriatric services	☒ (#Beds: 10)	☐	☐	☐
85d. Psychiatric education services	☐	☐	☐	☒
85e. Psychiatric emergency services	☒	☐	☐	☐
85f. Psychiatric outpatient services	☐	☐	☐	☒
85g. Psychiatric intensive outpatient services	☐	☐	☐	☒
85h. Social and Community psychiatry	☐	☐	☐	☒
85i. Forensic psychiatry	☐	☐	☐	☒
85j. Prenatal psychiatry and Postpartum psychiatry	☐	☐	☐	☒
85k. Psychiatric partial hospitalization services - adult	☐	☐	☐	☒
85l. Psychiatric partial hospitalization services - pediatric	☐	☐	☐	☒
85m. Psychiatric residential treatment - adult	☐	☐	☐	☒
85n. Psychiatric residential treatment - pediatric	☐	☐	☐	☒
85o. Suicide prevention services	☒	☐	☐	☐
86. Radiology, diagnostic: 86a. CT scanner	☒	☐	☐	☐
86b. Diagnostic radioisotope facility	☒	☐	☐	☐
86c. Electron beam computed tomography (EBCT)	☐	☐	☐	☒
86d. Full-field digital mammography(FFDM)	☒	☐	☐	☐

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
86e. Magnetic resonance imaging (MRI)	X			
86f. Intraoperative magnetic resonance imaging				X
86g. Magnetoencephalography (MEG)				X
86h. Multi-slice spiral computed tomography(<64 + slice CT)	X			
86i. Multi-slice spiral computed tomography (64+ slice CT)	X			
86j. Positron emission tomography (PET)	X			
86k. Positron emission tomography/CT (PET/ CT)	X			
86l. Single photon emission computerized tomography (SPECT)	X			
86m. Ultrasound	X			
87. Radiology therapeutic: 87a. Image-guided Radiation Therapy(IGRT)	X			
87b. Intensity-Modulated Radiation Therapy (IMRT)	X			
87c. Proton beam therapy				X
87d. Shaped Beam Radiation System	X			
87e. Stereotactic radiosurgery				X
87f. Basic interventional radiology				X
88. Robotic surgery	X			
89. Rural health clinic				X
90. Sleep center	X			
91. Social work services	X			
92. Sports medicine				X
93. Substance use disorder care Services 93a. Substance use disorder pediatric services	(#Beds: ____)			X
93b. Substance use disorder outpatient services				X
93c. Substance use disorder partial hospitalization services				X
93d. Medication Assisted Treatment for Opioid Use Disorder				X
93e. Medication Assisted Treatment for other substance use disorders				X

Ottumwa Regional Health Center (6621105)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
94. Support groups				X
95. Swing bed services				X
96. Teen outreach services				X
97. Tobacco treatment / cessation program	X			
98. Telehealth 98a. Consultation and office visits				X
98b. eICU				X
98c. Stroke care	X			
98d. Psychiatric and addiction treatment	X			
98e. Remote patient monitoring: 1. Post-discharge.				X
2. Ongoing chronic care management				X
3. Other remote patient monitoring				X
98f. Other telehealth				X
99. Transplant services: 99a. Bone marrow				X
99b. Heart				X
99c. Kidney				X
99d. Liver				X
99e. Lung				X
99f. Tissue				X
99g. Other				X
100. Transportation to health facilities (non-emergency)				X
101. Urgent care center				X
102. Violence Prevention Programs: 102a. For the workplace				X
102b. For the community				X
103. Virtual Colonoscopy				X
104. Volunteer services department	X			
105. Women's health center / services	X			
106. Wound management services	X			

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section C: Physician Arrangements	Answer	Answer (History)
107a. Does your organization routinely offer psychiatric consultation & liaison services in the following care areas?		
1. Emergency Services	Yes	Yes
2. Primary Care Services	No	No
3. Acute inpatient care	Yes	Yes
4. Extended care	No	No
107b. Does your organization routinely offer addiction/substance use disorder consultation & liaison services in the following care areas?		
1. Emergency Services	No	No
2. Primary Care Services	No	No
3. Acute inpatient care	No	No
4. Extended care	No	No
107c. Does your organization routinely screen for psychiatric disorders in the following care areas?		
1. Emergency Services	Yes	Yes
2. Primary Care Services	No	No
3. Acute inpatient care	Yes	Yes
4. Extended care	No	
107d. Does your organization routinely screen for substance use disorders in the following care areas?		
1. Emergency Services	No	No
2. Primary Care Services	No	No
3. Acute inpatient care	No	No
4. Extended care	No	

108a. For each of the physician-organization arrangements, please report the number of involved physicians in these arrangements.

	Number of Physicians	My Hospital	My Health System	Do Not Provide
1. Independent Practice Association (IPA)				X
2. Group practice without walls				X
3. Open Physician - Hospital Organization (PHO)				X
4. Closed Physician - Hospital Organization (PHO)				X
5. Management Service Organization (MSO)				X
6. Integrated Salary Model				X
7. Equity Model				X
8. Foundation				X
9. Other, please specify:				X

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

108b. For those arrangements reported in 108a., please report the approximate ownership share.

	Hospital ownership share %	Physician ownership share %	Parent corporation ownership share %	Insurance ownership share %
1. Independent Practice Association (IPA)				
2. Group practice without walls				
3. Open Physician-Hospital Organization (PHO)				
4. Closed Physician-Hospital Organization (PHO)				
5. Management Service Organization (MSO)				
6. Integrated Salary Model				
7. Equity Model				
8. Foundation				
9. Other, specified above:				

108c. If the hospital owns physician practices, how are they organized?

	Percent %	Number of Physicians
108c.1 Solo practice		
108c.2 Single specialty group		
108c.3 Multi-specialty group		

	Answer	Answer (History)
108d. Of the physician practices owned by the hospital, what percentage are primary care?		
108e. Of the physician practices owned by the hospital, what percentage are specialty care?		
109. Looking across all the relationships identified in question 108a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payers or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be any type of ownership)?	0	0
110a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?	No	No

110b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that apply).

- ☐ 1. Limited Service Hospital
- ☐ 2. Ambulatory surgical centers
- ☐ 3. Imaging Centers
- ☐ 4. Other

110c. If you selected '1'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that apply).

- ☐ 1. Cardiac
- ☐ 2. Orthopedic
- ☐ 3. Surgical
- ☐ 4. Other

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
110d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	No	No
111a. Bed changes: a. Was there a temporary increase in the total number of beds set up and staffed for use during the reporting period?	No	No
111b. Bed changes: b. Was there a temporary increase in the total number of ICU beds set up and staffed for use during the reporting period?	No	No

112. Airborne infection isolation rooms:

	Answer	Answer (History)
a. Please indicate the total number of airborne infection isolation rooms set up at the start of the reporting period?	5	5
b. Please indicate the total number of airborne infection isolation rooms set up at the end of the reporting period?	5	5
c. Please indicate how many rooms not set up as airborne infection isolation rooms at the end of the reporting period can be converted to airborne isolation rooms?	0	0
113. Temporary spaces: Please indicate if any temporary spaces such as tents or other spaces not typically used for clinical purposes were set up for using in triage, testing or treatment during the reporting period.	No	No

114. Ventilators:

a. How many adult (in use and not in use) mechanical ventilators were there in your facility at the start of the reporting period?	10	5
b. How many adult (in use and not in use) mechanical ventilators were there in your facility at the end of the reporting period?	10	10
c. How many pediatric/NICU (in use and not in use) mechanical ventilators were there in your facility at the start of the reporting period??	1	1
d. How many pediatric/NICU (in use and not in use) mechanical ventilators were there in your facility at the end of the reporting period?	1	1
115. Was there a temporary increase in the total number of emergency department beds set up and staffed for use during the reporting period?	No	No

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Insurance and Alternative Payment Models	Completed	06/15/2023	William Kiefer

Section D: Question	Answer
1. Does your hospital own or jointly own a health plan?	No
1a. In what states? (Select all that apply)	
2. Does your system own or jointly own a health plan?	No
2a. In what states? (Select all that apply)	
3. Does your hospital/system have a significant partnership with an insurer on an insurance company/health plan?	No
3a. In what states? (Select all that apply)	

4. Insurance
If yes, to 1, 2 and/or 3, please indicate the insurance products (check all that apply)

Insurance Product	Hospital	System	JV	No	Do Not Know
a. Medicare Advantage	☐	☐	☐	☐	☐
b. Medicaid Managed Care	☐	☐	☐	☐	☐
c. Health Insurance Marketplace ("exchange")	☐	☐	☐	☐	☐
d. Other Individual Market	☐	☐	☐	☐	☐
e. Small Group	☐	☐	☐	☐	☐
f. Large Group	☐	☐	☐	☐	☐
g. Other	☐	☐	☐	☐	☐

	Answer
If yes, to 4.g. Other Please specify:	

5. Does your health plan make capitated payments to physicians either within or outside of your network for specific groups or enrollees?

a. Physicians within your network	
b. Physicians outside your network	
c. If yes, which specialties?	

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

6. Does your health plan make bundled payments to providers in your network or to outside providers?

	Answer
a. Providers within your network	
b. Providers outside your network	
c. If yes, which specialties?	

7. Does your health plan offer shared risk contracts either to providers in your network or to outside providers? (i.e., other than capitation or bundled payment)

a. Providers within your network	
b. Providers outside your network	
c. If yes, which specialties?	

8. Does your hospital or health system fund the health benefits for your employees?	Yes
a. If yes, does the hospital or health system also administer the benefits (as opposed to contracting with a third party administrator)?	No
9. What percentage of the hospital's net patient revenue is paid on a capitated basis?	0
9a. In total, how many patients do you serve under capitated contracts?	
10. Does your hospital participate in any bundled payment arrangements?	No

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

10a. For which of the following payers and medical/surgical conditions does your hospital have a bundled payment arrangement? (Check all that apply).

	(a) Traditional Medicare	(b) Medicare Advantage Plan	(c) Commercial Insurance Plan	(d) Medicaid
1. Cardiovascular	☐	☐	☐	☐
2. Orthopedic	☐	☐	☐	☐
3. Oncologic	☐	☐	☐	☐
4. Neurology	☐	☐	☐	☐
5. Hematology	☐	☐	☐	☐
6. Gastrointestinal	☐	☐	☐	☐
7. Pulmonary	☐	☐	☐	☐
8. Infectious Disease	☐	☐	☐	☐
9. Hospitalist	☐	☐	☐	☐
10. Nephrology	☐	☐	☐	☐
11. Obstetrics	☐	☐	☐	☐
12. Endocrinology	☐	☐	☐	☐
13. Psychiatric Disorders	☐	☐	☐	☐
14. Substance Use Disorders	☐	☐	☐	☐
15. Other:	☐	☐	☐	☐

	Answer
10b.what percentage of the hospital's patient revenue is paid through bundled payment arrangements	
11.Does your hospital participate in a bundled payment program involving care settings outside of the hospital (e.g. physician, outpatient, post acute)?	
11a.If yes, does your hospital share upside or downside risk with any of those outside providers?	
12. What percentage of your hospital's patient revenue is paid on a shared risk basis (other than capitated or bundled payment)?	0
13. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
14.Does your hospital have contracts with commercial payers where payment is tied to performance on quality/ safety metrics?	No

15a. Has your hospital or health care system established an accountable care organization (ACO)?

- ☐ 1. My hospital/system currently leads an ACO
- ☐ 2. My hospital/system currently participates in an ACO (but is not its leader)
- ☐ 3. My hospital/system previously led or participated in an ACO but is no longer doing so
- ☒ 4. My hospital/system has never participated or led an ACO

15b. With which of the following types of payers does your hospital/system have an accountable care contract? (Select all that apply)

- [ ] 1. Traditional Medicare (MSSP and NextGen)
- [ ] 2. A Medicare Advantage plan
- [ ] 3. A commercial insurance plan (including ACA participants, individual, group, and employer markets)
- [ ] 4. Medicaid

15c. If you selected Traditional Medicare, in which of the following Medicare programs is your hospital/system participating? (Select all that apply)

- [ ] 1. MSSP BASIC Track, Level A
- [ ] 2. MSSP BASIC Track, Level B
- [ ] 3. MSSP BASIC Track, Level C
- [ ] 4. MSSP BASIC Track, Level D
- [ ] 5. MSSP BASIC Track, Level E
- [ ] 6. MSSP ENHANCED Track
- [ ] 7. Original MSSP program, Tracks 1, 1+, 2 or 3
- [ ] 8. Comprehensive ESRD Care

	Answer
15d. What percentage of your hospital's/system patients are covered by accountable care contracts?	
15e. What percentage of your hospital's/system patient revenue came from ACO contracts in 2022?	

16. Has your hospital/system ever considered participating in an ACO?

- [ ] a. Yes, and we are planning to join one
- [X] b. Yes, but we are not planning to join one
- [ ] c. No, we have not even considered it

17. Do any hospitals and/or physician groups within your system or the system itself, plan to participate in any of the following risk arrangements in the next three years? (Check all that apply)

- [ ] a. Shared Savings/Losses
- [ ] b. Bundled payment
- [ ] c. Capitation
- [ ] d. ACO (Ownership)
- [ ] e. ACO (Joint Venture)
- [ ] f. Health Plan (Ownership)
- [ ] g. Health Plan (Joint Venture)
- [ ] h. Primary care transformation, including direct contracting
- [ ] i. Other, please specify:
- [X] j. None

18. Does your hospital/system have an established medical home program?

	Answer
a. Hospital	No
b. System	No

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	06/15/2023	William Kiefer

Section E: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	217	217		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	60	86		
c. Bassinets set up and staffed for use at the end of the reporting period	10	10		
d. Births (exclude fetal deaths)	356	400		
e. Admissions (exclude newborns, include neonatal & swing admissions)	2,122	2,500		
f. Inpatient days (exclude newborns, include neonatal & swing days)	11,168	13,312		
g. Emergency department visits	15,750	15,736		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	108,983	115,960		
i. Inpatient surgical operations	512	747		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	4,900	5,282		

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
2. UTILIZATION BY PAYER (exclude newborns, Include neonatal & swing days & deaths)				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	1,077	1,341		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care?	451	436		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	6,460	8,074		
b. 2. How many Medicare inpatient days were Medicare Managed Care?	2,398	2,497		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	796	791		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care?	637	745		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	2,943	3,507		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care?	2,705	3,367		
e. 1. Total self-pay inpatient discharges	70			
e. 2. Total self-pay inpatient days	88			
f. 1. Total third-party (non-Medicare, non-Medicaid) inpatient discharges	520			
f. 2. Total third-party (non-Medicare, non-Medicaid) inpatient days	1,569			
g. 1. Other payer (government and non-government inpatient discharges	25			
g. 2. Other payer (government and non-government inpatient days	108			
h. Total inpatient discharges (all payers)(add a1,c1,e1,f1,g1)	2,488			

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	68,176,618	76,619,930		
*b. Tax appropriations	0	0		
*c. Other operating revenue	180,828	270,624		
*d. Nonoperating revenue	10,805	1,795		
*e. TOTAL REVENUE (add 3a thru 3d)	68,368,251	76,892,349		
f. Payroll expenses (only)	22,896,737	20,338,766		
g. Employee benefits	3,812,756	5,128,469		
h. Depreciation expense (for reporting period only)	4,622,443	4,756,728		
i. Interest expense	123,920	237,771		
j. Pharmacy Expense	4,389,783	3,048,147		
k. Supply expense (other than pharmacy)	6,319,400	8,530,874		
l. All other expenses	29,338,999	28,229,343		
m. TOTAL EXPENSES (Add 3f thru 3l. Exclude bad debt)	71,504,038	70,270,098		

	Answer	Answer (History)
n. Do your total expenses (E3.m) reflect full allocation from your corporate office?	Yes	Yes
*4. Revenue By Type		
a. Total gross inpatient revenue	77542140	86971680
b. Total gross outpatient revenue	243204265	238142583
c. Total gross patient revenue	320746405	325114263
*5. Uncompensated Care & Provider Taxes		
a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	8169203	8327128
1. Are you able to distinguish bad debt derived from patients with or without insurance?	Yes	Yes
2. If yes, how much is from patients with insurance?	3676141	3997021
b. Financial assistance (Includes charity care) (Revenue forgone at full-established rates. Include in gross revenue.)	118451	181333
c. Is your bad debt (5a.) reported on the basis of full charges?	Yes	Yes
d. Does your state have a provider Medicaid tax/assessment program?	Yes	Yes
e. If yes, please report the total gross amount paid into the program	496467	496467
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in:		
Deductions from net Patient Revenue.....	No	No
Total Expenses.....	Yes	Yes

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	88,974,311	100,800,458	19,001,308	22,262,258
6a1b. Managed care revenue	67,826,643	60,125,351	11,366,212	11,086,333
6a1c. Total (a + b)	156,800,954	160,925,809	30,367,520	33,348,591
6a2. Medicaid:				
6a2a. Fee for service patient revenue	2,627,831	2,233,717	481,991	408,613
6a2b. Managed care revenue	67,611,225	66,709,902	10,467,281	10,145,529
6a2c. Medicaid Graduate Medical Education (GME) payments			0	0
6a2d. Medicaid Disproportionate Share Hospital Payments (DSH)			30,399	0
6a2e. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments			0	0
6a2f. Other Medicaid			0	0
6a2g. Total (a-f)	70,239,056	68,943,619	10,979,671	10,554,142
6a3. Other Government:	5,988,761	6,257,136	1,138,423	1,326,039
*6b. NONGOVERNMENT				
6b1. Self-pay	6,392,366	7,121,673	446,460	2,343,698
6b2. Third-party payers:				
6b2a. Managed care (includes HMO and PPO)	11,806,154	12,673,955	4,139,261	4,800,181
6b2b. Other third - party payers	69,519,114	69,192,071	21,105,283	24,247,279
6b2c. Total Third - party payers (a+b)	81,325,268	81,866,026	25,244,544	29,047,460
6b3. All Other nongovernment	0	0	0	0
*6c. TOTAL	320,746,405	325,114,263	68,176,618	76,619,930

*6d. If you reported receiving Medicaid Supplemental Payments on line 6.a(2)e, please break the payment total into inpatient and outpatient care.

	Inpatient	Inpatient (History)	Outpatient	Outpatient (History)
Medicaid supplemental payments				

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section E: Question (continued)	Answer	Answer (History)
*6e. If you are a government owned facility(control codes 12-16 section b), does your facility participate in the Medicaid intergovernmental transfer or certified public expenditure program.	No	No

	Gross	Net
*6f. If yes, please report gross and net revenue.		

	Answer	Answer (History)
*6g. Are the financial data reported from your audited financial statement?	Yes	Yes
6h. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

7. COVID RELIEF FUNDS

*Include all funds received from federal and state governments for COVID relief, such as CARES Act Provider Relief Fund payments. Do not include any funds that constitute a loan and may be on the balance sheet as a liability.

*7a. Provider/COVID Relief Funds recognized as revenue in 2022	0	2,506
*7b. On which survey line did you report this revenue?		
1. Net patient revenue	No	No
2. Other operating revenue	No	
3. Nonoperating revenue	No	
*7c. Provider/COVID Relief Funds recognized as revenue in 2021 (please do not include these dollars in 7a)	2,506	0
*7d. Did you include these funds as revenue on the 2021 survey?	Yes	
*7e. If yes, on which survey line did you report this revenue?		
1. Net patient revenue	No	
2. Other operating revenue	Yes	
3. Nonoperating revenue	No	
*8. FINANCIAL PERFORMANCE - MARGIN		
*a. Total Margin	-17.97	-5
*b. Operating Margin	-9.47	5
*c. EBITDA Margin	-2.38	11
*d. Medicare Margin	-22.90	9
*e. Medicaid Margin	-37.50	-31
9. Fixed Assets		
9a. Property, plant and equipment at cost	78,847,933	73,398,680
9b. Accumulated depreciation	34,021,256	28,088,860
9c. Net property, plant and equipment (a - b)	44,826,677	45,309,820
9d. Total gross square feet of your physical plant used for or in support of your healthcare activities	270,499	270,499

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
10. Total Capital Expenses		
Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.	3,196,380	4,714,016
11. Information Technology and Cybersecurity		
a. *Overall IT Budget	2,611,211	2,372,791
b. *Number of internal IT staff (in FTEs)	5	5
c. *What percent of your IT budget is spent on cybersecurity?	3	3
d. *Number of internal staff devoted to cybersecurity (in FTEs)	0	
e. *Number of outsourced staff devoted to cybersecurity (in FTEs)	0	0
f. *What position does your cybersecurity lead report to?	N/A	
g. *Does your organization rank cybersecurity as an enterprise risk issue?	Yes	
h. *If yes, what priority number to rank it as?	0	
i. *How often is the board briefed on cybersecurity?	Other: Unknown	
j. *What do you view as your biggest cybersecurity threat? (Please rank the choices 1-9, with 1 being the biggest threat)		
1. Ransomware which may disrupt and delay patient care delivery	2	
2. Ransomware which may disrupt business operations	3	
3. Theft of sensitive patient data such as Protected Health Information (PHI) or Personally Identifiable Information (PII)	6	
4. Theft of medical research or intellectual property	9	
5. Cyber risk exposure through business associates. Business associate as conduit for cyber attacks or theft of your data stored by third parties	4	
6. Software and supply chain cyber risk	7	
7. Medical device cyber risk	8	
8. Phishing emails or other social engineering attacks which may result in the delivery of malware or ransomware into the organization	1	
9. Phishing emails or other social engineering attacks which may result in the theft of funds	5	

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

	Answer	Answer (History)
k. *Does your organization use any of the following cybersecurity techniques? (Check yes or no)		
1. Enterprise wide multi-factor authentication for all remote access to networks, data and applications	Yes	
2. Network segmentation	Yes	
3. Off line, network segmented, redundant network and data back ups	Yes	
4. Immutable backups		
5. Intrusion detection systems	Yes	
6. Employee cybersecurity education including phishing email simulations	Yes	
7. 24/7 Security Operations Center (SOC) monitoring all cyber incidents and events	Yes	
8. Highly efficient and effective patch management program	Yes	
9. Forced password change every 90 days or less	No	
10. Integration of cyber incident response plans with emergency management plans	No	
11. Cross function cyber incident response exercise for all leaders	No	
12. Relationship with local FBI and CISA offices	Yes	
13. Third Party Risk Management Program which assesses business associate access to networks and bulk sensitive data; mission criticality and life criticality of third party	No	

l. *How confident are you in the organization's ability to sustain care delivery through manual downtime procedures for up to four weeks, without the benefit of network and internet connected technology?

- [ ] 1. Confident
- [ ] 2. Somewhat confident
- [x] 3. Uncertain
- [ ] 4. Somewhat not confident
- [ ] 5. Not confident

m. *What do you view as your biggest challenges in improving your organization's cybersecurity posture? Please rank choices 1-6, with 1 being the biggest challenge

1. Funding	3	
2. Staffing	1	
3. Legacy insecure technology	2	
4. Leadership support	6	
5. Organizational culture	5	
6. Non-compliant third parties/business associates	4	

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

12. STAFFING	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	0	0	0	0	0	0	0
b. Dentists	0	0	0	0	0	0	0
c. Medical residents/interns	0	0	0	0	0	0	0
d. Dental residents/interns	0	0	0	0	0	0	0
e. Other trainees	0	0	0	0	0	0	0
f. Registered nurses	69	72	55	65	94.93	74	42
g. Licensed practical (vocational) nurses	4	5	4	7	4.93	3	8
h. Nursing assistive personnel	19	11	18	23	13.2	4	6
i. Radiology technicians	10	12	5	9	11.93	8	4
j. Laboratory technicians	10	22	15	12	26.67	9	7
k. Pharmacists, licensed	3	4	0	1	3	1	0
l. Pharmacy technicians	3	2	0	0	2.66	2	0
m. Respiratory therapists	6	5	4	4	8.62	4	2
n. All other personnel	161	136	165	55	137.86	31	17
o.Total facility personnel (add 12a through 12n)(Total facility personnel (a-o) should include hospital plus nursing home type unit/facility personnel reported in 12p and 12q)	285	269	266	176	303.8	136	86
p. Nursing home type unit/facility Registered Nurses	0	0	0	0	0	0	0
q. Nursing home type unit/facility personnel	0	0	0	0	0	0	0

	Answer	Answer (History)
r. For your employed RN FTEs reported above (E.12f. column 3) please report the number of full-time equivalents who are involved in direct patient care.	88.29	87

s. For your medical residents/interns reported above (E.12c. column 1) please indicate the number of full-time on payroll by specialty.

	Answer	Answer (History)
1. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics)	0	0
2. Other Specialties	0	0

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Please report the number of contracted FTEs for each occupational category. Personnel that are on the hospitals payroll and reported in E(12) should not be reported here.

13. CONTRACTED STAFF	CONTRACTED FTES	CONTRACTED FTES (History)
a. Registered nurses	13.12	
b. Radiology technicians	0.65	
c. Laboratory technicians	2.68	
d. Pharmacists licensed	0	
e. Pharmacy technicians	0	
f. Respiratory therapists	0.26	
g. All other contracted staff	0.91	

14. PRIVILEGED PHYSICIANS	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics)	0	0	3	4	7
b. Obstetrics/gynecology	0	0	3	2	5
c. Emergency medicine	0	0	12	0	12
d. Hospitalist	0	0	9	0	9
e. Intensivist	0	0	30	0	30
f. Radiologist/pathologist/anesthesiologist	0	0	35	0	35
g. Other specialist	0	0	63	11	74
h. Total (add 14a-14g)	0	0	155	17	172

15. HOSPITALISTS

	Answer	Answer (History)
15a. Do hospitalists provide care for patients in your hospital? (if yes, please report in E.14d.)	Yes	Yes
15b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	4	4

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

16. INTENSIVISTS

	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 17) (if yes, please report in E.14e.)	Yes	Yes

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are authorized to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care	4		4	
2. Cardiac intensive care	0			
3. Neonatal intensive care	0			
4. Pediatric intensive care	0			
5. Other intensive care	0			
6. Total	4		4	

17. ADVANCED PRACTICE REGISTERED NURSES / PHYSICIAN ASSISTANTS

	Answer	Answer (History)
a. Do advanced practice nurses/physician assistants provide care for patients in your hospital?(if no, please skip to 18)	Yes	Yes

b. If yes, please report the number of full time, part time and FTE advanced practice nurses/physician assistants who provide care for patients in your hospital.

Advanced Practice Registered Nurses Full-time	6	4
Advanced Practice Registered Nurses Part-time	26	29
Advanced Practice Registered Nurses FTE	6	5
Physician Assistants Full-time	2	2
Physician Assistants Part-time	0	0
Physician Assistants FTE	2	2

c. If yes, please indicate the type of service(s) provided. (Please check all that apply)

- [X] 1. Primary care
- [X] 2. Anesthesia services
- [X] 3. Emergency department care
- [X] 4. Other specialty care
- [ ] 5. Patient education
- [ ] 6. Case management
- [ ] 7. Other

18. FOREIGN EDUCATED NURSES

a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2022 vs. 2021?

- [ ] Did not hire foreign nurses
- [ ] Less
- [ ] More
- [X] Same

b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)

- [X] Africa
- [ ] Canada
- [ ] China
- [ ] India
- [ ] Other
- [ ] Philippines
- [ ] South Korea

19. WORKFORCE

19a. Does your hospital use artificial intelligence (AI) or machine learning in the following: (Check all that apply):

- [ ] 1. Predicting staffing needs
- [ ] 2. Predicting patient demand
- [ ] 3. Staff scheduling
- [ ] 4. Automating routine tasks
- [ ] 5. Optimizing administrative and clinical workflows
- [X] 6. None of the above

19b. How is your hospital incorporating workforce as part of the strategic planning process (Check all that apply):

- [X] 1. Conduct needs assessment
- [X] 2. Leadership succession planning
- [X] 3. Talent development plan
- [X] 4. Recruitment and retention planning
- [X] 5. Partnerships with elementary/HS to develop interest in health care careers
- [X] 6. Training program partnership with community colleges, vocational training programs
- [ ] 7. None of the above

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Addressing Patient Social Needs and Community Social Determinants of Health	Completed	06/15/2023	William Kiefer

Section F: Addressing Patient Social Needs and Community Social Determinants of Health

1. Which social needs of patients/social determinants of health in communities does your hospital or health system have programs or strategies to address? (Check all that apply)

- [X] a. Housing (instability, quality, financing)
- [X] b. Food insecurity or hunger
- [X] c. Utility needs
- [X] d. Interpersonal violence
- [X] e. Transportation
- [X] f. Employment and income
- [X] g. Education
- [X] h. Social isolation (lack of family and social support)
- [X] i. Health behaviors
- [ ] j. Other, please describe:

	Answer
2. Does your hospital or health system screen patients for social needs?	a. Yes for all patients

2a. If yes, please indicate which social needs are assessed. Check all that apply.

- [X] 1. Housing (instability, quality, financing)
- [X] 2. Food insecurity or hunger
- [X] 3. Utility need
- [X] 4. Interpersonal violence
- [X] 5. Transportation
- [X] 6. Employment and income
- [X] 7. Education
- [X] 8. Social isolation (lack of family and social support)
- [X] 9. Health behaviors
- [ ] 10. Other, please describe

	Answer
2b. If yes, does your hospital or health system record the social needs screening results in your electronic health record?	Yes
3. Does your hospital or health system utilize outcome metrics (for example, cost of care or readmission rates) to assess the effectiveness of interventions to address the patients' social needs?	No

4. Has your hospital or health system been able to gather data indicating that activities used to address the social determinants of health and patient social needs have resulted in any of the following (check all that apply):

- [ ] a. Better health outcomes for patients
- [ ] b. Decreased utilization of hospital or health system services
- [ ] c. Decreased health care costs
- [ ] d. Improved community health status
- [X] e. None of the above

5. Who in your hospital or health care system is accountable for meeting health equity goals? (Check all that apply):

- [ ] a. CEO
- [X] b. Designated Senior Executive (Chief Diversity Office, VP for DEI, etc.)
- [ ] c. Middle Management
- [ ] d. Committee or Task Force
- [ ] e. Division/Department Leaders
- [ ] f. Employee Resource Group
- [ ] g. None of the above

6. Who in your hospital or health care system is accountable for implementing strategies for health equity goals? (Check all that apply):

- [ ] a. CEO
- [X] b. Designated Senior Executive (Chief Diversity Office, VP for DEI, etc.)
- [ ] c. Middle Management
- [ ] d. Committee or Task Force
- [ ] e. Division/Department Leaders
- [ ] f. Employee Resource Group
- [ ] g. None of the above

7. Does your hospital or health care system use DEI disaggregated data to inform decisions on the following? (Check all that apply):

- [X] a. Patient outcomes
- [ ] b. Procurement
- [ ] c. Supply chain
- [ ] d. Training
- [ ] e. Professional development
- [ ] f. None of the above

8. Does your hospital or health care system have a health equity strategic plan for the following? (Check all that apply):

- [ ] a. Equitable and inclusive organizational policies
- [ ] b. Systematic and shared accountability for health equity
- [ ] c. Diverse representation in hospital and health care system leadership
- [ ] d. Diverse representation in hospital and health care system governance
- [ ] e. Community engagement
- [ ] f. Collection and use of segmented data to drive action
- [X] g. Culturally appropriate patient care
- [ ] h. None of the above

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

9. Please indicate the extent of your hospital's current partnerships with external partners for population and/or community health initiatives. Which types of organizations do you currently partner with in each of the following activities? (Check all that apply)

	Not involved	Work together to meet patient social needs	Participates in our Community	Work together to implement community-level initiatives
a. Health care providers outside of your systems	☐	☐	☐	☒
b. Health insurance providers outside of your own system	☐	☒	☐	☐
c. Local or state public health departments/organizations	☐	☐	☐	☒
d. Other local or state government agencies or social service organizations	☐	☐	☐	☒
e. Faith based organizations	☐	☒	☐	☐
f. Local organizations addressing food insecurity	☐	☐	☒	☐
g. Local organizations addressing transportation needs	☐	☐	☒	☐
h. Local organizations addressing housing insecurity	☒	☐	☐	☐
i. Local organizations providing legal assistance for individuals	☒	☐	☐	☐
j. Other community non-profit organizations	☐	☐	☐	☒
k. K - 12 Schools	☐	☐	☐	☒
l. Colleges or universities	☐	☐	☐	☒
m. Local businesses or chambers of commerce	☐	☐	☒	☐
n. Law enforcement/safety forces	☐	☐	☒	☐
o. Area Behavioral Health Providers	☐	☐	☐	☒
p. Area Agencies on Aging (AAA)	☐	☒	☐	☐

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	06/15/2023	William Kiefer

Section G: Supplemental Information

	Answer
1. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of your primary group purchasing organization:	Yes

Name	City	State
Healthtrust Purchasing Group (HPG)	Brentwood	TN

	Answer
2. Does the hospital purchase medical/surgical supplies directly through a distributor?	Yes

If yes, please provide the name(s) of the primary distributor.

Name: Cardinal Health

Name: Medline

Name: Owens & Minor

	Answer
3. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	0
4. Does your hospital have an established patient and family advisory council that meets regularly to actively engage the perspectives of patients and families?	No
5. Utilization of telehealth/virtual care	
a. Number of video visits: Synchronous visits between patient and provider that are not co-located, through the use of two-way, interactive, real-time audio and video communication.	0
b. Number of audio visits: Synchronous visits between a patient and a provider that are not co-located, through the use of two-way, interactive, real-time audio-only communication.	0
c. Number of patients being monitored through remote patient monitoring (RPM): Asynchronous or synchronous interactions between and patient and a provider that are not co-located involving the collection, transmission, evaluation, and communication of physiological data.	0
d. Number of patients receiving other virtual services: All other synchronous or asynchronous interactions between a provider and patient or provider and provider delivered remotely including messages, eConsults, and virtual check-ins.	0
6. Does your hospital have a partnership with a Community Mental Health Center or a Certified Community Behavioral Health Center?	
a. Community Mental Health Center	No
b. Certified Community Behavioral Health Center	No

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Decarbonization Goals

	Answer
7. Which of the following describe(s) your organizations decarbonization efforts?	e. We have not set any decarbonization targets/goals and uncertain if any plans to within the year.
If yes to, have your hospital set a decarbonization percentage reduction.	
% Reduction goal (e.g. xxx.xx)	
Target year to meet goal	
Baseline year	
Target year to meet goal?	
Baseline year	

Please feel free to expand on your response in the box below:

8. The federal government has recently released ambitious goals for federal facilities. It includes achieving a carbon pollution-free electricity sector by 2035 and net-zero emissions economy-wide by no later than 2050 with a 65% reduction in Scope 1 and 2 GHG emissions from Federal operations by 2030 (from 2008 levels). Irrespective of the exact targets and years, would your organization, in principle, be willing to support similar types of goals for the health sector? You can read the announcement by clicking on the question mark in red.	c. Unsure

Please feel free to expand on your response in the box below:

9. Do you believe the decarbonization goals for the health sector should be similar, more ambitious, or less ambitious than the targets set by the federal government? (check one of the following)	d. Unsure

Please feel free to expand on your response in the box below:

10. Does your organization have an executive leader responsible for environmental sustainability, including climate change mitigation?	No

Please feel free to expand on your response in the box below:

Please indicate below whether or not you agree to these types of disclosure:	I do not grant AHA permission to release my confidential data.

Use this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.

Thank you for your cooperation in completing this survey. If there are any questions about your responses to this survey, who should be contacted

Your Name & Title	William Kiefer
Your Name & Title	CEO
Your Email Address	[redacted]
Your Phone Number	
Your Fax Number	

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

Section Title	Status	Last Edit Date	Last Edit By
2021 Iowa Department of Public Health	Completed	06/15/2023	William Kiefer

State Supplement

	Answer
[redacted]	
a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?	None
b. Were these changes temporary (expected to be effective for less then one year) or permanent?	n/a
Bed Type Numbers - Beds and Utilization by Inpatient Service	
a. General Medical/Surgical(adult, include gynecology)	39
b. General Medical/Surgical (pediatric)	4
c. Obstetrics	17
d. Other Acute	0
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	0
f. Cardiac Intensive Care	0
g. Neonatal Intensive Care (exclude normal newborn)	0
h. Neonatal Intermediate Care	4
i. Pediatric Intensive Care	0
j. Burn Care	0
k. Other Special Care (definitive observation, step down, etc.)	0
l. Other Intensive Care	10
m. Rehabilitation	13
n. Chronic Disease	0
o. Alzheimer's or other Dementia Diagnosis	0
p. Hospice	0
q. Psychiatric Care	14
r. Substance Use Disorder	0

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
s. Developmental Disability	0
t. Skilled Nursing Care	0
u. Intermediate Care	0
v. Residential Care/Senior Housing	0
w. SubAcute Care	0
x. Total Facility (Add lines a thru w.)	101
a. Private	1984
b. Semi-Private	1984
c. OB	1890
d. Pediatric	1890
e. Substance Use Disorder Treatment	0
f. Detoxification	0
g. Rehabilitation	1641
h. Psychiatric	2264
i. Intensive Care Unit	3875
a. Amount of Charity	118451
b. Amount of Hill-Burton	0
c. Bad Debt	8169203
d. Total Non-Reimbursed	8287654
5. Data Release	Yes
[redacted]	

AHA Annual Survey - 2022

Ottumwa Regional Health Center (6621105)

State Supplement

	Answer
a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0
a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	70239056
b. Medicaid Contractual Adjustments	59286784
c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	10949272
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	10726170
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	223102
a. Charity Care Charge-level (should equal E.5b)	118451
b. Charity Care Cost-level	24492
9. a. How many total Auxiliary members and Volunteers (both adult and teen) did you have in your hospital?	34
9. b. How many total hours of service did the auxilians and volunteers give to the hospital?	1863
9. c. Total funds contributed to the hospital by the auxiliary and volunteer department?	0
9. d. Total funds contributed to the hospital by the hospital foundation?	0

2023 Iowa Department of Public Health

SA: State Addendum

[redacted]

1. Bed Changes

a. What changes in bed capacity or designation in beds by service occurred during the most recent fiscal years?

Due to a clerical error our bed count last year was reported incorrectly. This year's survey has the correct bed count.

b. Were these changes temporary (expected to be effective for less then one year) or permanent?

N/A

2. Bed Type Numbers - Beds and Utilization by Inpatient Service

Questions 2a thru 2x relate to section E1a. of the AHA Survey. *The total number of beds here should match the total licensed numbers as reported in section E1a. for licensed beds.*

Bed Type Numbers	Licensed/Registered Beds
a. General Medical/Surgical(adult, include gynecology)	138
b. General Medical/Surgical (pediatric)	20
c. Obstetrics	18
d. Other Acute	0
e. Medical / Surgical Intensive Care (include mixed ICU/CCU)	0
f. Cardiac Intensive Care	0
g. Neonatal Intensive Care (exclude normal newborn)	4
h. Neonatal Intermediate Care	0
i. Pediatric Intensive Care	0
j. Burn Care	0
k. Other Special Care (definitive observation, step down, etc.)	0

l. Other Intensive Care	10
m. Rehabilitation	13
n. Chronic Disease	0
o. Alzheimer's or other Dementia Diagnosis	0
p. Hospice	0
q. Psychiatric Care	14
r. Substance Use Disorder	0
s. Developmental Disability	0
t. Skilled Nursing Care	0
u. Intermediate Care	0
v. Residential Care/Senior Housing	0
w. SubAcute Care	0
x. Total Facility (Add lines a thru w.)	217

3. Current Room Rates by Type

Room Type	Rate
a. Private	2,222
b. Semi-Private	2,222
c. OB	2,222
d. Pediatric	2,222
e. Substance Use Disorder Treatment	0
f. Detoxification	0

g. Rehabilitation	1,838
h. Psychiatric	2,536
i. Intensive Care Unit	4,340

4. Amount of Non-Reimbursed Care by Type

	Amount
a. Amount of Charity	135,308
b. Amount of Hill-Burton	0
c. Bad Debt	9,424,083
d. Total Non-Reimbursed	9,559,391

5. Data Release

To comply with the Iowa uniform reporting requirement law, Iowa Hospital Association is authorized to release data to the Department of Health and Human Services.

☑ Yes

Iowa State supplement Addendum Form

6. SWING BED ADMISSIONS AND INPATIENT DAYS

[redacted]

a. Total facility SWING BED Admissions	0
b. Total facility SWING BED Inpatient Days	0

7. MEDICAID

a. Medicaid Gross Patient Revenue. (Total Medicaid charges)	67,785,711
b. Medicaid Contractual Adjustments	54,130,509

c. Net Medicaid Revenue (Medicaid Gross Patient Revenue less Contractual Adjustments)	13,655,202
d. Medicaid Cost (The cost of providing care to Medicaid recipients)	17,909,527
e. Medicaid Margin or Loss (Net Medicaid Revenue minus Medicaid cost)	-4,254,325

8. CHARITY CARE

a. Charity Care Charge-level (should equal E.5b)	135,308
b. Charity Care Cost-level	30,520

9. a. How many total Auxiliary members and Volunteers (both adult and teen) did you have in your hospital?

12

9. b. How many total hours of service did the auxilians and volunteers give to the hospital?

1,208

9. c. Total funds contributed to the hospital by the auxiliary and volunteer department?

0

9. d. Total funds contributed to the hospital by the hospital foundation?

0

Ottumwa Regional Health Center (6621105)

2023 AHA Annual Survey

A: Reporting Period

AHA Reporting

1. Reporting Period used (beginning and ending date):

From (mm/dd/yyyy) 01/01/2023
01/01/2022

To (mm/dd/yyyy) 12/31/2023
12/31/2022

2a. Were you in operation 12 full months at the end of your reporting period? (●) Yes ( ) No

2b. Number of days open during reporting period: 365
365

3. Indicate the beginning of your current fiscal year 01/01/2024

B: Organizational Structure

Organizational Structure

1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. SELECT ONLY ONE:

33 Corporation (Investor-owned, for-profit)

33 Corporation (Investor-owned, for-profit)

2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:

10 General medical and surgical

10 General medical and surgical

Other-specify treatment area:

3. OTHER

3a. Does your hospital have a REH designation (Rural Emergency Hospital)? ○ Yes ◉ No

3b. Does your hospital restrict admissions primarily to children? ○ Yes ◉ No

3c. Does the hospital itself operate subsidiary corporations? ○ Yes ◉ No

3d. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization

○ Yes ◉ No

3e. Is your hospital owned in whole or in part by physicians or a physician group?

○ Yes ◉ No

3g. Are any other types of hospitals co-located in your hospital?

- ○ Yes
- ◉ No

3i. Is your hospital designated as a state, jurisdiction, or federal Ebola or other Special Pathogens facility? (Check all that apply.)

- ☐ 1. Federal designation: Regional Emerging Special Pathogen Treatment Center
- ☐ 2. State/Jurisdiction designation: Special Pathogen Treatment Center
- ☐ 3. State/Jurisdiction designation: Special Pathogen Assessment Hospital
- ☐ 4. Frontline facility
- ☑ 5. None of the above

C: Facilities and Services

Facilities, Services & Beds

C. Facilities and Services

Please report the # of beds that were provided within your hospital and were set up and staffed for use at the end of the reporting period. If you choose to fill with last year's data before pushing save and validate make sure all questions have at least one field checked.	Owned or provided by my hospital or its subsidiary	Provided by my Health System (in my local community)	Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (in my local community)	Do not Provide
1. General medical - surgical care	☑ # Beds: 24 (20)	☐	☐	☐
2. Pediatric medical - surgical care	☑ # Beds: 4 (4)	☐	☐	☐
3. Obstetrics [Hospital level of unit (1-4)] (Please specify the level of unit provided by the hospital if applicable.)	☑ # Beds: 9 (9) Level: 2 (2)	☐	☐	☐
4. Medical-surgical intensive care	☐ # Beds: 0 (0)	☐	☐	☑
5. Cardiac intensive care	☐ # Beds: 0 (0)	☐	☐	☑
6. Neonatal intensive care	☐ # Beds: 0 (0)	☐	☐	☑
7. Neonatal intermediate care	☐ # Beds: 0 (3)	☐	☐	☑
8. Pediatric intensive care	☐ # Beds: 0 (0)	☐	☐	☑
9. Burn care	☐	☐	☐	☑

	# Beds 0 0				
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	 # Beds 0 0 Desc:	☐	☐	☐	☑
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	 # Beds 4 4 Desc: Med/Su Med/Surg Cardiac Intensive Care	☑	☐	☐	☐
12. Physical rehabilitation	 # Beds 13 10	☑	☐	☐	☐
13. Substance use disorder	 # Beds 0 0	☐	☐	☐	☑
14. Psychiatric care	 # Beds 14 10	☑	☐	☐	☐
15. Skilled nursing care	 # Beds 0 0	☐	☐	☐	☑
16. Intermediate nursing care	 # Beds 0 0	☐	☐	☐	☑
17. Acute long-term care	 # Beds 0 0	☐	☐	☐	☑
18. Other long-term care	 # Beds 0 0	☐	☐	☐	☑
19. Biocontainment patient care unit	 # Beds 0	☐	☐	☐	☑

20. Other care (Please specify the type of other care provided by the hospital if applicable.)	☐	☐	☐	☑

 # Beds

0

0

Desc:

Facilities & Services A..C

Facilities and Services A..C

*Please check services that were provided within your hospital for use at the end of the reporting period. If you choose to fill with last year's data before pushing save and validate make sure all questions have at least one field checked.	Owned or provided by my hospital or its subsidiary	Provided by my Health System (in my local community)	Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (in my local community)	Do not provide
21. Adult day care program	☐	☐	☐	☑
22. Airborne infection isolation room (Please specify the number of rooms)	☑	☐	☐	☐
23. Alzheimer Center	☐	☐	☐	☑
24. Ambulance services	☑	☐	☐	☐
25. Air Ambulance services	☐	☐	☐	☑
26. Ambulatory surgery center	☐	☐	☐	☑
27. Arthritis treatment center	☐	☐	☐	☑
28. Auxiliary	☑	☐	☐	☐
29. Bariatric/weight control services	☐	☐	☐	☑
30. Birthing room - LDR room - LDRP room	☑	☐	☐	☐
31. Blood Donor Center	☐	☐	☑	☐
32. Breast cancer screening / mammograms	☑	☐	☐	☐
33. **Cardiology and cardiac surgery services:** 33a. Adult cardiology services	☑	☐	☐	☐
33b. Pediatric cardiology services	☐	☐	☐	☑
33c. Adult diagnostic catheterization	☑	☐	☐	☐
33d. Pediatric diagnostic catheterization	☐	☐	☐	☑
33e. Adult interventional cardiac catheterization	☑	☐	☐	☐
33f. Pediatric interventional cardiac catheterization	☐	☐	☐	☑
33g. Adult cardiac surgery	☐	☐	☐	☑

33h. Pediatric cardiac surgery	☐	☐	☐	☑
33i. Adult cardiac electrophysiology	☑	☐	☐	☐
33j. Pediatric cardiac electrophysiology	☐	☐	☐	☑
33k. Cardiac rehabilitation	☑	☐	☐	☐
34. Case management	☑	☐	☐	☐
35. Chaplaincy/pastoral care services	☑	☐	☐	☐
36. Chemotherapy	☐	☐	☐	☑
37. Children's wellness program	☐	☐	☐	☑
38. Chiropractic services	☐	☐	☐	☑
39. Community outreach	☑	☐	☐	☐
40. Complementary and alternative medicine services	☐	☐	☐	☑
41. Computer assisted orthopedic surgery (CAOS)	☐	☐	☐	☑
42. Crisis prevention	☐	☐	☐	☑

Facillities and Services D..L

Facilities and Services

*Please check services that were provided within your hospital for use at the end of the reporting period. If you choose to fill with last year's data before pushing save and validate make sure all questions have at least one field checked.	Owned or provided by my hospital or its subsidiary	Provided by my Health System (in my local community)	Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (in my local community)	Do not provide
43. Dental services	☐	☐	☐	☑
44. Diabetes prevention program	☐	☐	☐	☑
45. **Emergency services:** 45a. On-campus emergency department	☑	☐	☐	☐
45b. Off-campus emergency department	☐	☐	☐	☑
45c. Pediatric emergency department	☑	☐	☐	☐
45d. Trauma center (certified) [Hospital Level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable). 45.e If column (1) is checked for 45d (Trauma center) does your hospital own the trauma certification?	☑ 4 3 ◉ Yes ○ No	☐	☐	☐
46. Enabling services	☑	☐	☐	☐
47. **Endoscopic services:** 47a.Optical colonoscopy	☑	☐	☐	☐

47b. Endoscopic ultrasound	☑	☐	☐	☐
47c. Ablation of Barrett's esophagus	☐	☐	☐	☑
47d. Esophageal impedance study	☐	☐	☐	☑
47e. Endoscopic retrograde cholangiopancreatography (ERCP)	☐	☐	☐	☑
48. Enrollment (insurance) assistance services	☑	☐	☐	☐
49. Employment support services	☐	☐	☐	☑
50. Extracorporeal shock wave lithotripter (ESWL)	☑	☐	☐	☐
51. Fertility clinic	☐	☐	☐	☑
52. Fitness center	☐	☐	☐	☑
53. Freestanding outpatient care center	☐	☐	☐	☑
54. Geriatric services	☑	☐	☐	☐
55. Health fair	☑	☐	☐	☐
56. Community health education	☑	☐	☐	☐
57. Genetic testing/counseling	☐	☐	☐	☑
58. Health screenings	☑	☐	☐	☐
59. Health research	☐	☐	☐	☑
60. Hemodialysis	☑	☐	☐	☐
61. HIV - AIDS services	☐	☐	☐	☑
62. Home health services	☐	☐	☐	☑
63. Hospice program	☐	☐	☑	☐
64. Hospital - based outpatient care center - services	☑	☐	☐	☐
65. Hospital at Home Program	☐	☐	☐	☑
66. **Housing services:** 66a. Assisted living	☐	☐	☐	☑
66b. Retirement housing	☐	☐	☐	☑
66c. Supportive housing services	☐	☐	☐	☑
67. Immunization program	☐	☐	☐	☑
68. Indigent care clinic	☐	☐	☐	☑
69. Linguistic/translation services	☐	☐	☑	☐

Facilities and Services M..P

C. FACILITIES AND SERVICES

*Please check services that were provided within your hospital for use at the end of the reporting period. If you choose to fill with last year's data before pushing save and validate make sure all questions have at least one field checked.	Owned or provided by my hospital or its subsidiary	Provided by my Health System (in my local community)	Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (in my local community)	Do not provide
70. Meal delivery services	☐	☐	☐	☑
71. Mobile health services	☐	☐	☐	☑
72. Neurological services	☐	☐	☐	☑
73. Nutrition programs	☑	☐	☐	☐
74. Occupational health services	☑	☐	☐	☐
75. Oncology services	☐	☐	☐	☑
76. Orthopedic services	☑	☐	☐	☐
77. Outpatient surgery	☑	☐	☐	☐
78. Pain management program	☑	☐	☐	☐
79. Palliative care program	☐	☐	☐	☑
80. Palliative care inpatient unit	☐	☐	☐	☑
81. Patient Controlled Analgesia (PCA)	☑	☐	☐	☐
82. Patient education center	☐	☐	☐	☑
83. Patient representative services	☑	☐	☐	☐
84. **Physical rehabilitation services:** 84a. Assistive technology center	☐	☐	☐	☑
84b. Electrodiagnostic services	☐	☐	☐	☑
84c. Physical rehabilitation outpatient services	☑	☐	☐	☐
84d. Prosthetic and orthotic services	☐	☐	☐	☑
84e. Robot-assisted walking therapy	☐	☐	☐	☑
84f. Simulated rehabilitation environment	☑	☐	☐	☐
85. Prenatal and Postpartum services	☑	☐	☐	☐
86. Primary care department	☐	☐	☐	☑
87. **Psychiatric services:** 87a.Psychiatric consultation - liaison services	☐	☐	☐	☑
87b. Psychiatric pediatric care **# Staffed Beds** 0	☐	☐	☐	☑
87c. Psychiatric geriatric care **# Staffed Beds** 0	☐	☐	☐	☑

10

87d. Psychiatric education services	☐	☐	☐	☑
87e. Psychiatric emergency services	☑	☐	☐	☐
87f. Psychiatric outpatient services	☐	☐	☐	☑
87g. Psychiatric intensive outpatient services	☐	☐	☐	☑
87h. Social and Community psychiatry	☐	☐	☐	☑
87i. Forensic psychiatry	☐	☐	☐	☑
87j. Prenatal psychiatry and Postpartum psychiatry	☐	☐	☐	☑
87k. Psychiatric partial hospitalization services - adult	☐	☐	☐	☑
87l. Psychiatric partial hospitalization services - pediatric	☐	☐	☐	☑
87m. Psychiatric residential treatment - adult	☐	☐	☐	☑
87n. Psychiatric residential treatment - pediatric	☐	☐	☐	☑
87o. Suicide prevention services	☑	☐	☐	☐

Facilities and Services R..W

Facilities and Services

***Please check services that were provided within your hospital for use at the end of the reporting period. If you choose to fill with last year's data before pushing save and validate make sure all questions have at least one field checked.**	**Owned or provided by my hospital or its subsidiary**	**Provided by my Health System (in my local community)**	**Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (in my local community)**	**Do not provide**
88. **Radiology, diagnostic:** 88a. CT scanner	☑	☐	☐	☐
88b. Diagnostic radioisotope facility	☑	☐	☐	☐
88c. Electron beam computed tomography (EBCT)	☐	☐	☐	☑
88d. Full-field digital mammography(FFDM)	☑	☐	☐	☐
88e. Magnetic resonance imaging (MRI)	☑	☐	☐	☐
88f. Intraoperative magnetic resonance imaging	☐	☐	☐	☑
88g. Magnetoencephalography (MEG)	☐	☐	☐	☑
88h. Multi-slice spiral computed tomography(<64 + slice CT)	☑	☐	☐	☐
88i. Multi-slice spiral computed tomography (64+ slice CT)	☑	☐	☐	☐
88j. Positron emission tomography (PET)	☐	☐	☑	☐
88k. Positron emission tomography/CT (PET/CT)	☐	☐	☑	☐

88l. Single photon emission computerized tomography (SPECT)	☑	☐	☐	☐
88m. Ultrasound	☑	☐	☐	☐
89. **Radiology therapeutic:** 89a. Image-guided Radiation Therapy(IGRT)	☑	☐	☐	☐
89b. Intensity-Modulated Radiation Therapy (IMRT)	☑	☐	☐	☐
89c. Proton beam therapy	☐	☐	☐	☑
89d. Shaped Beam Radiation System	☑	☐	☐	☐
89e. Stereotactic radiosurgery	☐	☐	☐	☑
89f. Basic interventional radiology	☐	☐	☐	☑
90. Robotic surgery	☑	☐	☐	☐
91. Rural health clinic	☐	☐	☐	☑
92. Sleep center	☑	☐	☐	☐
93. Social work services	☑	☐	☐	☐
94. Sports medicine	☐	☐	☐	☑
95. Substance use disorder care Services 95a. Substance use disorder pediatric services **# Staffed Beds** 0	☐	☐	☐	☑
95b. Substance use disorder outpatient services	☐	☐	☐	☑
95c. Substance use disorder partial hospitalization services	☐	☐	☐	☑
95d. Medication Assisted Treatment for Opioid Use Disorder	☐	☐	☐	☑
95e. Medication Assisted Treatment for other substance use disorders	☐	☐	☐	☑
96. Support groups	☐	☐	☐	☑
97. Swing bed services	☐	☐	☐	☑
98. Teen outreach services	☐	☐	☐	☑
99. Tobacco treatment / cessation program	☑	☐	☐	☐
100. **Telehealth** 100a. Consultation and office visits	☐	☐	☐	☑
100b. eICU	☐	☐	☐	☑
100c. Stroke care	☑	☐	☐	☐
100d. Psychiatric and addiction treatment	☑	☐	☐	☐
100e. Remote patient monitoring: 1. Post-discharge.	☐	☐	☐	☑
2. Ongoing chronic care management	☐	☐	☐	☑
3. Other remote patient monitoring	☐	☐	☐	☑

100f. Other telehealth	☐	☐	☑	☐
101. **Transplant services:** 101a. Bone marrow	☐	☐	☐	☑
101b. Heart	☐	☐	☐	☑
101c. Kidney	☐	☐	☐	☑
101d. Liver	☐	☐	☐	☑
101e. Lung	☐	☐	☐	☑
101f. Tissue	☐	☐	☐	☑
101g. Other	☐	☐	☐	☑
102. Transportation to health facilities (non-emergency)	☐	☐	☐	☑
103. Urgent care center	☐	☐	☐	☑
104. **Violence Prevention Programs:** 104a. For the workplace	☐	☐	☐	☑
104b. For the community	☐	☐	☐	☑
105. Virtual Colonoscopy	☐	☐	☐	☑
106. Volunteer services department	☑	☐	☐	☐
107. Women's health center / services (not related to pregnancy or postpartum care)	☑	☐	☐	☐
108. Wound management services	☑	☐	☐	☐

Physician Arrangements

109. Does your organization routinely integrate behavioral health services in the following care areas?

Integration ranges from co-located physical and behavioral health providers, with some screening and treatment planning, to fully integrated care where behavioral and physical health providers function as a true team in a shared practice.

	Yes	No
a. Emergency Services	○	◉
b.Primary Care Services	○	◉
c.Acute inpatient care	○	◉
d.Extended care	○	◉

110. Does your organization routinely offer psychiatric consultation & liaison services in the following care areas?

Consultation-liaison psychiatrists, medical physicians, or advanced practice providers (APPs) work to help people suffering from a combination of mental and physical illness by consulting with them and liaising with other members of their care team.

	Yes	No
a. Emergency Services	◉	○

	Yes	No
b.Primary Care Services	○	◉
c.Acute inpatient care	◉	○
d.Extended care	○	◉

111. Does your organization routinely offer addiction/substance use disorder consultation & liaison services in the following care areas?

	Yes	No
a. Emergency Services	○	◉
b.Primary Care Services	○	◉
c.Acute inpatient care	○	◉
d.Extended care	○	◉

112. Does your organization routinely screen for psychiatric disorders in the following care areas? *Screens can include, but are not limited to the PHQ-2 and PHQ9 depression screen, the Columbia DISC Depression Scale, and/or the GAD-2 and GAD-7 for anxiety disorders*

	Yes	No
a. Emergency Services	◉	○
b.Primary Care Services	○	◉
c.Acute inpatient care	◉	○
d.Extended care	○	◉

113. Does your organization routinely screen for substance use disorders in the following care areas? Screens can include but are not limited to the CAGE Substance Abuse Screening Tool, drug screening tool, and or TAPS: Tobacco, Alcohol, Prescription medication, and other Substance use Tool.

	Yes	No
a.Emergency Services	○	◉
b.Primary Care Services	○	◉
c.Acute inpatient care	○	◉
d.Extended care	○	◉

114a. For each of the physician-organization arrangements, please report the number of involved physicians in these arrangements.

	Number of Involved Physicians	My Hospital	My Health System	Do Not Provide

1. Independent Practice Association (IPA)		☐	☐	☑
2. Group practice without walls		☐	☐	☑
3. Open Physician - Hospital Organization (PHO)		☐	☐	☑
4. Closed Physician - Hospital Organization (PHO)		☐	☐	☑
5. Management Service Organization (MSO)		☐	☐	☑
6. Integrated Salary Model		☐	☐	☑
7. Equity Model		☐	☐	☑
8. Foundation		☐	☐	☑
9. Other, please specify:		☐	☐	☑

114b. For those arrangements reported in 114a., please report the approximate ownership share.

	Hospital ownership share %	Physician ownership share %	Parent corporation ownership share %	Insurance ownership share %
1. Independent Practice Association (IPA)				
2. Group practice without walls				
3. Open Physician-Hospital Organization (PHO)				
4. Closed Physician-Hospital Organization (PHO)				
5. Management Service Organization (MSO)				
6. Integrated Salary Model				
7. Equity Model				
8. Foundation				
9. Other, specified above:				

114c. If the hospital owns physician practices, how are they organized?

	Percent %	Number of Physicians
114c.1 Solo practice		
114c.2 Single specialty group		
114c.3 Multi-specialty group		

114d. Of the physician practices owned by the hospital, what percentage are primary care?

% 0

114e. Of the physician practices owned by the hospital, what percentage are specialty care?

% 0

114f. Looking across all the relationships identified in question 114a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payers or shared responsibility for financial risk or clinical performance between the hospital and physician? (Arrangement may be any type of ownership.)

Number of physicians

0

0

115a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?

○ Yes ◉ No

115d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?

○ Yes ◉ No

116a. Bed changes: a. Was there a temporary increase in the total number of beds set up and staffed for use during the reporting period?

- ○ Yes
- ◉ No

116b. Bed changes:

b. Was there a temporary increase in the total number of ICU beds set up and staffed for use during the reporting period?

- ○ Yes
- ◉ No

117. Airborne infection isolation rooms:

a. Please indicate the total number of airborne infection isolation rooms set up at the start of the reporting period.	5 5
b. Please indicate the total number of airborne infection isolation rooms set up at the end of the reporting period.	5 5
c. Please indicate how many rooms not set up as airborne infection isolation rooms at the end of the reporting period can be converted to airborne isolation rooms.	0 0

118. Temporary spaces:

Please indicate if any temporary spaces such as tents or other spaces not typically used for clinical purposes were set up for using in triage, testing or treatment during the reporting period.

- ○ Yes
- ◉ No

119. Was there a temporary increase in the total number of emergency department beds set up and staffed for use during the reporting period?

- ○ Yes
- ◉ No

D: Insurance and Alternative Payment Models

Insurance And Alternative Payment Models

1. Does your hospital own or jointly own a health plan?

○ Yes ◉ No

2. Does your system own or jointly own a health plan?

○ Yes ◉ No

3. Does your hospital/system have a significant partnership with an insurer on an insurance company/health plan?

○ Yes ◉ No

8. Does your hospital or health system fund the health benefits for your employees? ⓘ

◉ Yes ○ No

a. If yes, does the hospital or health system also administer the benefits (as opposed to contracting with a third party administrator)? ⓘ

○ Yes ◉ No

Insurance And Alternative Payment Models continued

ALTERNATIVE PAYMENT MODELS

9. What percentage of the hospital's net patient revenue is paid on a capitated basis? ⓘ

0

0

9a. In total, how many patients do you serve under capitated contracts? ⓘ

10. Does your hospital participate in any bundled payment arrangements?

- ○ Yes
- ◉ No

12. What percentage of your hospital's patient revenue is paid on a shared risk basis (other than capitated or bundled payment)?

0

0

13. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?

- ○ Yes
- ◉ No

14. Does your hospital have contracts with commercial payers where payment is tied to performance on quality/safety metrics?

- ○ Yes
- ◉ No

15a. Has your hospital or health care system established an accountable care organization (ACO)?

- ○ 1. My hospital/system currently leads an ACO
- ○ 2. My hospital/system currently participates in an ACO (but is not its leader)
- ○ 3. My hospital/system previously led or participated in an ACO but is no longer doing so
- ◉ 4. My hospital/system has never participated or led an ACO

16. Has your hospital/system ever considered participating in an ACO?

- ○ a. Yes, and we are planning to join one
- ◉ b. Yes, but we are not planning to join one
- ○ c. No, we have not even considered it

17. Do any hospitals and/or physician groups within your system or the system itself, plan to participate in any of the following risk arrangements in the next three years? (Check all that apply)

- ☐ a. Shared Savings/Losses
- ☐ b. Bundled payment
- ☐ c. Capitation
- ☐ d. ACO (Ownership)
- ☐ e. ACO (Joint Venture)

- [ ] f. Health Plan (Ownership)
- [ ] g. Health Plan (Joint Venture)
- [ ] h. Primary care transformation, including direct contracting
- [ ] i. Other, please specify:
- [x] j. None

18. Does your hospital/system have an established medical home program?

	Yes	No
a Hospital	○	◉
b.System	○	◉

E: Total Facility Beds, Utilization, Finances & Staffing

Nursing home unit/facility

1. Does your hospital own and operate a nursing home type unit / facility?

○ Yes ◉ No

Beds & Utilization

1. BEDS AND UTILIZATION

Fill out column (2) if hospital owns and operates a nursing home type unit/facility. Column (1) should be the combined total of hospital plus Nursing Home Unit/Facility	(1) Total Facility	(2) Nursing Home Unit/Facility
a. Total licensed beds.	217 217	
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	68 60	
c. Bassinets set up and staffed for use at the end of the reporting period	10 10	
d. Births (exclude fetal deaths)	297 356	
e. Admissions (exclude newborns, include neonatal & swing admissions)	1,917 2,122	
f. Discharges (exclude newborns, include neonatal & swing discharges)	1,907 2,488	
g. Inpatient days (exclude newborns, include neonatal & swing days)	9,989 11,168	
h. Emergency department visits	13,624 15,750	
i. Total outpatient visits (include emergency department visits & outpatient surgeries)	103,846 108,983	
j. Inpatient surgical operations	430 512	

k. Number of operating rooms	6 6	
l. Outpatient surgical operations	4,703 4,900	

Utilization by Payer

2. UTILIZATION BY PAYER (exclude newborns, Include neonatal & swing days & deaths)

Inpatient days and Totals discharge should equal Inpatient days and Discharge totals reported in E1e (Admissions) and E1f (Discharges).

Fill out column (2) if hospital owns and operates a nursing home type unit/facility. Column (1) should be the combined total of hospital plus Nursing Home Unit/Facility	(1) Total Facility	(2) Nursing Home Unit/Facility
a.1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	995 1,077	
a.2. How many Medicare inpatient discharges were Medicare Managed Care?	481 451	
b.1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	6,230 6,460	
b.2. How many Medicare inpatient days were Medicare Managed Care?	3,054 2,398	
c.1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	508 796	
c.2. How many Medicaid inpatient discharges were Medicaid Managed Care?	466 637	
d.1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	2,252 2,943	
d.2. How many Medicaid inpatient days were Medicaid Managed Care?	2,063 2,705	
e.1. Total self-pay inpatient discharges	44 70	
e.2. Total self-pay inpatient days	144 88	

f.1. Total third-party (non-Medicare, non-Medicaid) inpatient discharges	309 520	
f.2. Total third-party (non-Medicare, non-Medicaid) inpatient days	1,136 1,569	
g.1. Other payer (government and non-government inpatient discharges	51 25	
g.2. Other payer (government and non-government inpatient days	227 108	

Financial, Revenue, Uncompensated Care

3. FINANCIAL

Fill out column (2) if hospital owns and operates a nursing home type unit/facility. Column (1) should be the combined total of hospital plus Nursing Home Unit/Facility	**(1) Total Facility**	**(2) Nursing Home Unit/Facility**
*a. Net patient revenue **(treat bad debt as a deduction from revenue) (must equal 6c, column 2, Total net revenue)**	75,736,733 68,176,618	
*b. Tax appropriations	0 0	
*c. Other operating revenue	195,420 180,828	
*d. Nonoperating revenue	432 10,805	
*e. TOTAL REVENUE (add 3a thru 3d)	75,932,585 68,368,251	
f. Payroll expenses (only)	18,660,910 22,896,737	
g. Employee benefits	3,998,280 3,812,756	
h. Depreciation expense (for reporting period only)	4,842,051 4,622,443	
i. Interest expense	77,143 123,920	

j. Pharmacy Expense	1,817,316 4,389,783	
k. Supply expense (other than pharmacy)	7,329,096 6,319,400	
l. All other expenses	35,563,234 29,338,999	
m. TOTAL EXPENSES (Add 3f thru 3l. Exclude bad debt)	72,288,030 71,504,038	

n. Do your total expenses (E3.m) reflect full allocation from your corporate office?

(●) Yes ( ) No

***4. Revenue By Type**

a. Total gross inpatient revenue	70,892,036 77,542,140
b. Total gross outpatient revenue	250,635,366 243,204,265
c. Total gross patient revenue **(must equal 6c, column 1,Total gross revenue)**	321,527,402 320,746,405

***5. Uncompensated Care & Provider Taxes**

a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	9,424,083 8,169,203
1. Are you able to distinguish bad debt derived from patients with or without insurance?	(●) Yes ( ) No

2. If yes, how much is from patients with insurance?

4,806,282
3,676,141

b. Financial assistance (Includes charity care) (Revenue forgone at full-established rates. Include in gross revenue.) ⓘ

135,308

118,451

c. Is your bad debt (5a.) reported on the basis of full charges?

(•) Yes ( ) No

d. Does your state have a provider Medicaid tax/assessment program? ⓘ

(•) Yes ( ) No

e. If yes, please report the total gross amount paid into the program

496,467

496,467

f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in:

Total Expenses.....

(•) Yes

( ) No

Deductions from net Patient Revenue.....

( ) Yes

(•) No

***These data will be treated as confidential. See the full confidentiality statement at the end of Section E.**

Revenue by Payer

6. REVENUE BY PAYOR (report total facility gross and net figures)

*6a. GOVERNMENT

	(1) Gross	(2) Net
6a1a. Fee for service patient revenue ⓘ	80,567,783 88,974,311	16,091,234 19,001,308
6a1b. Managed care revenue ⓘ	77,862,759 67,826,643	12,594,863 11,366,212
6a1c. Total (a + b) ⓘ	158,430,542 156,800,954	28,686,097 30,367,520

6a2. Medicaid:		
6a2a. Fee for service patient revenue	3,043,642 2,627,831	1,060,339 481,991
6a2b. Managed care revenue	64,742,069 67,611,225	9,016,223 10,467,281
6a2c. Medicaid Graduate Medical Education (GME) payments		0 0
6a2d. Medicaid Disproportionate Share Hospital Payments (DSH)		91,198 30,399
6a2e. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments		6,900,000 0
6a2f. Other Medicaid		0 0
6a2g. Total (a-f)	67,785,711 70,239,056	17,067,760 10,979,671
6a3. Other Government:	9,238,347 5,988,761	1,827,002 1,138,423

***6b. NONGOVERNMENT**		
6b1. Self-pay	7,752,985 6,392,366	3,165,014 446,460
6b2. Third-party payers:		
6b2a. Managed care (includes HMO and PPO)	11,318,561 11,806,154	4,343,777 4,139,261
6b2b. Other third - party payers	67,001,256 69,519,114	20,647,083 21,105,283
6b2c. Total Third - party payers (a+b)	78,319,817 81,325,268	24,990,860 25,244,544
6b3. All Other nongovernment	0 0	0 0
***6c. TOTAL**	321,527,402 320,746,405	75,736,733 68,176,618

***6d. If you reported receiving Medicaid Supplemental Payments on line 6.a(2)e, please break the payment total into inpatient and outpatient care.**

	Inpatient	Outpatient
Medicaid supplemental payments	1,300,000	5,600,000

***6e. If you are a government owned facility(control codes 12-16 section b), does your facility participate in the Medicaid intergovernmental transfer or certified public expenditure program.**

○ Yes ◉ No

	Gross	Net
*6f. If yes, please report gross and net revenue.		

***6g. Are the financial data reported from your audited financial statement?** ◉ Yes ○ No

6h. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER? ○ Yes ◉ No

***7. FINANCIAL PERFORMANCE - MARGIN**

	%
*a. Total Margin	-23.35 -18
*b. Operating Margin	-13.84 -9
*c. EBITDA Margin	-6.69 -2
*d. Medicare Margin	-24.20 -23

*e. Medicaid Margin	-51.20	2

8. Fixed Assets

8a. Property, plant and equipment at cost	83,791,692	78,847,933
8b. Accumulated depreciation	38,882,401	34,021,256
8c. Net property, plant and equipment (a - b)	44,909,291	44,826,677
8d. Total gross square feet of your physical plant used for or in support of your healthcare activities	270,499	270,499

9. Total Capital Expenses

Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.

4,943,758

3,196,380

10. Information Technology and Cybersecurity

a. *Overall IT Budget	2,760,094	2,611,211
b. *Number of internal IT staff (in FTEs)	5	5
c. *What percent of your IT budget is spent on cybersecurity?	3	3
d. *Number of internal staff devoted to cybersecurity (in FTEs)	0	0
e. *Number of outsourced staff devoted to cybersecurity (in FTEs)	0	0

f. *What position does your cybersecurity lead report to?

HSC

N/A

g. *Does your organization rank cybersecurity as an enterprise risk issue?

(•) Yes ( ) No

h. *If yes, what priority number to rank it?

0

i. *How often is the board briefed on cybersecurity?

( ) Quarterly
( ) Semi-annually
( ) Yearly
( ) Never
(•) Other

Unknown

Unknown

j. *What do you view as your biggest cybersecurity threat? (Please rank the choices 1-9, with 1 being the biggest threat) (Please do not duplicate your rankings)

1. Ransomware which may disrupt and delay patient care delivery

1

2

2. Ransomware which may disrupt business operations

3

3

3. Theft of sensitive patient data such as Protected Health Information (PHI) or Personally Identifiable Information (PII)

2

6

4. Theft of medical research or intellectual property

9

9

5. Cyber risk exposure through business associates. Business associate as conduit for cyber attacks or theft of your data stored by third parties

7

4

6. Software and supply chain cyber risk

5

7

7. Medical device cyber risk

8

8

8. Phishing emails or other social engineering attacks which may result in the delivery of malware or ransomware into the organization

4

1

9. Phishing emails or other social engineering attacks which may result in the theft of funds

6

5

k. *Does your organization use any of the following cybersecurity techniques? (Check yes or no)

1. Enterprise wide multi-factor authentication for all remote access to networks, data and applications	(●) Yes ( ) No
2. Network segmentation	(●) Yes ( ) No
3. Off line, network segmented, redundant network and data back ups	(●) Yes ( ) No
4. Immutable backups	(●) Yes ( ) No
5. Intrusion detection systems	(●) Yes ( ) No
6. Employee cybersecurity education including phishing email simulations	(●) Yes ( ) No
7. 24/7 Security Operations Center (SOC) monitoring all cyber incidents and events	(●) Yes ( ) No
8. Highly efficient and effective patch management program	(●) Yes ( ) No
9. Forced password change every 90 days or less	( ) Yes (●) No
10. Integration of cyber incident response plans with emergency management plans	( ) Yes (●) No
11. Cross function cyber incident response exercise for all leaders	( ) Yes (●) No
12. Relationship with local FBI and CISA offices	(●) Yes ( ) No
13. Third Party Risk Management Program which assesses business associate access to networks and bulk sensitive data; mission criticality and life criticality of third party	( ) Yes (●) No

l. *How confident are you in the organization's ability to sustain care delivery through manual downtime procedures for up to four weeks, without the benefit of network and internet connected technology?

- ( ) 1. Confident
- ( ) 2. Somewhat confident
- (●) 3. Uncertain
- ( ) 4. Somewhat not confident
- ( ) 5. Not confident

m. *What do you view as your biggest challenges in improving your organization's cybersecurity posture? (Please rank choices 1-6, with 1 being the biggest challenge) (Please do not duplicate your rankings)

1. Funding	3
2. Staffing	1

3

	1
3. Legacy insecure technology	2 2
4. Leadership support	6 6
5. Organizational culture	5 5
6. Non-compliant third parties/business associates	4 4

***These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.**

***For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.**

☐ No

***The state/metropolitan/regional association and CHA may not release these data without written permission from the hospital.**

Staffing

11. STAFFING ⓘ

Report full-time (35 hours or more) and part-time (less than 35 hours) personnel who were on the hospital/facility **payroll at the end of your reporting period.** Include members of religious orders for whom dollar equivalents were reported. Exclude private-duty nurses, volunteers, and all personnel whose salary is financed entirely by outside research grants. Exclude physicians and dentists who are paid on a fee basis. FTE is the total number of hours **worked** (excluding non-worked hours such as PTO, etc.) by all employees over the full (12 month) reporting period divided by the normal number of hours worked by a full-time employee for that same time period. For example, if your hospital considers a normal workweek for a full-time employee to be 40 hours, a total of 2,080 would be worked over a full year (52 weeks). If the total number of hours worked by all employees on the payroll is 208,000, then the number of Full-Time Equivalents (FTE) is 100 (employees). The FTE calculation for a specific occupational category such as Registered nurses is exactly the same. The calculation for each occupational category should be based on the number of hours worked by staff employed in that specific category.

For each occupational category, please report the number of staff vacancies as of the last day of your reporting period. A vacancy is defined as a budgeted staff position which is unfilled as of the last day of the reporting period and for which the hospital is actively seeking either a full-time or part-time permanent replacement. Personnel who work in more than one area should be included only in the category of their primary responsibility and should be counted only once.

	Full-Time (35 hr/wk or more) on Payroll (Headcount)	Part-Time (less than 35 hr/wk) on Payroll (Headcount)	FTE	Vacancies (Headcount)
a. Physicians ⓘ	0 0	0 0	0 0	0 0
b. Dentists ⓘ	0 0	0 0	0 0	0 0
c. Medical residents/interns	0	0	0	0

	0	0	0	0
d. Dental residents/interns	0 0	0 0	0 0	0 0
e. Other trainees	0 0	0 0	0 0	0 0
f. Registered nurses	38 69	54 55	41 95	84 74
g. Licensed practical (vocational) nurses	10 4	7 4	7 5	1 3
h. Nursing assistive personnel	18 19	17 18	17 13	7 4
i. Radiology technicians	10 10	6 5	10 12	8 8
j. Laboratory technicians	14 10	18 15	22 27	7 9
k. Pharmacists, licensed	3 3	0 0	2 3	1 1
l. Pharmacy technicians	2 3	1 0	3 3	2 2
m. Respiratory therapists	8 6	2 4	6 9	2 4
n. All other personnel	85 161	76 165	62 138	19 31
o.**Total facility personnel (add 11a through 11n) (Total facility personnel (a-o) should include hospital plus nursing home type unit/facility personnel reported in 11p and 11q)**	188 285	181 266	170 304	131 136
p. Nursing home type unit/facility Registered Nurses	0	0	0 0	0
q. Nursing home type unit/facility personnel	0 0	0 0	0 0	0

r. For your employed RN FTEs reported above (E.11f. column 3) please report the number of full-time equivalents who are involved in direct patient care. (Must not be greater than Total FTE RNs reported in 11f, column 3, above)

37

88

s. For your medical residents/interns reported above (E.11c. column 1) please indicate the number of full-time on payroll by specialty.

1. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics)	0 0
2. Other Specialties	0 0

12. CONTRACTED STAFF

Please report the number of contracted FTEs for each occupational category. Personnel that are on the hospitals payroll and reported in E(11) should not be reported here.

	CONTRACTED FTES
a. Registered nurses	48 13
b. Radiology technicians	1 1
c. Laboratory technicians	1 3
d. Pharmacists licensed	0 0
e. Pharmacy technicians	0 0
f. Respiratory therapists	2 0
g. All other contracted staff	3 1

13. PRIVILEGED PHYSICIANS

Report the total number of physicians with privileges at your hospital by type of relationship with the hospital. The sum of the physicians reported in 13a-13g should equal the total number of privileged physicians (13h) in the hospital.

	(1) Total Employed	(2) Total Individual Contract	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged

a. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics)	0 0	0 0	9 3	3 4	12 7
b. Obstetrics/gynecology	0 0	0 0	3 3	3 2	6 5
c. Emergency medicine	0 0	0 0	15 12	0 0	15 12
d. Hospitalist	0 0	0 0	12 9	0 0	12 9
e. Intensivist	0 0	0 0	14 30	0 0	14 30
f. Radiologist/pathologist/anesthesiologist	0 0	0 0	22 35	0 0	22 35
g. Other specialist	0 0	0 0	61 63	8 11	69 74
h. Total (add 13a-13g)	0 0	0 0	136 155	14 17	150 172

14a. Do hospitalists provide care for patients in your hospital?

(if yes, please report in E.14b.) (•) Yes ( ) No

14b. If yes, please report the total number of full-time equivalents (FTE) hospitalists.

FTE 4
4

15a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 16)

(if yes, please report in E.15b.) (•) Yes ( ) No

INTENSIVIST CLOSED

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are authorized to care for ICU patients.)

	FTE	Closed to intensivists
1. Medical-surgical intensive care	4 4	☐
2. Cardiac intensive care	0 0	☐
3. Neonatal intensive care	0 0	☐
4. Pediatric intensive care	0 0	☐
5. Other intensive care	0 0	☐
6. Total	4 4	☐

16a. Do Advanced Practice Providers provide care for patients in your hospital?

(if no, please skip to 17) ◉ Yes ○ No

16b. If yes, please report the number of full time, part time and FTE advanced practice nurses/physician assistants (PAs) who provide care for patients in your hospital.

	Full-time	Part-time	FTE
Advanced Practice Registered Nurses	6 6	28 26	6 6
Physician Assistants (PAs)	2 2	0 0	2 2

16c. If yes, please indicate the type of service(s) provided. (Please check all that apply)

- ☑ 1. Primary care
- ☑ 2. Anesthesia services
- ☑ 3. Emergency department care
- ☑ 4. Other specialty care
- ☐ 5. Patient education
- ☐ 6. Case management

- [ ] 7. Other

17. FOREIGN-EDUCATED NURSES

a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2023 vs. 2022?

- ○ More
- ○ Less
- ○ Same
- ◉ Did not hire foreign nurses

b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)

- [ ] Africa
- [ ] South Korea
- [ ] Canada
- [ ] Philippines
- [ ] China
- [ ] India
- [ ] Other

18a. Does your hospital use artificial intelligence (AI) or machine learning in the following: (Check all that apply):

- [ ] 1. Predicting staffing needs
- [ ] 2. Predicting patient demand
- [ ] 3. Staff scheduling
- [ ] 4. Automating routine tasks
- [ ] 5. Optimizing administrative and clinical workflows
- [x] 6. None of the above

18b. How is your hospital incorporating workforce as part of the strategic planning process (Check all that apply):

- [x] 1. Conduct needs assessment
- [x] 2. Leadership succession planning
- [x] 3. Talent development plan
- [x] 4. Recruitment and retention planning
- [x] 5. Partnerships with elementary/HS to develop interest in health care careers
- [x] 6. Training program partnership with community colleges, vocational training programs
- [ ] 7. None of the above

F: Addressing Patient Social Needs and Community Social Determinants of Health

Social And Community Health

1. Which social needs of patients/social determinants of health in communities does your hospital or health system have programs or strategies to address? (Check all that apply)

- [x] a. Housing (instability, quality, financing)
- [x] b. Food insecurity or hunger
- [x] c. Utility needs
- [x] d. Interpersonal violence
- [x] e. Transportation
- [x] f. Employment and income
- [x] g. Education
- [x] h. Social isolation (lack of family and social support)
- [x] i. Other, please describe

2. Does your hospital or health system screen patients for social needs?

- ○ a. Yes for all patients
- ◉ b. Yes for some patients
- ○ c. No

2a. If yes, please indicate which social needs are assessed. Check all that apply.

- [x] 1. Housing (instability, quality, financing)
- [x] 2. Food insecurity or hunger
- [x] 3. Utility need
- [x] 4. Interpersonal violence
- [x] 5. Transportation
- [x] 6. Employment and income
- [x] 7. Education
- [x] 8. Social isolation (lack of family and social support)
- [x] 9. Other, please describe

2b. If yes, does your hospital or health system record the social needs screening results in your electronic health record?

- (●) Yes
- ( ) No

3. Does your hospital or health system utilize outcome metrics (for example, cost of care or readmission rates) to assess the effectiveness of interventions to address the patients' social needs?

- ( ) Yes
- (●) No

4. Has your hospital or health system been able to gather data indicating that activities used to address the social determinants of health and patient social needs have resulted in any of the following (check all that apply):

- [x] a. Better health outcomes for patients
- [ ] b. Decreased utilization of hospital or health system services
- [ ] c. Decreased health care costs
- [ ] d. Improved community health status
- [ ] e. None of the above

5. Who in your hospital or health care system is accountable for meeting health equity goals? (Check all that apply):

- [ ] a. CEO
- [x] b. Designated Senior Executive (Chief Diversity Office, VP for DEI, etc.)
- [ ] c. Middle Management
- [ ] d. Committee or Task Force
- [ ] e. Division/Department Leaders
- [ ] f. Employee Resource Group
- [ ] g. None of the above

6. Who in your hospital or health care system is accountable for implementing strategies for health equity goals? (Check all that apply):

- [ ] a. CEO
- [x] b. Designated Senior Executive (Chief Diversity Office, VP for DEI, etc.)
- [ ] c. Middle Management
- [ ] d. Committee or Task Force
- [ ] e. Division/Department Leaders

- [ ] f. Employee Resource Group
- [ ] g. None of the above

7. Does your hospital or health care system use DEI disaggregated data to inform decisions on the following? (Check all that apply):

- [x] a. Patient outcomes
- [ ] b. Procurement
- [ ] c. Supply chain
- [ ] d. Training
- [ ] e. Professional development
- [ ] f. None of the above

8. Does your hospital or health care system have a health equity strategic plan for the following? (Check all that apply):

- [ ] a. Equitable and inclusive organizational policies
- [ ] b. Systematic and shared accountability for health equity
- [ ] c. Diverse representation in hospital and health care system leadership
- [ ] d. Diverse representation in hospital and health care system governance
- [ ] e. Community engagement
- [ ] f. Collection and use of segmented data to drive action
- [x] g. Culturally appropriate patient care
- [ ] h. None of the above

9. Please indicate the extent of your hospital's current partnerships with external partners for population and/or community health initiatives. Which types of organizations do you currently partner with in each of the following activities? (Check all that apply)

	Not involved	Work together to meet patient social needs	Participates in our Community	Work together to implement community-level initiatives
a. Health care providers outside of your systems	☐	☐	☐	☑
b. Health insurance providers outside of your own system	☐	☑	☐	☐
c. Local or state public health departments/organizations	☐	☐	☐	☑
d. Other local or state government agencies or social service organizations	☐	☐	☐	☑
e. Faith based organizations	☐	☑	☐	☐

f. Local organizations addressing food insecurity	☐	☐	☑	☐
g. Local organizations addressing transportation needs	☐	☐	☑	☐
h. Local organizations addressing housing insecurity	☑	☐	☐	☐
i. Local organizations providing legal assistance for individuals	☑	☐	☐	☐
j. Other community non-profit organizations	☐	☐	☐	☑
k. K - 12 Schools	☐	☐	☐	☑
l. Colleges or universities	☐	☐	☐	☑
m. Local businesses or chambers of commerce	☐	☐	☑	☐
n. Law enforcement/safety forces	☐	☐	☑	☐
o. Area Behavioral Health Providers	☐	☐	☐	☑
p. Area Agencies on Aging (AAA)	☐	☑	☐	☐

G: Supplemental Information

Complete all information and press "Save and Validate" to save the data and check for errors.

1. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of your primary group purchasing organization:

(!)

- (●) Yes
- ( ) No

Name	City	State
Healthtrust Purchasing Group	Brentwood	Tennessee
Healthtrust Purchasing Group (HPG)	Brentwood	Tennessee

2. Does the hospital purchase medical/surgical supplies directly through a distributor? (!)

- (●) Yes
- ( ) No

If yes, please provide the name(s) of the primary distributor.

Name: Cardinal Health

Cardinal Health

Name: Medline

Medline

Name: Owens & Minor

Owens & Minor

3. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools? (!)

3

0

4. Does your hospital have an established patient and family advisory council that meets regularly to actively engage the perspectives of patients and families?

- ○ Yes
- ◉ No

5. Utilization of telehealth/virtual care

a. **Number of video visits:** Synchronous visits between patient and provider that are not co-located, through the use of two-way, interactive, real-time audio and video communication. 0

0

b. **Number of audio visits:** Synchronous visits between a patient and a provider that are not co-located, through the use of two-way, interactive, real-time audio-only communication. 0

0

c. **Number of patients being monitored through remote patient monitoring (RPM):** Asynchronous or synchronous interactions between and patient and a provider that are not co-located involving the collection, transmission, evaluation, and communication of physiological data. 0

0

d. **Number of patients receiving other virtual services:** All other synchronous or asynchronous interactions between a provider and patient or provider and provider delivered remotely including messages, eConsults, and virtual check-ins. 0

0

6. Does your hospital have a partnership with a Community Mental Health Center or a Certified Community Behavioral Health Center?

	Yes	No
a.Community Mental Health Center	○	◉
b.Certified Community Behavioral Health Center	○	◉

7. Which of the following describe(s) your organizations decarbonization efforts?

- ○ a. We have set a **decarbonization percentage reduction** goal.

- b. We have set a **net-zero emissions** goal.
- c. We have set both a **decarbonization percentage reduction** and a **net-zero emissions goal** .
- d. We have not set any decarbonization targets/goals but plan to within the year.
- (●) e. We have not set any decarbonization targets/goals and uncertain if any plans to within the year.

Please feel free to expand on your response in the box below:

8. The federal government has recently released ambitious goals for federal facilities. It includes achieving a carbon pollution-free electricity sector by 2035 and net-zero emissions economy-wide by no later than 2050 with a 65% reduction in Scope 1 and 2 GHG emissions from Federal operations by 2030 (from 2008 levels). Irrespective of the exact targets and years, would your organization, in principle, be willing to support similar types of goals for the health sector? You can read the announcement by clicking on the exclamation mark in blue.

- a. Yes
- b. No
- (●) c. Unsure

Please feel free to expand on your response in the box below:

9. Do you believe the decarbonization goals for the health sector should be similar, more ambitious, or less ambitious than the targets set by the federal government? (check one of the following)

- a. Similar
- b. More ambitious
- c. Less ambitious
- (●) d. Unsure

Please feel free to expand on your response in the box below:

10. Does your organization have an executive leader responsible for environmental sustainability, including climate change mitigation?

○ Yes ◉ No

Please feel free to expand on your response in the box below:

Please indicate below whether or not you agree to these types of disclosure:

○ I hereby grant AHA permission to release my hospital's revenue data to external users that the AHA determines have a legitimate and worthwhile need to gain access to these data subject to the user's agreement with the AHA not to release hospital specific information.

◉ I do not grant AHA permission to release my confidential data.

Use this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.

Thank you for your cooperation in completing this survey. If there are any questions about your responses to this survey, who should be contacted

Your Name & Title

William Kiefer — CEO

William Kiefer — CEO

Your Email Address

[redacted]

Your Phone Number

Your Fax Number

APOGEE PROGRAM COMPARISON (HM ONLY)

12 MONTH ROLLING AVERAGE: OCTOBER 2023-SEPTEMBER 2024

10+ FTE's

Facility	Compensation	Coverage Model	FTE Count	Daily Encounters	Collections per Encounter	RVU's per Encounter	Subsidy per FTE	Subsidy per Patient Day
Conemaugh Memorial	$300k/$145k/$150k	14+4	18.49	122	$87	2.03	$16,294	$81
Havasu Regional	$340k/$180k	13+4 -> 11+3	15.10	76	$96	2.23	$20,384	$134
Lake Cumberland (HM)	$349k/$140k/$155k	14+6	20.19	129	$84	2.23	$17,734	$91
Marquette (HM)	$365k/$131k	9+6	15.30	89	$89	2.10	$17,726	$101
Raleigh General	$340k/$386k/$140k	12+2	13.53	69	$56	2.28	$30,333	$212
Sovah-Danville	$335k/$135k	12+1+2 -> 11+0	11.14	64	$102	2.37	$20,137	$115
Sovah-Martinsville	$335k/$145k	8+6 -> 8+4	13.10	72	$95	2.24	$14,018	$83
Wilson Medical	$300k/$135k	11+3	14.29	86	$86	2.04	$15,988	$88

8 FTE's

Maria Parham	$300k/$165k	6+2	8.29	51	$89	2.20	$15,723	$85

4-6 FTE's

Ottumwa Regional	$350k/$175k	4+2	6.01	23	$92	2.15	$25,966	$225
Person Memorial	$330k/$165k	2+2.6 -> 2+2	4.33	15	$101	2.30	$18,810	$175
STRHS-Lawrenceburg	$350k/$135k/$140k	2+4	6.08	20	$79	2.21	$16,947	$173
STRHS-Pulaski	$315k/$140k/$145k	2+4	6.03	23	$90	2.50	$14,871	$128
STRHS-Winchester	$330k	4+0	4.19	25	$94	2.42	$24,630	$137
Valley View	$386k/$150k/$159k	2+2	4.41	16	$76	2.43	$40,585	$358

1-3 FTE's

Conemaugh Meyersdale	$155k	.1+2	2.08	4	$61	1.77	$24,220	$449
Conemaugh Miners	$340k/$145k	.5+1	1.20	4	$88	2.21	$40,792	$169
Conemaugh Nason	$340k/$145k	1.5+2 -> 2+1	3.22	16	$94	2.22	$31,656	$111
STRHS-Sewanee	$330k	.25+0	0.48	3	$97	2.59	$17,186	$86

Glint Report for Lifepoint Health
Exported: 11 Sep 2024

Report Template Title Comments
Filters:
Culture of Safety and Hospital Name Ottumwa Regional
Date: 13 Jul 2022
Responses: 314 of 466
Response Rate: 67%

Section Name Comments
Comments ALL

Survey Name	Pulse Date (mm/dd/yyyy)	Question	Question Name	Team	Translated Answer in English
June 2022 CoSE	06/15/2022	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	I have always tried to go above and beyond,
June 2022 CoSE	06/15/2022	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	I wish the organization was better at fostering opportunities for community outreach and involvement. I feel like the fact that we are a nonprofit keeps us from really immersing ourselves in the community and becoming an organization that can be trusted. I worked for a rural state hospital and we would do all kinds of volunteer work all over the city and I felt a greater sense of belonging and pride there than I do here.
June 2022 CoSE	06/15/2022	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	there's not much for retention pay. retirement isnt matched, ipers would be nice
June 2022 CoSE	06/15/2022	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	Within my unit/department
June 2022 CoSE	06/15/2022	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	I feel like an outcast at this hospital. I have overheard my peers making judgmental comments about me. I feel like administration intentionally makes certain individuals not feel welcome at this facility.
June 2022 CoSE	06/15/2022	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	My direct leader and my senior leadership group at this organization make me feel inclusive.
June 2022 CoSE	06/15/2022	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	in my department we work very well together to keep patient's safe and well cared for, cannot speak for the rest of the organization
June 2022 CoSE	06/15/2022	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	My coworkers make me feel this way. Not the people higher up than us.
June 2022 CoSE	06/15/2022	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	Rarely do I feel like anyone even cares that I am here.
June 2022 CoSE	06/15/2022	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	It seems like there is plenty of work that needs to get done, but not enough employees to get it done. It sure would be nice if we could work on keeping good help by offering better wages or hiring good people with good wages in order to work done.
June 2022 CoSE	06/15/2022	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	I feel we need better wages so we could get more people interested in working here. But you have to always take care of the ones that have stayed and worked and picked up extra duties.
June 2022 CoSE	06/15/2022	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	Try and make improvements with documentation etc and just get told why its to hard or why it cant happen. We are very much a "this is the way it has always been done" facility.
June 2022 CoSE	06/15/2022	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	Incredibly resistant to change & change is SO slow!
June 2022 CoSE	06/15/2022	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	Many ideas get tabled for various reasons, usually budget or a lack of other resources like staff.
June 2022 CoSE	06/15/2022	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	My unit/department, however, does improve

June 2022 CoSE	06/15/2022	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	forced to utilize outdated/end of life equipment due to no $ to replace what is needed. Corporate level issue.
June 2022 CoSE	06/15/2022	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	My department does no improve from mistakes. Instead of training the employees for everything they should know they cut them short and then we end up with employees that do not know how to do the job.
June 2022 CoSE	06/15/2022	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	We are asked to analyze budgets and line items repeatedly, searching for ways to decrease our annual spend d/t LifePoint budget cuts. However we have the same volumes if not growing volumes.
June 2022 CoSE	06/15/2022	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	they attempt to make good changes but follow through is lacking on levels
June 2022 CoSE	06/15/2022	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	There have been multiple ideas jumped around to make things better in our department and no one seems to want to change anything.
June 2022 CoSE	06/15/2022	There is a just process for handling safety-related errors here.	Just Response - GPS	Ottumwa Regional	Put in a variance and never hear about it again.
June 2022 CoSE	06/15/2022	There is a just process for handling safety-related errors here.	Just Response - GPS	Ottumwa Regional	Errors have occurred and when brought up to management. No one did anything to prevent it from happening again.
June 2022 CoSE	06/15/2022	There is a just process for handling safety-related errors here.	Just Response - GPS	Ottumwa Regional	never get feedback regarding process outcome
June 2022 CoSE	06/15/2022	There is a just process for handling safety-related errors here.	Just Response - GPS	Ottumwa Regional	We have reported our inability to hear overhead pages in our department. This is a major safety issue and it is still going on. If I don't know where a Code Zero or a Dr. Armstrong is I cannot respond appropriately in a timely manner.
June 2022 CoSE	06/15/2022	There is a just process for handling safety-related errors here.	Just Response - GPS	Ottumwa Regional	From what I have seen safety matters within the ORMICS Dept Yes my boss is on them right away. Safety concerns within the ED especially with physician is just kept hush hush. NEVER have I seen a variance being addressed about safety concerns in the ED and it just continues.
June 2022 CoSE	06/15/2022	I have the resources I need to do my job well.	Resources	Ottumwa Regional	Staffing is a real issue that impacts all of our abilities to effectively do our jobs well
June 2022 CoSE	06/15/2022	I have the resources I need to do my job well.	Resources	Ottumwa Regional	All departments are understaffed. Even when fully staffed the processes do not run well.
June 2022 CoSE	06/15/2022	I have the resources I need to do my job well.	Resources	Ottumwa Regional	short staffed, constantly. Equipment shortages.
June 2022 CoSE	06/15/2022	I have the resources I need to do my job well.	Resources	Ottumwa Regional	using old equipment in desperate need of replacement
June 2022 CoSE	06/15/2022	I have the resources I need to do my job well.	Resources	Ottumwa Regional	Do to the lack of nursing staff... my nurses are overworked and hard to get cares done, such as passing meds and getting things done in timely manner
June 2022 CoSE	06/15/2022	I have the resources I need to do my job well.	Resources	Ottumwa Regional	The department as a whole (techs, phlebotomist, accessoners, etc) do not have the tools to do our job. We are constantly running out of things to be able to draw blood, transfer it to the correct tubing, and running the actual test needed and ordered by the provider. This has been an on going problems for MONTHS. There is no way for us to continue to treat patient who are ill without these things.
June 2022 CoSE	06/15/2022	I have the resources I need to do my job well.	Resources	Ottumwa Regional	Staff are expected to work understaff consistently.
June 2022 CoSE	06/15/2022	I have the resources I need to do my job well.	Resources	Ottumwa Regional	I think as a department we have a lot to work on. I understand that ORMICS is going to be hard on our equipment, but when we do not have the essentials to work or do our job it effects our patient care.

June 2022 CoSE	06/15/2022	I have the resources I need to do my job well.	Resources	Ottumwa Regional	Would be nice to have reliable ambulances
June 2022 CoSE	06/15/2022	I have the resources I need to do my job well.	Resources	Ottumwa Regional	Our equipment is not reliable. We have ambulances that are incredibly high miles, that consistently have issues.
June 2022 CoSE	06/15/2022	I have the resources I need to do my job well.	Resources	Ottumwa Regional	Equipment is outdated and needs to be updated and need to have supply orders fulfilled better
June 2022 CoSE	06/15/2022	I feel I can report compliance concerns without fear of retaliation.	Compliance	Ottumwa Regional	Have reported some issues and was told they would get looked into and nothing was done
June 2022 CoSE	06/15/2022	I feel I can report compliance concerns without fear of retaliation.	Compliance	Ottumwa Regional	I feel there is no privacy when it comes to voicing concerns. When issues arise I find that the word travels to different departments.
June 2022 CoSE	06/15/2022	I feel I can report compliance concerns without fear of retaliation.	Compliance	Ottumwa Regional	I have reported many times about things that have concerned me without result. To the new and old administrative staff.
June 2022 CoSE	06/15/2022	I feel I can report compliance concerns without fear of retaliation.	Compliance	Ottumwa Regional	I have reported things in the past, and then find out after the fact, that management had told the person reported on, that they would call down the person that reported them. And allow them to confront them.
June 2022 CoSE	06/15/2022	I feel I can report compliance concerns without fear of retaliation.	Compliance	Ottumwa Regional	No. I have reported issues and asked to remain anonymous, only to find out later that someone leaked my information.
June 2022 CoSE	06/15/2022	The patient safety-related training I receive is effective.	Training - GPS	Ottumwa Regional	I do not feel I have received training, I have had to personally go and seek education myself.
June 2022 CoSE	06/15/2022	The patient safety-related training I receive is effective.	Training - GPS	Ottumwa Regional	What training?
June 2022 CoSE	06/15/2022	The patient safety-related training I receive is effective.	Training - GPS	Ottumwa Regional	What training?
June 2022 CoSE	06/15/2022	People at my organization live the company values.	Values	Ottumwa Regional	I don't know
June 2022 CoSE	06/15/2022	People at my organization live the company values.	Values	Ottumwa Regional	I feel most people are just here for a paycheck or until they find something better.
June 2022 CoSE	06/15/2022	People at my organization live the company values.	Values	Ottumwa Regional	We are all humans with different ways of seeing/doing things.
June 2022 CoSE	06/15/2022	People at my organization live the company values.	Values	Ottumwa Regional	Are there company values….?
June 2022 CoSE	06/15/2022	People at my organization live the company values.	Values	Ottumwa Regional	A lot of people just show up for work here. I don't feel like there's a lot of pride in being an employee at ORHC.
June 2022 CoSE	06/15/2022	People at my organization live the company values.	Values	Ottumwa Regional	My coworkers are all trying but we are all tired and worn out from lack of staff and lack of leadership.
June 2022 CoSE	06/15/2022	People at my organization live the company values.	Values	Ottumwa Regional	If management takes care of the employees, they will be more likely to embrace the organization and it's values. In health care, as an employee, you are there because you care. Our patient's get A+ care because WE care not because of the organization's values.
June 2022 CoSE	06/15/2022	People at my organization live the company values.	Values	Ottumwa Regional	I do not feel like 98% of people here care about the values or even live up to any of them.

June 2022 CoSE	06/15/2022	People at my organization live the company values.	Values	Ottumwa Regional	Not at all. Everyone from management to cleaning staff only do as little as they can to get by without being fired. There is no accountability, definitely no respect for others perspectives, no integrity to do the right thing, only the quick thing with the least effort, no empathy for the feelings and needs of others, and the organization as a whole does not take responsibility for the health care of the patients that they are entrusted with. This organization's management definitely does not lead by example.
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	Same comment as above. I cannot recommend a place to work when they do not place value in their employees beyond ice cream days.
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	I feel we have great benefits, the only issues is our wages.
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	I would recommend it but not as a "GREAT PLACE TO WORK" there are too many things that need to improve to be called "great"
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	Team work is minimal. There aren't enough nurses. Majority of Paramedics/EMTs not willing to help nursing staff. Organization in the facility is terrible & has been for years. Many newer staff are chased off by the attitude of senior staff & how they are treated by senior staff.
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	I would be happy to tell a friend or community member to work here but I hear a lot of people saying that they'd never want to work here or that they used to work here and left because they didn't feel valued or listened to as staff.
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	Upper Management is easy to talk to. Very friendly staff
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	Lack of leadership in my department is wearing us all really thin. Working overtime every day is hard to keep up with a family at home counting on me.
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	This rating is decreased for reasons including non-competitive salaries, lack of 401k math similar to IPERS at most other competing organizations surrounding our facility, and negative culture.
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	I used to refer people to work with us all of the time, but now I feel terrible, guilty, if I ask anybody to join our team.
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	i would not recommend this employer because of the lack of merit and/or cost of living increases and the fact that the 401k match is pitiful. How do you expect employees to have a nest egg to retire with?
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	I enjoy my job and my coworkers but hate that there is no recognization here at all. I have worked in Monroe county and they make work a fun and happy place to be at. Managers praise you in all that you are doing well in and also come talk to you about things that need some work. I enjoy this service because we are busy and we get to do a lot more calls than monroe county but I wish some things were different. Im not a pizza party here and there when we are so busy no one got lunch kind of person. Dont get me wrong I love food but sometimes thats not what we need all the time.
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	Most days are alright, it's not the work that is not great, it is the people. Most of the people I work with do not treat you with respect.

					Other staff, outside of nurses, need decent pay raises to help with inflation.
June 2022 CoSE	06/15/2022	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	
June 2022 CoSE	06/15/2022	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	I agree that you can move up but again compensation is bad. I feel they don't look at how many years you have also been here when you change position and that just because you are making more money than the person before you, you should still be able to get a raise.
June 2022 CoSE	06/15/2022	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	I have grown a lot over my time here because I put in the effort. This is a personal responsibility not that of the organization.
June 2022 CoSE	06/15/2022	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	There has been a lot of "promises" of different shifts given to people but it has never happened.
June 2022 CoSE	06/15/2022	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	I don't see ORHC as a place I could work for forever, it is more like a starting point for other things. I wish I saw more of a future here but this feels like a stale environment.
June 2022 CoSE	06/15/2022	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	Our tuition assistance program is only $10,000 for life. If an employee starts here out of high school and uses the tuition assistance to start an associate's degree, they will never be able to use tuition money to increase their education to obtain a post associates degree or bachelor's degree which is required for all management positions.
June 2022 CoSE	06/15/2022	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	I have lots of ideas on how to better my education but am met with hurdles and negative feedback from management on not having time, resources, or money to further these.
June 2022 CoSE	06/15/2022	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	I feel good for myself but not some of my less vocal co workers
June 2022 CoSE	06/15/2022	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	When asking for classes to learn from we either get sent some papers to look at or we get left on the back burner. If there is a class we will get a message about it the day before. People with young children like myself have to find a baby sitter and are usually unable to make any classes.
June 2022 CoSE	06/15/2022	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	I get very few opportunities to show what I am capable of, otherwise I am constantly stepped on.
June 2022 CoSE	06/15/2022	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	yes you have the resources but are not used as should
June 2022 CoSE	06/15/2022	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	Staffing issues contribute to patient safety
June 2022 CoSE	06/15/2022	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	A lot of equipment is old and out dated.
June 2022 CoSE	06/15/2022	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	I think this hospital could use a lot of structural upgrades in order to improve patient care and safety. We have a lot of old equipment and a lot of spaces that are not conducive for safe, efficient care. I think efficiency and ease of use contributes to safety compliance.

June 2022 CoSE	06/15/2022	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	We have times where we do not have the equipment to move a patient in the best way possible. If ORMICS is out on calls we have a lack of personnel/personnel with less experience responding to Dr. Armstrong's. For the last one there are steps being taken using Handle With Care to remedy this. We have requested the volume for overhead pages to be turned up in our department. This has been and continues to be an issue. ORMICS cannot respond to issues appropriately in a timely manner if we do not know what is going on and where it is.
June 2022 CoSE	06/15/2022	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	Unsafe ambulances
June 2022 CoSE	06/15/2022	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	See above comments about ambulance safety.
June 2022 CoSE	06/15/2022	We discuss ways to prevent safety errors from happening again.	Learning From Mistakes - GPS	Ottumwa Regional	things are 'discussed', but i don't see any results...
June 2022 CoSE	06/15/2022	We discuss ways to prevent safety errors from happening again.	Learning From Mistakes - GPS	Ottumwa Regional	My department takes the time to discuss.
June 2022 CoSE	06/15/2022	We discuss ways to prevent safety errors from happening again.	Learning From Mistakes - GPS	Ottumwa Regional	We do in OUR work area.
June 2022 CoSE	06/15/2022	At work, I feel cared about as a person.	Care	Ottumwa Regional	My director cares about his staff
June 2022 CoSE	06/15/2022	At work, I feel cared about as a person.	Care	Ottumwa Regional	By my co workers
June 2022 CoSE	06/15/2022	At work, I feel cared about as a person.	Care	Ottumwa Regional	Not at all!
June 2022 CoSE	06/15/2022	At work, I feel cared about as a person.	Care	Ottumwa Regional	As a nurse I feel that this facility does not care about its employees, your a number here and your thoughts, ideas and feelings DO NOT matter.
June 2022 CoSE	06/15/2022	At work, I feel cared about as a person.	Care	Ottumwa Regional	OUR TEAM works well together and cares about what others think and feel. That concern continues outside of the hospital.
June 2022 CoSE	06/15/2022	At work, I feel cared about as a person.	Care	Ottumwa Regional	We rarely get positive feedback. It is usually negative.
June 2022 CoSE	06/15/2022	At work, I feel cared about as a person.	Care	Ottumwa Regional	There are very few people I work with that I feel care about me, most people do not care about me at all.
June 2022 CoSE	06/15/2022	At work, I feel cared about as a person.	Care	Ottumwa Regional	I've acquired a $1 raise off of my start rate in 6 years of working here. Inflation is destroying me. Help!
June 2022 CoSE	06/15/2022	My input about patient safety is valued here.	Voice - GPS	Ottumwa Regional	I no longer feel my voice is valued.
June 2022 CoSE	06/15/2022	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	no hourly rounding especially in the er, i know its busy "sometimes", but i work here i see all the bull talking at nurse station and the drama talk between departments, no excuses
June 2022 CoSE	06/15/2022	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	We wait to long to replace safety critical items such as beds, lift equipment etc.
June 2022 CoSE	06/15/2022	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	the way I do things around here, not always WE
June 2022 CoSE	06/15/2022	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	there are some changes, but maybe metal detectors at least in the ER would be good

June 2022 CoSE	06/15/2022	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	The only thing that worries me is when everyone is run ragged that is when mistakes are made.
June 2022 CoSE	06/15/2022	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	All efforts are made, sometimes lack of staff on other units may effect this.
June 2022 CoSE	06/15/2022	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	Depends on your nurse
June 2022 CoSE	06/15/2022	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	Some people on some days
June 2022 CoSE	06/15/2022	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	It seems like it corporate driven and communication isn't important.
June 2022 CoSE	06/15/2022	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	leader boards that were placed up for concerns i have seen questions not answered for up to 6 months, or if answered its the easy way out no explanation
June 2022 CoSE	06/15/2022	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	Communication is a struggle
June 2022 CoSE	06/15/2022	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	The communication here is terrible. We don't even send out emails when employees leave or are terminated.
June 2022 CoSE	06/15/2022	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	I feel we lack communication
June 2022 CoSE	06/15/2022	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	If you are not in administration you hear very little.
June 2022 CoSE	06/15/2022	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	Many years ago, we used to have a newsletter and get emails and celebrate accomplishments and learn about future goals and progress and it really fostered team building and organizational pride
June 2022 CoSE	06/15/2022	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	In my position, I am PRN, meaning I am not here all the time. My schedule is constantly getting re-arranged. I do NOT get notified about these changes from administration. I get notified through a co-worker that works full time here because I ask them. There have been MULTIPLE times where I have reached out to my "administration" and not gotten a response. This department needs a new administrative that wont be your friend, but your boss.
June 2022 CoSE	06/15/2022	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	Lots of emails go out. But most are generalized for whole company. Don't get a lot of communication from my director specifically about our place
June 2022 CoSE	06/15/2022	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	##### HR Director keeps everyone informed well
June 2022 CoSE	06/15/2022	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	I fee like things get swept under the rug here and are hush hush. I get that as employees we do not need to know everything but some things would be nice.
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	drama is the main topic anymore with this company not caring for their employees,
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	I this this depends on the departments

June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	Hard to get a hold of staff at times and when you do they are often rushed, rude and dismissive.
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	I feel there is an extreme lack of understanding between departments. We have a lot of opportunities to improve processes between departments but a lot of finger pointing gets done and I don't feel like anything ever gets resolved. I wish we could all walk in each others shoes to create a more cooperative, supportive environment.
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	I believe rather than ask for help, staff move forward and do what they think is best; that is a safety concern for patients and staff alike
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	There seems to be a huge downfall between all departments. Housekeeping, dietary, lab and radiology all have different priorities.
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	nurse to pt ratio very uneven, trying to find a nurse to explain what is going to happen, or to find a nurse to help with pt exam,, delays pt care
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	very difficult to give report to the floors. Operator sends most calls to ER for the charge RN to figure out
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	It feels disconnected due to the constant question of the plan for the day or what is going on between our department and others with little to no communication from any leaders.
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	CNAs never get report from the oncoming unit about the patient.
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	Very hard to receive communication between hospital and clinics. A EHR that links the two places would be helpful.
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	It seems that departments work within their own area and not with other depts.
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	Communication between departments needs to improve we need to be educated on what each of us do to help make the patients experience better
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	communication is the worst skill for employees around here. TOO many people assuming communication and not asking for clarification
June 2022 CoSE	06/15/2022	The exchange of information between departments occurs smoothly.	Exchange - GPS	Ottumwa Regional	some issues occurred during admitting patients from the clinic to the hospital
June 2022 CoSE	06/15/2022	Teams at my organization collaborate effectively to get things done.	Collaboration	Ottumwa Regional	The clinics work hard at helping each other out

June 2022 CoSE	06/15/2022	Teams at my organization collaborate effectively to get things done.	Collaboration	Ottumwa Regional	Each department is very much its own entity. ICU travelers in particular act far superior and are quite rude to other staff.
June 2022 CoSE	06/15/2022	Teams at my organization collaborate effectively to get things done.	Collaboration	Ottumwa Regional	Due to staffing no one is able to have time to collaborate effectively
June 2022 CoSE	06/15/2022	Teams at my organization collaborate effectively to get things done.	Collaboration	Ottumwa Regional	no team work between departments due to short staffing issues, no one has time to help or extra hands to help the next department due to no staffing and increased work loads but lets hire travelers and pay them 3 and 4 times what are regular staff makes
June 2022 CoSE	06/15/2022	Teams at my organization collaborate effectively to get things done.	Collaboration	Ottumwa Regional	each department and the relationships therein
June 2022 CoSE	06/15/2022	Teams at my organization collaborate effectively to get things done.	Collaboration	Ottumwa Regional	we start strong, getting frontline staff involved is difficult with staff matrix as staff are sent home when census drops rather than using time for improvement projects
June 2022 CoSE	06/15/2022	Teams at my organization collaborate effectively to get things done.	Collaboration	Ottumwa Regional	Teams at MY CLINIC do!!
June 2022 CoSE	06/15/2022	Teams at my organization collaborate effectively to get things done.	Collaboration	Ottumwa Regional	When I first started here (2020) we had full staff that respected the administrative we had. Since then we have lost both the people that filled those positions. The personal that is now filling in those position have lost sight of the big picture (taking care of employees mental and physical health.) With these personal there is no "teams" it is each individual for themselves. No one helps on another in this department.
June 2022 CoSE	06/15/2022	Teams at my organization collaborate effectively to get things done.	Collaboration	Ottumwa Regional	It depends on who is working.
June 2022 CoSE	06/15/2022	Teams at my organization collaborate effectively to get things done.	Collaboration	Ottumwa Regional	It seems that departments don't always work well together, usually it's a staffing issue.
June 2022 CoSE	06/15/2022	There is good communication between leaders and employees here about patient safety.	Communication - GPS	Ottumwa Regional	I feel most people will speak up for patient safety but they also get tired of hearing the same excesses.
June 2022 CoSE	06/15/2022	There is good communication between leaders and employees here about patient safety.	Communication - GPS	Ottumwa Regional	Good communication with our director and coordinators
June 2022 CoSE	06/15/2022	There is good communication between leaders and employees here about patient safety.	Communication - GPS	Ottumwa Regional	There is communication, with a newsletter and huddles, it is surprising how many people don't read their emails and contracted services like EVS and dietary communication could be better
June 2022 CoSE	06/15/2022	There is good communication between leaders and employees here about patient safety.	Communication - GPS	Ottumwa Regional	Our "leaders" don't care half of the time. Not even about their employees.
June 2022 CoSE	06/15/2022	There is good communication between leaders and employees here about patient safety.	Communication - GPS	Ottumwa Regional	

					It depends on the clinic and specific providers.
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	
					staff are exhausted, mistakes can be made in these situations
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	
					the hourly rounding is strongly not happening multiple times witnessed my self, no communication from doctors
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	
					This would depend on the type of care that was needed. Certain specialties are lacking the staff and resources needed to confidently tell others to seek care here.
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	
					my family and I have always received great care.
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	
					I would allow my family to have surgery here as long as they were going home same day. I wouldn't want them to have to stay here overnight.
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	
					This hospital is dirty! I hear stories in the community and see first hand accounts of unclean patient care areas.
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	
					depending upon where you work, such as in ER or Behavioral Health, there are increased risks; the training is good and needs to continue or increase the frequency
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	
					Due to staffing, if too many high acuity patients, it takes up the majority of staff and others get put on the back burner
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	
					Alot depends on which Doctor or practice
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	
					If I was half dying by the county line between Wapello and Monroe counties, I would drag myself across the county line to Monroe.
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	
					Some days some providers
June 2022 CoSE	06/15/2022	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	

June 2022 CoSE	06/15/2022	I can speak up about patient safety without fear of retaliation.	Psychological Safety - GPS	Ottumwa Regional	No fear or retaliation or action of any kind actually.
June 2022 CoSE	06/15/2022	I can speak up about patient safety without fear of retaliation.	Psychological Safety - GPS	Ottumwa Regional	Maybe won’t be retaliated against but many times it falls on deaf ears.
June 2022 CoSE	06/15/2022	I can speak up about patient safety without fear of retaliation.	Psychological Safety - GPS	Ottumwa Regional	I feel if I speak up it will be disregarded or treated poorly for voicing concerns regarding safety.
June 2022 CoSE	06/15/2022	I can speak up about patient safety without fear of retaliation.	Psychological Safety - GPS	Ottumwa Regional	I personally never have spoke up about a safety issue because I have seen others speak up and get ignored. I do not fear retaliation, I just don't want to waste my breath on deaf ears.
June 2022 CoSE	06/15/2022	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	back to patient rounding not happening
June 2022 CoSE	06/15/2022	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	They say so but the bank account does not back it up.
June 2022 CoSE	06/15/2022	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	Financial priorities seem to be on facility attractiveness rather than staffing and updated equipment requests
June 2022 CoSE	06/15/2022	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	Often pts are held in ED or transferred out losing revenue that could be retained for improvements in our facility.
June 2022 CoSE	06/15/2022	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	Local leadership's actions demonstrate this as a priority. Division leadership would rank a 1 as they don't make it a priority when they do not purchase the capital that is needed for our organization and they do not do anything to combat staffing issues, resulting in staff working unsafely either due to lack of staff, burnout, or fatigue.
June 2022 CoSE	06/15/2022	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	Although this should be top priority, sadly, its not. Leadership does not look into the patient safety as they should.
June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	I have a great director who tries to keep everyone in the loop But I have not had a sit down evaluation in several years.
June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	More praise than feedback
June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	##### is probably the glue that holds the Dept togethet
June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	I feel my manager has a disconnect from what is happening in our department
June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	I feel like I rarely receive feedback, positive or negative. I am extremely paranoid that my team members and supervisors discuss issues behind my back without face-to-face resolution.
June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	I have worked at this organization for 2.5 years and have not had a performance review.

June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	Have been here at my current job over a year and have not had a yearly review.
June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	By manager is only seen in the mornings for half an hour at most.
June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	Currently do not have management and feel that we need to have our voices heard and communication between employees and all levels of the organization to be able to accomplish our goals affectively.
June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	My supervisor has not given me any feedback on anything since I started working here.
June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	My manager and coworkers are the best. The only reason I haven't left.
June 2022 CoSE	06/15/2022	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	We do not see or hear from our managers unless we reach out with a complaint that then seems to be brushed off.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy working with my peers and assisting to improve processes.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The type of work I do and the people I work directly with.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The patients
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Most of the people, including my boss and the C.E.O. are very friendly. This makes me want to go to work each day.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Caring staff
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people i work with
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	#####, my manager, is fantastic. He truly cares about his employees and does everything he can to ensure they are taken care of to the best of his ability.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Challenging work, committed department management
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like that it is small enough to know most everyone and develop good relationships but not so small that there isn't always something to learn.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	That I work for the busiest service in Southeast Iowa and I've found some of my best friends working here.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Helping patients and their families with getting connected to resources that they may need or want.

June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy coming to work knowing that most people treat you like your family and safe place to work at.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Involvement from administration
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel a sense of teamwork with my other leaders
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel like I do a good job and am allowed to work independently. Also, my PTS accumulation.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Being of assistance to those who care for our patients.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The leadership team that I work with cares about our staff and works tirelessly to improve work environment and recognizes me and other managers/directors for our what we do every day.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	i have a great team of coworkers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My patients and department
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Helping others
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The team that I work with.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people that I work with. It's our people that keep many of us going during such a hard time for our industry.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I do like the particular physician I am working for and this physician is very responsive to his staff and appreciative of his staff.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like that I have co-workers that I can rely on when I need help.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Patient care and knowing I am making a positive difference in the health of the patients I see.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	taking care of patients and contribute to community with my work
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The only thing keeping me here are our patients & my immediate team members. Not the organization
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The patients
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The providers I work for at my Office
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I work with some of the best Medical Technologist and Medical Lab Techs. I'm grateful for that.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The patient interaction is what I love about being a nurse
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Several great co-workers at this facility.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the people I work with; they have become my family
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The clinical work that I do and the people I work closely with.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My manager is very knowledgeable and is willing to train and educate her employees.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my Manager
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Helping patients
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love that my managers (##### and #####) listen to my needs and act on my needs. I love the One Day Surgery team.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	EMPLOYEES
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love working with my group of workers and ##### is a awsome boss to work for she goes above and beonded to help if we need it.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My co-workers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love doing the work I do it it ever learning
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I get a paycheck.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	about the only good thing i can think of right off the top of my head is it is worm in the winter and cool in the summer
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I live that i work at a busy place that i can gain real world experience.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Vacation time.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel we have great benefits,
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with and the patients that appreciate us.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	knowing that what we provide here at ORHC is important to the community
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	working with my co workers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like the people I work with
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I get to do the type of work I like doing. I get to help others all the time which is what I completely desire to do.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Several great people to work with , strong circle of staff that get things done
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The doctor and nurse I work with is the only reason I stay
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my coworkers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Coworkers are friendly.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy my third shift because I am away from the drama and from techs that can make you feel like crap. I enjoy thirds because I have better communication with the nurses as well with my supervisor
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love most of my co-workers.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers in my department.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Team work!
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people in my department. We all get along well and try to help each other in any way we can. We get stuff done but we also have fun.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	some of the people i work with
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My team! The ones who participate & work as a team & the relationships that we build/have built are what keeps me there
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people, we all have struggled together and the team at this hospital does care about each other.

June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love most when a patient tells me I've made a difference in their experience. Whether they let me know verbally or with a simple smile. My bosses and coworkers may not let me know I'm making a difference but my patients do.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My co-workers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The friends I have made here
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I do love my job as a nurse, but what I am sick of in this organization is the lack of support by senior team members and the short staffing issues, no raises and being told things are gonna get better when they have not gotten better in 3 years, I could go someplace else and make way more money, but this is convienent for me (close to home) , this facility needs to work on recruiting home town people and retaining their good employees
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my coworkers are in the same predicament i am and we help each other out
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy my co-workers and being able to help the patients who come in
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel like the people that I work directly with value me.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love getting to take care of the community we serve and enjoy the feeling of knowing I worked hard and helped others.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	teamwork within my department
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	what i do for my occupation.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	We work well as a team
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	THE PEOPLE I WORK WITH
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The family feel in my department. Everyone working together to bring this hospital back to the way it used to be perceived as a trusted place to go
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the people I work with. I believe in the Ottumwa community. I believe this place CAN be better when we have the right leadership.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my director is easy to talk with about issues that come up
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with directly in my department are wonderful and I enjoy my specific job; working with the patients I work with and making a difference for those people and their families in some small way.

June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Every day is different
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	helping patients
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have great collegues and management is easy to approach. I have been given flexibility to improve workflow in my office with a lot of friction. It has helped everyone.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	RELATIVELY CLOSE TO HOME.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people and their desire to do well in caring for patients
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with. I enjoy my job when I am able to do so and I like the flexibility at times that my job allows.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	the amount of responsibility that has been/is given to me is within my abilities, i am guided with advice from dept mgr(even if it's something i don't want to hear...)
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Supportive peers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Some coworkers are great to work with. I enjoy what I do as a whole.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the work I do!! I love anatomy and find the human body fascinating therefore, I love what I do and feel like I do matter to the patient and the doctor's making diagnoses for their patients.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	CoWorkers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have an amazing director and managers of my department. They go above and beyond to give our patients amazing hometown care. They do everything within their power to take care of their staff. As far as our hospital being part of Lifepoint, it feels like we are a number, a budget, anything but a care giving institution. Many of our services are hired out, such as dietary, housekeeping, laundry. As a result, no one cares if they do a good job, no one cares if there is enough staff to do all the things that need done. Surrounding county or state medical facilities have increased wages across the board, but not us. Our staff leaves, and the rest are expected to pick up the slack, do more with less and not get paid more. Our management, and our corporate company need to increase pay, and staff, and be accountable for our building and the services we provide for our community.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I really enjoy my coworkers, and the patients. I love how easy it is to talk to upper management if I need anything, they really embody the "open door" policy.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love my job/career. I feel that my immediate supervisors care about everyone in our department. And they try to the best of their abiltiy to keep things working smoothly. Unfortunatly most decisions come from corporate, they have very little autonomy. I was taught many years ago, 36 to be exact, that autonomy was very important to what we do as nurses. I feel as though we are all puppets to our corporate owners. I will always do my very best to treat others especially my patients and co-workers as I would want to be treated, with respect and dignity.

June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The girls that work on my unit and my department manager
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Our leader is compassionate, caring, a resource to go to, fair, straightforward.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My co-workers and my supervisor
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Taking care of patients in a timely manner and my team I work with.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	We have a very close knit team.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my coworkers are great and I like talking with patients each day and getting to know them
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The hours.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The sense of family from being a part of the organization. Work family.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy working with my receptionist and the provider. We make a great team and support each other. We work hard and make sure our work is done and done right. We have each others back and that is what team work is.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers. We have to work together to get things done.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	on
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	This is a good place to work, however the manager has not clue what she is doing.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Flexibility
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my boss and co workers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like the team I work with. We work well together and make sure our patients are well served. We all pitch in where needed.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	It's the worst job I've held in and outside of healthcare.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Co-workers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My co-workers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My boss.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	helping patients
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I think the "organization" makes it difficult to get things accomplished. With my degree in managment I understand that there needs to be a balance to make a business run efficiently. However, our job is to care for people and sometimes it just feels like that is lost.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I work from home where it is clean.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My manager, #####, is the most responsive, approachable, supportive, and effective manager I have had in my medical career. He actively removes barriers from medical practice leading to increased productivity. We need more of #####'s "do what is best for the patient" approach in healthcare.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	That I get to experience new things working on the medical field.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love what I do, I do not necessarily love the organization.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Ability to care for patients.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the people I work with.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have flexibility with my schedule
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love being about to help aid in the treatment of patients. I love helping my patient start to feel better and have brighter outlooks on life knowing we have treat their illness.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	the nurses in the department i work for
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	complaints never get followed through on. i was ran out of my unit by another staff and the manager so much bullying and work place harassment,
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love that I am caring for members of my community since I do reside in town. I also enjoy caring for members of the surrounding community. I have a really good director that is engaged with her staff. I feel that the benefits are good here. There are people that have been working here for a long time that I love to see every time I work. I feel that I have autonomy here at work, but still there is still good teamwork that I know I can depend on if I need. I really appreciate working for the director that I do, and for the unit I work on,. We have a good leader on our unit and a good team.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Able to care for people of my community

June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	co workers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Team work and acute services provided
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	There is good teamwork among my peers in my specific department.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Serving my home town.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Paycheck
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Flexible schedule and most co workers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I think those directly above me have my back and will always try to help me to be better.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Most front line co workers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy working with the team that I employ. I enjoy making a difference in the lives of the citizens of Southern Iowa. I enjoy working for a healthcare corporate structure that provides charity care and gives back.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The patients
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Helping patients making them smile
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My Director is the best to work for!
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel supported in the workplace and able to speak up about concerns.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The provider I work with and the work we do together as a team. We truly make a difference to our patients and that is very satisfying.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The fact I can make a difference in patients care'
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Serving the people in my community
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	That I get to work and my local community, helping to take care of friends and family.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the trust/confidence I get from my co-workers and supervisor
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have some great coworkers.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel like my management team encourages me every day. They seem to always find a positive way to help me continue with my education and learning
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love my co-workers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	love my actual job, manager tries very hard
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy the interaction with the patients, knowing I am helping them
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like that I help patients when they are in need of my help. I like that I can make a difference.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I do get along well with my immediate team and staff.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Some of the staff can be very friendly
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Autonomy to do my job... just need help sometimes.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the doctor I work with and my coworkers. We work great together to provide the deliver the best care possible to our patients.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the opportunities this place grants me!
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the work I do and the people I work with.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love my team at Easy care. We all work well together.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My hours
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Not a lot of micromanaging.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My patients.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The patient care
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The understanding you get when you need to take time off
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy the care I give
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I don't. I work in an area the past year that needs lots of help and quality improvement and it is known and not acted upon.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers, and the opportunity to run a decent amount of calls.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people in my department.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Knowing what I work for everyday has an impact in helping patients
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with. Radiology is amazing!
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers are awesome. We have the camaraderie that comes from working in the trenches.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My managers are good at making us feel like they care about us as a person.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	people I work with
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Benefits
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	unknown
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy very few of my coworkers, but I love what I do for our community.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Coworkers feel like family.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I LOVE THE OFFICE I WORK IN, THE SMALL STAFF, THE PHYSICIAN IS THE BEST TO WORK WITH.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Taking care of people who have a real need. Working with solid teams and other service lines that have a similar mentality to patient care.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	i love the people i work with and the patients i work for
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love to take care of patient's and their families. I do love a large number of my coworkers. I do love my supervisor, although he seems unable to provide a lot of feedback, or seems uninterested at times I do believe he has all of our best interest at heart. Most problems that are perceived as problems with the manager seem to be problems with management above him.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Helping people

June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My manager and my coworkers on my particular floor. WFC
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love knowing I can help individuals who are struggling (patients) & help my community.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	i feel valued as an employee
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy helping patients and working for outstanding physicians.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My co-workers
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Friendly coworkers, amazing director (#####) and great teamwork.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Co workers, teamwork, the communication amongst the team.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love knowing that I am helping keep patients healthy, and being able to talk with them everyday.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	It's not the organization it's helping the patients that makes me feel very good .
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Getting to meet new people everyday, and hopefully making their day a little better with my help.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	i am able to do my job and not feel overwhelmed with management
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My director is such a positive light to our unit. Leadership plays a big role in how successful our team is as a whole, and ##### makes us feel cared for in the work place, as well as outside the work place. I also love our team of nurses on my unit. They are wonderful and make each day rewarding to be here. I am passionate about the work we do and the care we give our patients.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My boss is great. She communicates with me, gives me feedback. She works with me.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	As a single woman k I am they give me the opportunity to be able to work a little extra time I thank [redacted] for k that extra time is a great help for me again thank you.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with, who are all travel nurses.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The staff I work with and the patients.
June 2022 CoSE	06/15/2022	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Certain groups of people are amazing to work with. We all work together to and help each other improve.

June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	I have worked here for over 30 years. Because I became a nurse after we became for profit, I do no make the same wage as those who were. I have been a dedicated, hard working employee to this organization and do not feel I am being compensated.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	nice place of employment, but the advertisement of new hire states room for growth and higher opportunity's, which in my department that is false. also economy is rising and haven't seen any raises
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	I am very happy working at the clinics but feel that the hospital needs and their employees take priority over ours and it is hard to explain this to my staff. It makes them feel like they are not as important or valued
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	The biggest issue I have with the organization is the lack of correlation between performance reviews and pay increases. Consistent and great performances in a position should warrant a pay increase. It is hard to maintain the same vigor for my position and organization when I do not feel the compensation from the organization matches my commitment level. I have increasingly been thinking of applying for other positions when I am otherwise quite happy in my position at ORHC.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	Not happy as I once was. Everything seems geared to trying to get the next new person. Nothing or very little for those loyal employees.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	I have always loved my job, but with the staff shortage and picking up extra duties there is no compensation for it.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	Missing in this organization is professionalism, respect within, and appreciation.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	Under payed!!
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	I leave feeling frustrated because they are continually giving more task to be completed but making it impossible to succeed because they is not enough time in a day to get it done so lunches are being missed and breaks that are no longer possible to take, Amd there is not enough staff to help us succeed.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	call pay isn't worth taking call, especially multiple times a week. being stuck 30 minutes from Ottumwa and planning for daycare under 30 minutes away from work is difficult for only $2 an hour.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	I love what I do everyday helping patients, but we have no real leadership here. I am working long days every day with hardly a thank you.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	My direct supervisors are amazing, but compared to the organization as a whole I would same I am not very happy.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	My job within the organization is not supported. My "administration" does not hold the staff accountable for their actions and does not appreciate the staff that does work hard everyday.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	An organization requires strong leadership from the highest level of the corporate structure, supported with budget dollars to improve poor functioning equipment and decrepit buildings, along with a positive morale installation in order to appropriately adjust the culture of an organizational structure at any level.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	I would like to clarify that I love the work that I do, just not the environment.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	We need higher wages and more benefits. We need to hire more staff and spend up the hiring process as we often loose potential new hires because our process takes to long and no body understands why.
June 2022 CoSE	06/15/2022	How happy are you working at your organization?	eSat	Ottumwa Regional	I do not like working for this organization. I feel we are under valued and under paid as employees. Not just nurses. Every single employee. I do love my coworkers and my manager. They are the only reason I have not left. [redacted]
June 2022 CoSE	06/15/2022	I feel empowered to make decisions regarding my work.	Empowerment	Ottumwa Regional	I feel that my director allows us to make decisions as long as it does not hurt the patient or the clinics.

					Only because I do. Easier to ask for forgiveness than approval.
June 2022 CoSE	06/15/2022	I feel empowered to make decisions regarding my work.	Empowerment	Ottumwa Regional	
					I feel my co-workers like to micro manage my work.
June 2022 CoSE	06/15/2022	I feel empowered to make decisions regarding my work.	Empowerment	Ottumwa Regional	
					constant micromanagement
June 2022 CoSE	06/15/2022	I feel empowered to make decisions regarding my work.	Empowerment	Ottumwa Regional	
					Multiple co-workers have offered ways to improve things around the department but have been shot down for not being part of the administrative personal.
June 2022 CoSE	06/15/2022	I feel empowered to make decisions regarding my work.	Empowerment	Ottumwa Regional	
					I have in the past made decisions as a TL, that get overruled or ignored.
June 2022 CoSE	06/15/2022	I feel empowered to make decisions regarding my work.	Empowerment	Ottumwa Regional	I have brought ideas on team building and organization that are not recognized.
					I feel the mentality is "They are just doing their jobs."
June 2022 CoSE	06/15/2022	Employees who prioritize patient safety are appreciated here.	Recognition - GPS	Ottumwa Regional	
					This is hard to answer as staff who were liaisons for infection control and safety are not getting the time to participate; again due to limited staff or because of the staff matrix.
June 2022 CoSE	06/15/2022	Employees who prioritize patient safety are appreciated here.	Recognition - GPS	Ottumwa Regional	
					there is no real appreciation for us as workers...
June 2022 CoSE	06/15/2022	Employees who prioritize patient safety are appreciated here.	Recognition - GPS	Ottumwa Regional	
					I watch my peers advocate for patient safety, speak up when they have concerns, and listen to leadership be dismissive and judgmental.
June 2022 CoSE	06/15/2022	Employees who prioritize patient safety are appreciated here.	Recognition - GPS	Ottumwa Regional	
					Invest in employees with reward and recognition for employees, cost of living raise in light of inflation (this is straight forward regardless of constraints to retain employees), opportunity for work from home models of options to complete work in fewer days on site - basically listen to and invest in the employees of the organization.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	
					Updating equipment that is end of life instead of making work arounds that affect time that staff could be spending with patients. Update the computer system to improve efficiency in the teams that would allow for less time spent at the computer and more time at the bedside. Improve benefits like health insurance for part time employees to help attract employees that are working at close facilities receiving benefits that the organization does not offer, Increase support staff's pay to be able higher and retain more support staff.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	
					Remodel, cleanliness (consistently receive negative comments and how dirty and unkempt our hospital is. Patients choose other facilities for care because of this.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	
					Tennessee leadership
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	
					Holding employees accountable for their attitudes to patients and coworkers. Raising pay for non-travel positions.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	
					staffing is an issue as like most of the US, but focusing on retention of the staff we do have
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	From within the clinics. Some of them are very toxic work environments with toxic staff and providers.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Treat full time employees better than temp staff. Get supplies we need to complete our job. Don't say we cant get certain supplies when we can order them on Amazon and have them here in two days - it shows admin cares more about $ than about staff having tools to safely complete our jobs.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Cleanliness
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	1. Focus should be on increasing pay for full-time nurses not to just compete with surrounding market, but to out compete them. We NEED to be the highest paying nursing position in the area in order to establish a good pool of full-time nurses. 2. Focus on the physical building and rooms/technology: Be a place that physicians and nurses can be proud to say they work in and patient's don't mind staying in. 3. Professionalism: Once a quality nursing pool is established through high wages, make sure we are exuding professionally what it means to give high level patient centered care.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Salary
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I think that this organization should consider to change holiday time off policies for people that have office hours and are forced to use vacation time when they are not required to work because of the national holiday.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Continue to have employee meetings giving everyone the chance for communication from Admin
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	You need to concentrate on bonuses for the employees that worked thru the pandemic especially in these times of inflation. A little extra help would be so appreciated. Extra bonuses at Christmas would improve morale as well for the employees that continue to work everyday and help with this hospital instead of giving the incentives to the locums or travelers. We need to reward the employees that have committed to this organization and are doing the main body of work and not to the ones that are coming for 13 weeks and then leaving again.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Compensate me. Sweeten employee benefits.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Recruitment and retention strategies to have adequate staff to do all that is needed for the patients
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Culture
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	When you are the frontline healthcare employee coming in dealing with the major events over the last few years, it sure would be nice to feel like you appreciated. Many places out there including ones that wasn't a health filed got raises and recognized for all the extra time and for stepping up doing extra work.

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Retention of current staff that have stayed with us, especially over the past 2 years. Moral fatigue is present in every department and there is not enough support from the organizational level to provide enough staffing to alleviate the stress of frontline staff and managers/directors. Front line staff that had the resiliency to stay in health care over the past 2 years are struggling to continue and are looking to potentially leave the profession. Drastic measures to support these people are needed in order to retain them in the organization and profession and to get away from reliance of contract staffing. A majority of staff do not find the EAP valuable and feel it is impersonal to not have a local support system.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	pay, communication, get out of the administration hall and involve your selves with your team
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	retention employee recognition pay scale benefits cleanliness of facility
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I strongly feel customer service across the board could improve. I moved here from a large city that had 2 large health systems. Customer service was incredibly important in both. Always have a smile and greet every person you see in the hall, treat coworkers from EVS to the CEO with the same respect. Personally escort anyone who is lost. Make each patient feel that they are extremely important to us personally. Everyone in the hospital was required to answer call lights, not just nurses, and the words " That's not my job" were NEVER acceptable. We had yearly meetings to remind everyone of the importance of "5 star" customer service. I have been here for over 5 years and I KNOW we are capable of service of this calibre. Unfortunately, I find myself apologizing to patients more often than hearing gratitude for how they have been treated.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay commensurate with responsibility. Clean environment. I'm ashamed of how filthy the hospital has become.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Make employees feel valued. Increase wages. Wages are the biggest issue my department has. Over 90% of the time when someone leaves it is because of wage. If an applicant does not accept an offer it is because of wage.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Place value on retaining your employees who show up and work hard every day. Replacing a pizza party with ice cream or candy to show appreciation does not work. That should not be done in place of properly compensating employees. We worked the pandemic. Calling us heroes does not feed our families in this economy.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing is a huge issue. Clinic staff feel overworked, underpaid and undervalued. Employees are leaving because wages here are not competitive with other employers in the area.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We need more fun. More laughter, light-hearted competition, meetings (gasp), celebrations, etc. We have spent so much time a part over the last two years. Once spirits are lifted and more employees engage, development of mod-high performers into frontline leaders to drive quality and satisfaction.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Retention of loyal employees
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication is always the key and it is sorely lacking here. Also it seems there could be more of a stream lined communication between the hospital and the clinics.

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Employees don't feel valued or respected. Increase the 401k match.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Retention of valued employees. Updating/purchasing of needed equipment.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	You might want to look beyond the money & FTE's. Nobody believes that LifePoint cares about them at all.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Housekeeping, the entire campus is disgusting looking, floors have dust bunnies on them that roll down the halls when you walk, the clinics that are not on main campus are just forgot about, the eddyville clinic has had any updates sine it opened.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	communication
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	everywhere
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing. Pay employees what they are worth and retention will increase. A far better solution than employing travelers at 4 times the pay. Right now we seem to have critical staffing shortages in every department and people are burning out under the extra hours and workload.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	1) We need to update our facility. It looks very gloomy in the hallways. Sometimes when I walk in and I just want to turn around and walk out. 2) Facility needs to be clean. I often see it not maintained. Toilets have not been cleaned etc. 3) Transparency on the pay scale. It's not right to know a newer employee with no experience and a two year degree with no certificating is getting paid a $1.00 less then a employee with 10 years and a four year degree and has their board certification. How does this make your team feel valued?
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Increasing pay, especially for those who have continued to work throughout the last two years of COVID.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Reward and recognize loyal employees. Raises should be given yearly. Spend money to keep employees happy here instead of giving it to temporary employees. Clean this hospital up. Hospital is extremely dirty especially restrooms.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	increase capital resources. much of the equipment is in disrepair and in need of updating
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	The recent R1 outsourcing of the business office and admitting.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Focus on employee work/life balance. Tools and resources to encourage employees taking breaks and caring for themselves. Focus on process bottlenecks and rework to improve work flows and decrease frustration.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Making sure that the employees feel that they are needed and wanted. Show the ones that work hard that they are appreciated.

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Getting a cleaning company that actually will clean.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	More pay is always an improvement opportunity. Especially with the rising cost of everything.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Raises and employee retainment
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	UPDATED EQUIPMENT WOULD IMPROVE WORK
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Accountability. We will keep a warm body because we don't have enough staff. This drives off the good employees. I don't just mean low performers, I mean people that create conflict and are insubordinate.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Employee benefits
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Listening to your employee when they speak.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better pay-Management who cares about what is really going on in the workplace.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	You can start by increasing the wages to match or better other hospitals in the surrounding areas. Better insurance and 401 and other benefits.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Focus more on the care, recognition, retention, and competitive pay for our employees.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	More employees
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We lost the sick bank . only contributes up to certain amount in 401 K . My scale has been capped for years . not adjusted for cost of living expanse . Only get up 500.00 bonus a year for raises that are given . Not giving raises .
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Reward the employees who have been faithful to this organization. The ones who have been loyal. We need raises and more employees.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	updated equipment
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I feel that we really need to look at wages for the clinics, It is bad that you can go to a fast food place and make more money than you can as a front receptionist the 1st person our patients see when they walk in the door.

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Take care of your employees that you have. If you treat us better more people will want to come here to work. We have a bad reputation as a place to work and a place to get care.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	invest in the physical site..... very outdated
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Possibly more dedicated staff. We lose staff and the remaining is expected to pick up the load. The problem is we are already drowning and more jobs are expected to be completed in addition to the heavy load because we have less staff.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Control the frustrations.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Need more staff to do the things that need to be done. Some staff are doing things that should be done by other departments which keeps them from getting their own duties done.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	You need to focus on hiring to fill open positions and retaining the current staff. The Staff that are currently here are overwhelmed and overworked.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay your employees better.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	pay your employee"s better
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Facility appearances, changing the culture of employees and the community, we lose local patrons and staff due to lack of information or false information being spread by misunderstandings, we as a local center are not involved in the community much, or compared to where we were years ago. more community involvement!, more marketing of services and culture.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Overall cleanliness of the hospital could be better, as well as prompt solutions to maintenance issues. It seems to take months and constant reminders to get anything fixed. I've had patients mention the broken appliances as well as how dirty the walls and floor appear. Frankly it is embarrassing to have to explain why there is no running water in some bathrooms and why the paint on the walls are chipping and visibly dirty. I feel as a nurse I clean what I can but I can't be scrubbing the floors and walls.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Everything from poor managment to under paid
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	long term employees that stayed and worked through the pandemic. Nurses are not the only employees in this hospital.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Administration, from the top down.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Increase wages, add benefits back, management to be more respectful and professional. Individuals be accountable for actions.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay rates should be improved in order to encourage people to come here to work.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	The lab needs more employees and better management and more recognition from higher up.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Hiring staff and someone to train them correctly, and not after a month let them work the floors with so many doubts and questions.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Make sure your employees are taken care of . We work hard.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Wages, benefits & enough staff
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Incentives, pay raises, yearly evaluations, praises/acknowledgement for good duties/work. Treating staff better to keep staff nurses/employees compared to travel/contract nurses.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Give employees more pay. Hard to make needs meet.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Invest in newer/better functioning equipment and increase employee wages to make them competitive with other organizations/facilities around here.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	more respect as a person
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	the people behind the scenes doing there work daily
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Everything trickles down from the top
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing, we have to have unsafe nurse to patient ratios and support staff isn't close to enough. Nothing else matters till it gets fixed.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Improving processes. Improving pay. Improving morale. Nurses can drive 20-30 minutes & make more money to do less work. There is no incentive to stay at ORHC.

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Housekeeping, maintenance
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	reward the staff that continues to stay here and work comparable pay to the other hospitals around here. I
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	STAFF RETENTION AND COMPETITIVE WAGES
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	hiring more qualified workers and communication
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better pay
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Upper management
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	competitive pay
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I think there needs to be a bigger focus on employees. I don't always feel like a valued employee and I often hear similar feedback from others. I feel that I am a vital member of the organization but I don't necessarily feel recognized or rewarded for the services I provide here. I had to really advocate for myself during a period of staff turnover in order to get myself a raise which I feel was completely called for given the circumstances. This was uncomfortable for me and made me feel incredibly small that I even had to ask for a fair retention incentive. There is ample job opportunities at the moment and I wish more places would work to retain their staff instead of trying to recruit new employees after they leave.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	communication. staffing needs to be improved. call pay needs to be increased.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Hiring nursing staff
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	OR upgrades long over due, Improve the flow, continue to cross-train
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	the patients
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Employee satisfaction
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Overall appearance of hospital to the community. Still most people dont trust us as a place to come during a emergency.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	The attitudes. The recognition for staff. Give us something that makes us feel like it is a benefit to work for this organization. There are no perks. There's no benefit for staff retention.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Educated staff
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Care about the employees and need better wages
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	recognize all staff and the great work they do
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Current administration fosters an atmosphere of intimidation; and communication is limited to negative and sometimes hostile memos, emails, insinuations and remarks meant to minimize questions, suggestions and interactions in general.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	tending to staff
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better communication from the corporate and local administration to all staff. Email is not always a good venue. Need to work on staff satisfaction, retention and loyalty
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Our front desk and nursing staff pay is far below market standard in southeast Iowa. The closes comparable hospital system to Ottumwa Regional is Southeast Iowa Medical Center in Burlington, IA. They advertise the lowest paid position is $15/hr. Our staff makes aroud $4/hr less. Front desk, LPNs and RNs can also get more competitive pay with incredible State retirement from four critical access hospitals that are a short 20 minute drive in each direction from Ottumwa. We are spending an exorbitant amount of on hiring and training new staff instead of putting those funds toward retention. Between Southeast Iowa Medical Center and the four local critical access hospitals paying staff $8,000 to $15,000 more per year annually, we are not able to retain QUALITY supportive staff. Many of the staff that are retained, stay as they cannot secure more lucrative employment elsewhere. Is this the image Lifeport wants to market to the community?
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	i REALIZE THAT WE HAVE TO MAKE A PROFIT TO STAY IN BUSINESS, BUT IF A LITTLE OVERTIME MEANS YOU CAN COMPLETE YOUR JOB BEFORE LEAVING FOR THE DAY, OR YOU CAN GO THAT EXTRA MILE TO PROVIDE SERVICE FOR OUR PATIENTS OR CO-WORKERS THEN WHY NOT?
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staff would feel more appreciated if they saw investments in the facility. Floors need cleaned and replaced and it feels like its always other places. Share more of the wealth. Paint would be great, cleaning would be great especially deep cleaning of unit room floors, cost of living raises. Keep the good people and continue to incentivize them for doing good and staying.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Inclusion of new staff in committees

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication. Stronger management. Follow-up. Compensation. Retention. Teamwork.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	by recognizing the employees SO MUCH MORE, the ones who are true and dedicated to this facility, ESPECIALLY the ones who are dedicated to this facility... you want to keep employees, or attract other employees? adjust our pay scales... it's not about the money, but it is about the money, it's easy really, you want to make more money? you start by paying us more... it's pretty hard for us to see/hear about all the travelers that come and go... have a respectable pay scale, that attracts some to stay(understanding that there will always be a need for help)
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We need a strong leadership with an ample caring workforce team.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Hire more employee's and leadership staff for the lab
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay, Benefits, and Accountability
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better pay. More staff. Better accountability in all departments
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Appreciation of employees that shows like raises that make up for the rise in cost of living and shows appreciation for someone who has been with this company over 7 years. Dr.'s who don't drive patient's away like Dr #####. An O.B. clinic that is more organized, doesn't drive patient's away. Updated WFC unit. Retaining employees. We do not feel appreciated by the organization only our director. We want higher pay for what we do. We don't want pizza and food and such. Yes it is nice and shows appreciation but pay raises that help to support our families and put gas in our vehicles to get here do a better job. Better house keeping and enough house keepers. This facility is dirty and it is embarrassing to try and explain to patient's and their family when you find something unclean. Tearing wallpaper on the walls and nasty carpeting are embarrassing. Leaking roof with spots on the tiles every time it rains is embarrassing.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	1)Our pay is substandard to area hospitals in our location. You are willing to pay travelers and contract workers much more than those of us that have commited our entire life and career to this institution. 2) Our retirement match is next to nothing. Yet you advertise retirement benefits in your advertising. These are 2 major reasons we are unable to hire new employees and retain them.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Employee raise increase, contribute more to our 401k, cleaner hospital, hallways dirty garbage over flowing. Our carpets havent been cleaned in over 5 years.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Personal communication between departments. Improve/ replace overhead communication system
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	ORMICS.

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	instead of paying for travel agency's pay your current employees more to retain them and offer competitive wages to bring permanent employees in not ones that leave after there contract is up.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Wages
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Listen to concerns
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I feel that raises are important to make the employees feel reckognized for all their hard work and for staffing issues that arise at times
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	management
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Community involvement - getting patients involved in decision making and also having more resources available to the community.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication, Better Pay Rates, Fairness, Better Leadership
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	staffing
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	More staff, working equipement, pay raises, and safety. Security that can actually help take down patients and prevent staff from being assaulted on a daily basis.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Floors cleanliness
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	competitive in wages and bonuses, more modern updates to units
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better pay, better benefits so the need for travel nurse would be none.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	benefits and pay for employees. Especially the ones who are full time and not travelers.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I think there needs to be more management presence at the clinics.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Stop favoritism, be consistent, make change and get management that advocates for chajge and improvement. Have better policies in place.

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	INcentive for employees that have been here
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Treat the dedicated employees that have been here the same as the new ones coming in ,pay the dedicated ones more than the new employees coming in and they get the bonus and more pay with no experience
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better wages and benefits to keep and attract staff. Other hospitals are increasing their wages and benefits in order to keep staff or hire new staff. ORHC does not seem to grasp this as a priority. We losing good staff and not attracting new staff. This has been problem for the last several years and does not get address. Second updating equipment needs to be look at as whole We are working with updated equipment and we have nothing in return to improve the equipment needs for our hospital. Lastly Food quality is poor. Pt, family members of pt, and staff complain about it. This is a key part in regards to marketing and Pt satisfaction scores. No variety in the menu. Other hospitals allow pt to pick from a menu. We do not. We are not comparable to other hospitals when it comes to food services.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Stop tolerating bad behavior. Increase wages to make ORHC more competitive to recruit and retain more competent and vested local staff.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We are very low paid employees regardless of our time with the organization. We are expected to do alot of work for a little pay and work not in the scope of our job description or credentials so we have alot of turn over and employees that don't value their jobs or really care if they work for ORHC . We have college educations and are paid less than department store employees
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay scale
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Adequate and consistent staffing, but that is a national concern throughout healthcare delivery not specific to this organization.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Regularly offer/require small group training for staff for clinical improvement in their area of focus. Give local managers the freedom and ability to make decisions, not have to check with corporate on EVERTHING- it makes them look like puppets and gives off a less approachable/friendly working relationship. Update the building/facility to appeal to customers and employees. Hold routine meetings (during working hours) to recognize employees to their peers for good work and the ability to compliment each other on day to day work. Retention bonuses/options for employees. Replace outdated old equipment.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	PAAAAAAAAAY
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Need more staffing. Need to be compensated for doing the extra work. Also feel like your previous work experience should be included in your pay.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	ADMINISTRATIVE. Not only for me, but currently and fellow employees of the lab have all had issues with our administrative personal. They do not treat us as employees. They do not care about our families at home. They do not care if you are in school to better yourself (and as I am in nursing school to better my life I am not as "good" as I used to be since I can not fill the hours they are requesting me to.) They do not care about your mental or physical health. They do not care about your feelings. They just simply do not care and that is why our turn over rate in the lab is so high.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	renovations, updating equipment to function better in labor delivery wireless monitors so our patients can walk freely without monitors/wires
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	better managers and following through on complaints. stop the bullying and harassment
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	The areas that need improvement have already been addressed. To state them here would be redundant. Perhaps a cost of living pay increase, the cost of living has increased significantly.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	pay staff what their worth for the work they perform and attract more individuals who will want to be staff and not rely so much on travelers
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	pay and benefits
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Money, leadership development, leadership staffing and focus
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Discrimination and culture safety
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Our pay. Dr's that treat staff with respect and not degrade them infront of patients . Quit adding other departments responsibility to nursing. Functioning equipment, (ie wall b/p cuffs..) Cleanliness of all areas, (daily cleaning of patients room never happens unless nursing has time to do)
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better communication

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I wish there was a simple answer for this. First off, better pay. ORMICS, the ambulance service, is THE LOWEST PAID SERVICE in a 60 mile radius and has the HIGHEST CALL VOLUME around. We're losing good medics to smaller services because they pay better. That's a problem. Second, there is ZERO accountability for staff issues. People constantly show up late, call off, break things, and have horrible attitudes, and nothing gets done about it. Get rid of the toxic people who are dragging down the service. Third, our ambulances are garbage. They are constantly in the shop being worked on. We have rigs with 300,000 + miles on them, when the industry standard for replacement is 150,000 miles. Last, we need to recruit hospitalists who will actually keep patients in our facility. We transfer so many patients to larger hospitals becomes they don't want to keep them here. We have a big hospital with a lot of possibilities, but we seem to only have the resources of a critical access facility.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	pay and benefits and proper equipment
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I think we need accountability to be pushed much more on our side of the organization. I think this will help motivate people to work together more and improve themselves at work.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	'-Culture Engagement and Adjustment at the Local and Corporate Level -Streamlined Education benefits for staff based on position in the organization and tenure to the organization (i.e.. $10,000 for every 5 years of tenure to the organization, or members of the "leadership growth program" are allotted $20,000 to obtain education to become a manager or director) -Merit increases are based not only on hospital performance but economical performance and adjustments including inflation.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication getting departments what is needed to get job done
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Some units need nurses that provide attention to patients like I enjoy and care about their jobs
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Get rid of Meditech. It is antiquated and error prone. Standardize EPIC across all hospitals.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better pay and more staff
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	The culture in this organization is very poor. There needs to be more focus on improving Employee Culture.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Hold staff more accountable to actions
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	COMMUNICATION, COMMUNICATION, COMMUNICATION
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	communication
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staff retention and better equipment
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	First thing, we need to raise the pay. When paramedics can go work in fast food, and make nearly what they make as paramedics, it is disturbing. when staff members have to work an incredible amount of overtime, to make up the difference, it's dangerous. Our ambulances need to be safer. I need to not worry about whether or not a door is going to come open, or the air conditioner is going to fail, or there is going to be a carbon monoxide leak inside the cab, where my patient may be. I need to be confident that when driving emergent, the lights and sirens are working properly. When we drive emergent, it is more of a safety issue for others around us. And when our lights do not work, or our sirens are intermittent, it's incredibly dangerous for everyone involved.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	More competitive pay, better training programs for staff and especially management, have clear department and organizational goals to work towards. Reward people that work hard instead of just making them do more work then their coworkers who continue to coast under the radar.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Improving planning and communication are always good starts
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Actually listening to the employees when there are concerns
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	better wages, better benifits, supplies needed to do the job
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better communication and trust within the organization. Everyone should feel important
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication, more staffing ,CNA's per patients to provide quality care. Improve on cleaning patient rooms and hospital overall
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Improving their staff financially... we are way behind our competitors.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication, communication, communication! As an example, I have sent emails, but may or may not receive an email back to discuss the topic, provide a resolution, or just to say, "I received your email".
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	COMMUNICATION!

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Employee wages and 401k match. With the price of living going up every year, and significantly lately, our wage is essentially going down. The hospital charges have gone up, but employees have not seen any increase especially after tackling the Covid-19 pandemic where we put our own lives at risk to take care of our community.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Empower the employees to better themselves and have better compensation for the work employees do.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Improving wages and improving communication on the why, when and how of changes that are made. Listen and act when employees voice concerns over processes and protocols. Improve working relationships between departments within the hospital and also with the clinics.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	The people seem to be unhappy here, so I believe working with those who need help would be a start.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We need to explain more to our patients about their care. Staff need to communicate better and be respectful of each other.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Make employees feel appreciated. We received nothing for nurses week or hospital week. (I was not here the day they brought us a donut) Working in a clinic away from the hospital we are not recognized. We also were told we were going to get a meal or something for Christmas and then nothing.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Taking feedback, a lot of things are "because that's the way we've always done it here".
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay, accountability of people in management, cleanliness, teamwork and collaboration.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Increase pay and hire more people!
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Look at the compensation vs what contract people make.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	accountability with staff
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	listen to employee input on needed changes set quality improvement projects in place to better processes
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Focus on your employees and not money. You wouldn't have a business without your employees.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Increase wages, more staff, and better communication
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Valuing employees, and facility presentation
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Raising pay and focus on the employees that are currently here to help make them want to stay and listen to what they have to say.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Organization and utilization. There are things not being done that have been reported over and over.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Consistent adequate staffing that focuses on patient safety as the first priority, patient satisfaction second, profit last.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	fair wage increase, more staff, better communication.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We are constantly understaffed, underpaid, have to work crazy hours, and deal with multiple patients. Half of our equipment is old and does not work half the time.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Stronger discipline of employees who consistently do not meet expectations Higher standards for leaders Provide staff with everything they need to quickly/efficiently get their work done. Lack of equipment or equipment being out for repair for long periods of time are very aggravating to staff who want to come to work and get their job done timely and do their job well.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	pay is terrible, the work load is heavy without receiving enough to make it in this economy
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	This facility puts their focus in compensating travelers or those only willing to work for "critical incentive" although I do see this as an effective way to cover shifts or have people here to work, I feel as they are only here for the money and certainly not to take care of patient's to the best of their ability. HOW could they? some of them work 48+ hours in a row just for that all mighty dollar. On the other side of that coin there are people like myself that commit to be here every single scheduled shift. You don't have to fill this spot because I am here, and there is no "extra" for us. I honestly (if I didn't care about the people, and patients) could go ahead and go PRN, pick up my same shifts for $650 a shift and stop working my other job. Instead I stay committed, make my $216 for the shift and then supplement more income somewhere else.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Update equipment for better patient care. Increase pay to a competitive wage.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Raises
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Too many management and senseless positions. You need to get rid of some of these positions so that money can be freed up to pay employees a fair wage and then you will be able to recruit more good staff to work here.

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We need raises, a clean facility, more help in every single department.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Decent pay raises!!!
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I'm eating 1 meal a day & working 12 hr shifts, in order to pay all my bills via inflation. I'm trying my best & have since Covid started. Please... I love my job, help.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing. Giving incentives to the employees that show up every day and go over and beyond when they are at work.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	making it easier for all shifts to attend mandatory training
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Appreciating and valuing the employees that do continue to show up to work.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Retention bonuses for employees that continue to work for the organization. Better retirement.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Ward clerk at night shift would be helpful.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Competitive wages without it being last minute picking up. Which would allow better staffing and ability to have more admitted patients.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	More cleaning & updates
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Your employees
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Having needed supplies. Even with scanning would be nice if distribution would come and make sure we are stocked up good at least before the weekend. Also would be nice if our supplies from kitchen were better stocked. Particularly box lunches on med surg (we get peoplethat a were npo all day and miss all their meals then are hungryat night), soup, and peanut butter. Also more dibetic freindly foods stocked on the floor.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	More rewards, not syringe pens, to make the workers feel more appreciated for the countless amount of hours they put in this hospital.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Cleanliness!!! Please!!! We desperately need well trained housekeeping to help out facility be successful to the public eye. And Taking care of the nursing staff.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	hire employees with proper credentials for the job they're applying for

June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	on pay raises you can make just as much flipping burgers
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better pay, better facilities.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	No to discrimination
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better working environment. Increase wages.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication. Effective staffing.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Retention of long term employees
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Benefits
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Compensating employees for their time, so they don't leave for other organizations.
June 2022 CoSE	06/15/2022	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing to begin with
June 2022 CoSE	06/15/2022	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	This could be much better. An electronic recognition system would make a world of difference. peer-to-peer recognition that can be tracked by managers would be awesome.
June 2022 CoSE	06/15/2022	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	The Hospital pays extra for those who pick up extra shifts, the clinics do not get extra pay to pick up extra shifts.
June 2022 CoSE	06/15/2022	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	I am satisfied with my manger but not with administration.
June 2022 CoSE	06/15/2022	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	Recognition and praise is limited the longer I work at this facility from administration, directors or supervisors.
June 2022 CoSE	06/15/2022	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	When I go above and beyond it rarely gets noticed, but yet I see others do the same thing and get recognized for it. I've accepted that I am invisible in my department
June 2022 CoSE	06/15/2022	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	I feel that there have been attempts at using recognition to get ORMICS staff to help more in the ER. However, I feel that those who routinely go above and beyond are just expected to do that same level without recognition.
June 2022 CoSE	06/15/2022	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	Have went above and beyond my job title with no recognition.

June 2022 CoSE	06/15/2022	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	Ive worked for this company for 3 years and have maybe missed 2 days of work. I recognize and praise myself.
June 2022 CoSE	06/15/2022	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	Feel that recognition in my department needs to be improved so employees will want to do more.
June 2022 CoSE	06/15/2022	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	Cnas all quit. I'm doing my job & cna job (only get my salary though doing 2 people's jobs at once each day). People say I do a good job, but I'm exhausted & frustrated & receive really no reward for all the extra work.
June 2022 CoSE	06/15/2022	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	I think the team does as well as they can w the resources available to practice medicine safely
June 2022 CoSE	06/15/2022	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	within my department
June 2022 CoSE	06/15/2022	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	This is different from department to department, I know on my unit we do support each other and care highly about patient safety.
June 2022 CoSE	06/15/2022	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	We do in OUR work area.
June 2022 CoSE	06/15/2022	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	departments are variable some are better than others
June 2022 CoSE	06/15/2022	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	Differs with different people
June 2022 CoSE	06/15/2022	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	I think that within my power I can safely take care of patients. If there is a group problem or facility wide problem or problem w a certain specialist such as cardiology nothing is going to get done to change it
June 2022 CoSE	06/15/2022	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	Nursing staff -not Admin-is exemplary when it comes to protecting patients and improving outcomes.
June 2022 CoSE	06/15/2022	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	we do well, but sustaining a "fix" is hard anywhere you are with staff turnover in most industries
June 2022 CoSE	06/15/2022	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	I only see quick fixes implemented and no plans that have been sustainable.
June 2022 CoSE	06/15/2022	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	People do not care about permanent fixes, they would rather do a "quick fix".
June 2022 CoSE	06/15/2022	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	

June 2022 CoSE	06/15/2022	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	another process or check list is created that doesn't get done because we have too much of it
June 2022 CoSE	06/15/2022	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	within my department
June 2022 CoSE	06/15/2022	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	I personally have never known what happens after a Variance is filed
June 2022 CoSE	06/15/2022	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	I have had conversations with staff but directors and admin have not had input in the discussion
June 2022 CoSE	06/15/2022	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	Maybe they have, but not that I am aware of--but this is only based on recent experience.
June 2022 CoSE	06/15/2022	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	I have not had to fill out a patient safety event since working at the organization. I do not have an example to base this response on.
June 2022 CoSE	06/15/2022	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	don't know
June 2022 CoSE	06/15/2022	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	We will have meetings with some department staff who will pick the lowest ranked items on the survey and will try to come up with ideas on how to improve those.
June 2022 CoSE	06/15/2022	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	Usually just see the results posted in the NEXT meeting. Nothing seems to change around here.
June 2022 CoSE	06/15/2022	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	In the recent mandatory hospital wide meetings, I noticed that everywhere we strive to be in the top 10% except when it comes to employee satisfaction. In this category it's ok to be average. After the surveys are completed, there will be groups within departments that will brainstorm as to how to improve and steps may be taken, but overall little is done or sustained. I feel we try to put Band-Aids on big wounds.
June 2022 CoSE	06/15/2022	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	I have lost faith in my organization.
June 2022 CoSE	06/15/2022	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	I don’t think this will matter for anything!
June 2022 CoSE	06/15/2022	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	I feel like we do these every year and nothing changes
June 2022 CoSE	06/15/2022	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	There will absolutely not be a single action that comes out of this survey.

Glint Report for Lifepoint Health
Exported: 11 Sep 2024

Report Template Title: Comments
Filters:
Culture of Safety and En(Hospital Name Ottumwa Regional
Date: 26 May 2023
Responses: 264 of 414
Response Rate: 64%

Section Name Comments
Comments ALL

Survey Name	Pulse Date (mm/dd/yyyy)	Question	Question Name	Team	Translated Answer in English
May 2023 CoSE	05/01/2023	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	As a clinic employee, I do not feel the same sense of belonging as the hospital employees do.
May 2023 CoSE	05/01/2023	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	There are too many silos between departments. There are many departments that we work great with, but there are so many that they are rude, condescending, and unappreciative. Support services are treated less than by these departments.
May 2023 CoSE	05/01/2023	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	I FEEL LIKE I BELONG WHEN I AM WITH THE TEAM I WORK WITH DAILY.
May 2023 CoSE	05/01/2023	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	Administration seem to have little to no regard for some of the departments. Ours specifically continues to hemorrhage staff, and are still expected to do the same amount of work with half the staff, as well as put ourselves in extremally dangerous positions, just to cover shifts. Administration continues to find new and exciting ways to show that they have zero interest in the well-being of the EMS staff, or the community at-large.
May 2023 CoSE	05/01/2023	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	Retired work prn
May 2023 CoSE	05/01/2023	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	I have the best manager and no matter what I know that I can go to her for anything!!
May 2023 CoSE	05/01/2023	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	Nurses are not rewarded or recognized properly for great service or years of experience. For example brand new nurses are hired at a higher rate than an employee that has been here for 10 years.
May 2023 CoSE	05/01/2023	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	in my dept, i feel like i am trusted to 'help carry the load' if you will', as for hospital wide, it's a litte bit rougher...
May 2023 CoSE	05/01/2023	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	We are like a family in the OB department.
May 2023 CoSE	05/01/2023	I feel a sense of belonging at my organization.	Belonging	Ottumwa Regional	Unsure of any improvements that have been made for quite some time. Outdated equipment, nothing gets fixed or replaced
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	WE NEED TO GET BETTER TRANSITIONS WITH OUR 3RD PARTY COMPANIES. FOR EXAMPLE R1 NEEDS TO HAVE BETTER WAYS OF SEEING IF A PATIENT IS ON SCHEDULES AND NOT CCALLING PATIENTS THAT HAVE MOVED OR CANCELLED
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	I strongly agree with the continuous improvement. Given how many visitors have been here the last year and all of the look ats we have had, we can't help but improve. As I said before, I truly believe that the people who work here are here for the right reasons..... exceptional patient care.
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	Constantly having equipment breakdown and bring up to management about getting new equipment and all we hear back is that we have no money to replace equipment. We are wasting valuable time as short staffed as we are trying to piece together failing equipment.
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	See questions 2 and 3 above for the amazing ways that our organization continually impedes our ability to be more effective and efficient. In fact, I have a picture on my phone of the new algorithm required for EMS to find coverage for transfers. What was a simple process, now requires multiple phone calls to administration for approval to do what we have been trained to do.

May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	They continue to worry about the bottom dollar over staff. The most recent change to transfers creates an enormous delay in patient care, which has, and will continue to cost lives.
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	Significant improvement recently!
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	I believe that we are getting there, but there is a lot of work that still needs to be done.
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	We have been using the same broken systems for years.
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	I am hopeful improvements will continue with the new CEO/CNO
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	Question 17 (not enough room) *Improve staff morale -Don't schedule long term staff and permanent staff on weekends and allow traveler RNs to refuse to work weekends -Have travelers and temp staff take on the same responsibilities as permanent staff and be held accountable for following policies just like permanent staff. This includes monthly QAs/outdate checks -Temp employees are more invested in the organization than travelers. They are better for our permanent staff. They stay longer. They are more accountable. They take more ownership of the work environment than travelers. -Don't cut temp employee pay and untruthfully say it saves money over travelers. This is not true, and repeating that falsehood further alienates staff and increases distrust of current management -Don't, in the future, provide staff from a company that is in anyway owned by administration or their family members
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	i think its hard to ask this question at this time due to the new leadership roles... i think that there could be positive things come from this, and i know it will take time, but i need to 'see it to believe it'
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	Use information to improve work by people Doing the work.
May 2023 CoSE	05/01/2023	My organization continually improves the way work gets done.	Continuous Improvement	Ottumwa Regional	No
May 2023 CoSE	05/01/2023	I feel empowered to correct potential safety hazards.	Ownership - GPS	Ottumwa Regional	When you turn in environmental (housekeeping issues) it goes in one hand and out the other and let to keep happening
May 2023 CoSE	05/01/2023	I feel empowered to correct potential safety hazards.	Ownership - GPS	Ottumwa Regional	I don't feel I am, but again, I do what's best for the patient.
May 2023 CoSE	05/01/2023	I feel empowered to correct potential safety hazards.	Ownership - GPS	Ottumwa Regional	see above.
May 2023 CoSE	05/01/2023	I feel empowered to correct potential safety hazards.	Ownership - GPS	Ottumwa Regional	

May 2023 CoSE	05/01/2023	I feel empowered to correct potential safety hazards.	Ownership - GPS	Ottumwa Regional	No, because I wonder if my speaking up with cause me to lose my job. Because then its considered "negativitly".
May 2023 CoSE	05/01/2023	There is a just process for handling safety-related errors here.	Just Response - GPS	Ottumwa Regional	I am locked out of online variance reporting!!
May 2023 CoSE	05/01/2023	There is a just process for handling safety-related errors here.	Just Response - GPS	Ottumwa Regional	No, because concerns in the past that have been voiced go unaddressed.
May 2023 CoSE	05/01/2023	There is a just process for handling safety-related errors here.	Just Response - GPS	Ottumwa Regional	I believe so.
May 2023 CoSE	05/01/2023	There is a just process for handling safety-related errors here.	Just Response - GPS	Ottumwa Regional	Variance completed, manager responds and that is pretty much the end of it.
May 2023 CoSE	05/01/2023	I have the resources I need to do my job well.	Resources	Ottumwa Regional	staffing is an issue and it makes it difficult to perform your job duties when you have to fill in to cover staffing gaps. We struggle hiring staff due to wage issues
May 2023 CoSE	05/01/2023	I have the resources I need to do my job well.	Resources	Ottumwa Regional	It would be nice to have more educational opportunities about my line of work
May 2023 CoSE	05/01/2023	I have the resources I need to do my job well.	Resources	Ottumwa Regional	With the exception of our terrible IT system, I feel that we have the resources we need.
May 2023 CoSE	05/01/2023	I have the resources I need to do my job well.	Resources	Ottumwa Regional	Well, we do have ambulances, so that's cool. I know at least one has more than 300,000 miles on it. The others aren't far behind. There have been several times where we only have one operable ambulance serving our county, while the others are taken to the next county over for servicing when we have two major dealerships in town who could do the work locally. Also, I feel like staffing is a resource. We are so short-staffed that we often have one person responding to a call alone, with the HOPES of have a first-responder to drive us back.
May 2023 CoSE	05/01/2023	I have the resources I need to do my job well.	Resources	Ottumwa Regional	We lack many things, including reliable and safe ambulances to transport our pts. We can't even have decent pens, because the bean counters felt the need to micromanage our supplies. Because BIC ballpoint works wonders from behind a desk, they feel this is the best practice. Never mind those in the field that need sturdy and reliable writing utensils. Although, this may trigger "exciting announcements" that we will get those pens back, because those are the problems that we fix.
May 2023 CoSE	05/01/2023	I have the resources I need to do my job well.	Resources	Ottumwa Regional	significant lack of staff and good equipment to perform patient care. Dissatisfied staff.
May 2023 CoSE	05/01/2023	I have the resources I need to do my job well.	Resources	Ottumwa Regional	we usually don't have enough resources to make our patients happy here. with WFC a wireless fetal monitoring system would be nice for our inductions that want to walk around to help with pain or to progress labor to if you have a mom thats hard to pick instead of constantly going into room exposing the mother just to readjust the monitor. and we don't have the resources if we need it if we need to vent a baby because there is not a vent to a nicu baby before ambulance crew gets here.
May 2023 CoSE	05/01/2023	I have the resources I need to do my job well.	Resources	Ottumwa Regional	Our equipment is pretty good, sometimes we need to replace more than 3 things.
May 2023 CoSE	05/01/2023	I have the resources I need to do my job well.	Resources	Ottumwa Regional	Equipment needs updated which would make things run more efficiently and increase turn around time.
May 2023 CoSE	05/01/2023	I have the resources I need to do my job well.	Resources	Ottumwa Regional	I am unsure if I will arrive at my patient safely. Shortages make things difficult but I realize that this is a nationwide problem. I do not trust our trucks,
May 2023 CoSE	05/01/2023	I feel I can report compliance concerns without fear of retaliation.	Compliance	Ottumwa Regional	I have made reports in the past, with major fears of it being shared with those individuals. Plus the feeling of "it does not matter if it is turned in", because things never change.,

		I feel I can report compliance concerns without fear of			Retaliation isn't a fear. But reporting anything and actually expecting things to change is laughable.
May 2023 CoSE	05/01/2023	retaliation.	Compliance	Ottumwa Regional	
		I feel I can report compliance concerns without fear of			you will fired
May 2023 CoSE	05/01/2023	retaliation.	Compliance	Ottumwa Regional	
		I feel I can report compliance concerns without fear of			I do going forward!
May 2023 CoSE	05/01/2023	retaliation.	Compliance	Ottumwa Regional	
		I feel I can report compliance concerns without fear of			There has been retaliation and confrontation prior when i have filed an incident report.
May 2023 CoSE	05/01/2023	retaliation.	Compliance	Ottumwa Regional	
		I feel I can report compliance concerns without fear of			When I reported concerns up the chain to corporate the way the provider treated me afterwards was considerably worse
May 2023 CoSE	05/01/2023	retaliation.	Compliance	Ottumwa Regional	
		I feel I can report compliance concerns without fear of			There are people that said too much and are no longer here.
May 2023 CoSE	05/01/2023	retaliation.	Compliance	Ottumwa Regional	
		The patient safety-related training I receive is			Redundant education
May 2023 CoSE	05/01/2023	effective.	Training - GPS	Ottumwa Regional	
		The patient safety-related training I receive is			what training am I suppose to receive?? I use the training I received at other locations as my guidelines.
May 2023 CoSE	05/01/2023	effective.	Training - GPS	Ottumwa Regional	
		The patient safety-related training I receive is			I have not received patient safety or training.
May 2023 CoSE	05/01/2023	effective.	Training - GPS	Ottumwa Regional	
		The patient safety-related training I receive is			No, health stream is not effective. Its just a task oriented point and click
May 2023 CoSE	05/01/2023	effective.	Training - GPS	Ottumwa Regional	
		People at my organization live the company			Your just filling a spot needed
May 2023 CoSE	05/01/2023	values.	Values	Ottumwa Regional	
		People at my organization live the company			what are the organization company values?
May 2023 CoSE	05/01/2023	values.	Values	Ottumwa Regional	
		People at my organization live the company			Not sure what the company values are
May 2023 CoSE	05/01/2023	values.	Values	Ottumwa Regional	
		People at my organization live the company			I feel as tho William is here to make a difference but the people on units do not portray the mindset or effort to live out the company values. But this could be from not feeling valued as employees.
May 2023 CoSE	05/01/2023	values.	Values	Ottumwa Regional	
		People at my organization live the company			I believe for the most part that people in the organization are here for the right reasons which is part of the company's values. These company values need to be on display because not everyone knows of them and since we have had so many corporate and management changes few know what they are, but more importantly what they mean. I am truly hopeful that our culture changes.
May 2023 CoSE	05/01/2023	values.	Values	Ottumwa Regional	
		People at my organization live the company			eh, not so sure on this one...
May 2023 CoSE	05/01/2023	values.	Values	Ottumwa Regional	

May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	Constantly short staff. Low wages. Poor leadership. Would definitely not recommend for friends/family to work, nor would I want myself, friends and/or family cared for within the walls of this hospital
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	ORHC does not offer competitive wages with other area hospitals (They have improved nursing staff pay but not CMA pay or patient service rep pay) There is alot of dysfunction and under staffed
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	I feel like the quality of nurses a providers we have make it difficult to refer my friends or family to work here. There is a lacking of things to be proud of
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	We have good benefits but our pay is low compared to other places
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	I had said for years that I would never work here. I still feel that way. I am hopeful for the future, but I am not sure I would recommend this organization as a great place to work. Right now, I feel administration is trying to fix the perceptions and many, many other issues, but can you un-do everything that has brought this facility so low and truly turn it around in a timely manner. I would love for this facility to a top 100 employer for the state, but so much status quo needs to be changed.
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	I am emotionally and mentally exhausted, doing to many other extra's and not getting any positive feed back.
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	Not even a little bit. We have the highest 911 call volume (5000 + per year) in a 90 mile radius and the lowest pay of any surrounding ambulance service. Administration has removed our ability to make real-time decisions that affect the working crews and citizens of OUR communities. We can no longer make decisions about calls and transfers based on our staffing without "C-suite" approval. The manager avoids confrontation so much so that there is no accountability and it literally feels like "Who's Line" where it's all made up and rules don't matter. I would not recommend this place to anyone.
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	Pay is terrible and not enough help
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	The organization needs to work on having a more inviting place to work as in changing the way the atmosphere is from culture setting, to attitudes, pay incentives, pay increases, to having a warm inviting place of wanting to stay and make a career here.
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	mixed feelings, love The Doctors i work for and most of my co workers, but feel like the management does not appreciate or even notice the hard work that i put in every second of everyday, im constantly getting ridiculed.
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	This hospital is a great place to work, and like all things good and bad come from it. Unfortunately now is just hard on all of us, but I am not giving up on ORHC.
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	Raises are unfair, not recognized for extra work of certifications. When you send your concerns to HR and administration they blow you off and don't respond
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	

May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	Our pay scale does not compare to facilities around us.
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	again, with the amount of thing that is happening around here, it will take a while to straighten things out and to build the peoples trust in us again, but in time, i can see hope...
May 2023 CoSE	05/01/2023	I would recommend my organization as a great place to work.	Recommend	Ottumwa Regional	I love working in this community and working with the people of this community. I do not like feeling insecure and not wanted in a work place.
May 2023 CoSE	05/01/2023	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	I would like to have the opportunity to attend the Leadership Academy or see it offered to clinic managers
May 2023 CoSE	05/01/2023	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	I don't believe the lower paid employees have the same opportunity as the higher paid employees. We could offer classes in excel, word, etc. OJT for positions that need filled by qualified staff that may not meet the qualifications on paper. I think we could do much better at this. Since William has arrived, this has improved, but there is still a long way to go.
May 2023 CoSE	05/01/2023	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	The only learning opportunity here is Health Streams. And there is no growth here. There's only stagnation that somehow seems to get promoted.
May 2023 CoSE	05/01/2023	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	We have no growth opportunities. It used to the that the TL position was that of pride, because it meant that you can handle it. That is not the case, and even the TL's are treated as though they do not know what they are doing. This is a dead end job, and this is why staff are leaving in droves.
May 2023 CoSE	05/01/2023	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	Of recent we have had more leadership education which is nice. Although the last one was a 3 part and information was good but I was only able to physically be involved for 1 section the other has to be done independently due to short staffing and having to cover the floor.
May 2023 CoSE	05/01/2023	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	There is a big lack of communication from HR about positions. I applied for a position months ago and have not heard anything from HR regarding this.
May 2023 CoSE	05/01/2023	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	i feel if we need more education so we can go as nurses computer healthstream are good for some people to learn off of. if we do want to learn something new we have to find our own conferences and pay out of our pockets because we don't reimbursed enough to go to the conference because we don't get paid enough to be able to afford to go to conferences that will cost 200-600 dollars to go
May 2023 CoSE	05/01/2023	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	Used to, in the past we did a lot to grow our employees. Anymore its a constant fight to do things and get them paid for.
May 2023 CoSE	05/01/2023	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	Only certain employees are offered opportunities. Bachelors degree is not recognized in this facility.
May 2023 CoSE	05/01/2023	I have good opportunities to learn and grow within my organization.	Growth	Ottumwa Regional	There is no education department. There hasn't been any classes or education going out since people have left those positions.
May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	again, all our ambulances have high miles that's not safe.
May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	We use equipment beyond useful life and only get it replaced when it can't be fixed.

May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	We need windows in all the doors and buttons to page for help if threatened or assaulted. Every public room needs a panic button,
May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	See answer 20.
May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	In the ER and EMS we do.
May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	No metal defectors which might help
May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	although slowly improving
May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	We don't pay enough to our central sterile staff that handle hundreds of thousands of dollars worth of equipment and it shows in equipment damage.
May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	We do but people frequently don't use them.
May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	Need ultrasound all the time not just Monday through Friday- there are emergent needs.
May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	As a nurse I believe all in healthcare are doing the best we can with the resources we have. For the most part we are innovative when need be, especially when we have to switch between various products to accomplish the same end goal.
May 2023 CoSE	05/01/2023	We have the resources we need to keep patients safe.	Resources - GPS	Ottumwa Regional	Lacking experienced/long term staff
May 2023 CoSE	05/01/2023	We discuss ways to prevent safety errors from happening again.	Learning From Mistakes - GPS	Ottumwa Regional	No errors are occurring related to patient care or safety.
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	only on my immediate work area
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	Except for a few key people around me and in my department, I haven't been asked sincerely how I am doing since I started here. I've been asked how are things going, but not how am I doing.
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	PRETTY MUCH ONLY WITH THE TEAM I WORK WITH DAILY. OTHER THAN THAT NOT MUCH
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	Not even a little. Again, administrations sees to it that EMS is unimportant and that our focus should be getting patients out of their hospital, rather than 911 calls and helping to save the lives of the citizens of our community. We have several staff who work 36, 48, and even 96 hour stretches to help cover our community. Administration has proven that they have no understanding or appreciation of the only full-time ambulance service covering 40,000 people in 400 square miles.
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	Not even a little bit. There is zero regard for staff working long hours to ensure that there is ambulance coverage for the community. The supe awesome Christmas bonus that we get every year is a slap in the face, as it may buy a dozen eggs and a gallon of milk. The expectations that we come to work and do the jobs of many with few, and the quality and quantity is the same, is asinine, yet it exists.
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	So much so that I doubt that this survey is actually read by a real person.
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	no because the pay is terrible, no help
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	HAVE BEEN INFORMED STAFFING IS MORE IMPORTANT THAN MY PERSONAL HEALTH BY MANAGMENT
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	I felt supported and cared about by my C suite person but my immediate Director does not reach out much. She stays in her office and has little interaction with any of her staff. She says she cares but does little to show. I'm sure she is busy but there is more to being a Director than sitting in there office. A director is suppose to be a Leader.
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	By my own coworkers but not anyone else in the facility.

May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	Milestones are not acknowledged appropriately. No benefit to being a longtime employee.
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	in our dept, we are like an extended family- still have our quiffs, but still care to see that everyone is ok in their struggles...
May 2023 CoSE	05/01/2023	At work, I feel cared about as a person.	Care	Ottumwa Regional	No the opposite feels true. We are all down here in our cubby feeling like the unwanted children of the organization, except by other staff in the ER there are a lot of them that know that we do have value to us.
May 2023 CoSE	05/01/2023	My input about patient safety is valued here.	Voice - GPS	Ottumwa Regional	Safety of our EMS crews is brought up regularly, yet nothing changes. Admin just finds new and exciting ways to crap all over those crews.
May 2023 CoSE	05/01/2023	My input about patient safety is valued here.	Voice - GPS	Ottumwa Regional	not when there is a high cost $ to it (equipment)
May 2023 CoSE	05/01/2023	My input about patient safety is valued here.	Voice - GPS	Ottumwa Regional	See no changes
May 2023 CoSE	05/01/2023	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	PEOPLE NEED TO DOUBLE CHECK PATIENT INFORMATION AND ALLERGIES
May 2023 CoSE	05/01/2023	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	I think the only concern is money. If the mindset was to ensure patient safety, we would have changes the way the ED and EMS operates years ago.
May 2023 CoSE	05/01/2023	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	I would say that a majority of us are patient advocates and we will do what is necessary for patient safety.
May 2023 CoSE	05/01/2023	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	only feel this way on the BHU
May 2023 CoSE	05/01/2023	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	We try, but with late labs and short staff it is difficult
May 2023 CoSE	05/01/2023	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	We need to implement/ be more observant of the plans or safety process we explain to the patient.
May 2023 CoSE	05/01/2023	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	Patients arrive every day without pre procedure check lists, allergy bands, correct consents or consents at all. Education has been provided and there is not consequence for not doing it. Witnessed a manager tell staff its "no big deal" when it comes to completing the check list. It is a big deal its patient safety.
May 2023 CoSE	05/01/2023	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	I have seen multiple times where doctors' wishes and convenience for doctors is held to a higher standard than what's truly best for the patient. This is NOT okay.
May 2023 CoSE	05/01/2023	Ensuring patient safety is part of the way we do things around here.	Safety Habits - GPS	Ottumwa Regional	My boss does a good job not the company as in the admin
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	There have been many changes in titles within the Ottumwa Health Group (the clinics) and new "roles" These people just get appointed to the titles and its not communicated to the employees that this is happening.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	There have been meetings to help keep us updated. That's helpful. If we can talk about the communication between employees and HR I would give that a -1. It is hard to ever get a response. If they would even give an adequate time frame in which you could hear back - that would be better than nothing at all.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	

May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	I feel we do a good job of communicating, but we get so much new information it gets overwhelming and people easily forget
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	As earlier mentioned, simply contacting our human resources director is not an easy task. We should be able to contact this person whenever necessary, however 90% of the time our phone calls don't get returned.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	I FEEL WILLIAM KIEFER DOES A GREAT JOB COMMUNICATING WITH EMPLOYEES. KEITHA CUTSFORTH ALSO DOES A GREAT JOB OF COMMUNICATING AND TRYING TO MEET THE NEEDS OF HER EMPLOYEES.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	It could be better. At least quarterly town hall meetings. Never get consistent info on raises or job evaluations. I think the rule is 7 touches before someone remembers. We need to be over communicating right now. I think a daily e-mail to all employees with info would be great. Just bullet points with pertinent information because not all directors share info from flash. For Example: 1. Fire Door Inspections today and tomorrow. You may see ##### with a Guest. 2. HSC conversion on patient kleenex. Expect smaller boxes. 3. Floors being re-work in ER hallway this weekend. 4. Etc.... Just one liners that give info that everyone might need to know.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	Months of no leadership and when interim management is put in place all we hear are rumors and "in time" we will have more information and never really get any information.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	E-mails, which nobody reads, and Town Hall Meetings, where they take great pride in celebrating "Jean Day" but continue to erode the confidence of the direct patient care staff by providing false reassurances. But hey, they get to wear jeans on Fridays, so that's cool for them.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	Constant emails, sometimes multiple in a day, which nobody really reads. We have town hall meetings, where clinical staff gets to listen to how nonclinical staff get to wear jeans! So that's fun.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	It seems like the confidentiality has went over board when it comes to communicating with staff in letting them knowing what is going on the in the hospital. It seems like employees find out more outside of work from the community then what we find out from our own Administration Team or Directors/Mangers.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	I feel that there could be more communication from the high up staff. When we are hearing more and seeing things out in the community, before hearing it here that is a problem. We understand of course there are things that can't be said but a heads up about situations would be better then nothing.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	There can be improvement in that area.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	We find out from floor staff when the ICU is closed or other important notices such as that. Communication is poor.
May 2023 CoSE	05/01/2023	My organization does a good job of communicating with employees.	Communication	Ottumwa Regional	

		My organization does a good job of communicating with			The regular town hall meetings have been a great improvement. The director continues to withhold information to certain staff.
May 2023 CoSE	05/01/2023	employees.	Communication	Ottumwa Regional	
		My organization does a good job of communicating with			Much better over the past year.
May 2023 CoSE	05/01/2023	employees.	Communication	Ottumwa Regional	
		My organization does a good job of communicating with			new leadership roles, there has been some work done in this area, a long ways to go though...
May 2023 CoSE	05/01/2023	employees.	Communication	Ottumwa Regional	
		My organization does a good job of communicating with			I am only left with rumors not official information or memos
May 2023 CoSE	05/01/2023	employees.	Communication	Ottumwa Regional	
		The exchange of information between departments occurs			Unsure
May 2023 CoSE	05/01/2023	smoothly.	Exchange - GPS	Ottumwa Regional	
		The exchange of information between departments occurs			Lab resulting things has been horrible of late
May 2023 CoSE	05/01/2023	smoothly.	Exchange - GPS	Ottumwa Regional	
		The exchange of information between departments occurs			Communication between departments, doctors and nurses needs to change for the patients and everyone involved.
May 2023 CoSE	05/01/2023	smoothly.	Exchange - GPS	Ottumwa Regional	
		The exchange of information between departments occurs			THERE ARE TIMES WHERE THERE ARE 3 DIFFERENT RESPONSES BECAUSE NONE OF THE DEPARTMENTS TALK CORRECTLY OR GIVE ACCURATE INFORMATION
May 2023 CoSE	05/01/2023	smoothly.	Exchange - GPS	Ottumwa Regional	
		The exchange of information between departments occurs			Depends on who is speaking with who. As stated above, admin does not care to listen and address the issues that matter. Only jeans day every Friday.
May 2023 CoSE	05/01/2023	smoothly.	Exchange - GPS	Ottumwa Regional	
		The exchange of information between departments occurs			Information comes from leaders? not between departments?
May 2023 CoSE	05/01/2023	smoothly.	Exchange - GPS	Ottumwa Regional	
		The exchange of information between departments occurs			THERE IS NO COMMUNICATION AT ALL HERE
May 2023 CoSE	05/01/2023	smoothly.	Exchange - GPS	Ottumwa Regional	
		The exchange of information between departments occurs			Its hard to get ahold of people to give report. No designated person on the floor for report. Often put off for several minuets to hours.
May 2023 CoSE	05/01/2023	smoothly.	Exchange - GPS	Ottumwa Regional	
		The exchange of information between departments occurs			There are several newer nurses that do not understand to stop for 5 seconds for EMS report. On scene report does have a lot of information and could be valuable to the patient's care.
May 2023 CoSE	05/01/2023	smoothly.	Exchange - GPS	Ottumwa Regional	

		The exchange of information between departments occurs			Departments need to understand that everyone is busy. We are not always near a phone or are busy with other patients. We are often at core staff.
May 2023 CoSE	05/01/2023	smoothly.	Exchange - GPS	Ottumwa Regional	
		The exchange of information between departments occurs			I believe there is a huge opportunity for improving communication between departments. I believe the idea of closed loop communication would drastically change communication between departments and correct miscommunication.
May 2023 CoSE	05/01/2023	smoothly.	Exchange - GPS	Ottumwa Regional	
		Teams at my organization collaborate effectively to get things			No collaboration at all. Constantly short staffed with no help.
May 2023 CoSE	05/01/2023	done.	Collaboration	Ottumwa Regional	
		Teams at my organization collaborate effectively to get things			for the most part, I agree. However, there is definitely room for improvement. There are still too many departments that are not team players. With that being said, there are excellent Directors to work with and are very goal oriented and work well with others.
May 2023 CoSE	05/01/2023	done.	Collaboration	Ottumwa Regional	
		Teams at my organization collaborate effectively to get things			depending on the team
May 2023 CoSE	05/01/2023	done.	Collaboration	Ottumwa Regional	
		Teams at my organization collaborate effectively to get things			the only reason the lab hasn't shut down is because of my amazing coworkers who all step up and do way more than they need to be doing and no one is getting compensated for all the extra they are doing.
May 2023 CoSE	05/01/2023	done.	Collaboration	Ottumwa Regional	
		Teams at my organization collaborate effectively to get things			I feel as though it is not about getting things done, its about saving as much money as possible.
May 2023 CoSE	05/01/2023	done.	Collaboration	Ottumwa Regional	
		Teams at my organization collaborate effectively to get things			Our floor team work has always been amazing!
May 2023 CoSE	05/01/2023	done.	Collaboration	Ottumwa Regional	
		Teams at my organization collaborate effectively to get things			i see some actions being taken, but again, we have a long row to hoe...
May 2023 CoSE	05/01/2023	done.	Collaboration	Ottumwa Regional	
		There is good communication between leaders and employees here about			Frontline leaders need to provide feedback to the staff that complete incident reports about their safety concerns.
May 2023 CoSE	05/01/2023	patient safety.	Communication - GPS	Ottumwa Regional	
		There is good communication between leaders and employees here about			Most concerns are brushed aside, unless someone is seriously injured and then its a concern
May 2023 CoSE	05/01/2023	patient safety.	Communication - GPS	Ottumwa Regional	
		There is good communication between leaders and employees here about			See answer to question 20.
May 2023 CoSE	05/01/2023	patient safety.	Communication - GPS	Ottumwa Regional	
		There is good communication between leaders and employees here about			Emails and policy updates are shared when applicable.
May 2023 CoSE	05/01/2023	patient safety.	Communication - GPS	Ottumwa Regional	

May 2023 CoSE	05/01/2023	There is good communication between leaders and employees here about patient safety.	Communication - GPS	Ottumwa Regional	Really the only time I hear about patient safety is when we are preparing for a survey.
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	This 100% on what department they need care in.
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	I would NOT let anyone I care about come here for anything.
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	The hospital lacks proper cleaning!! Clinics do not receive correct PPEs for chemo disposal? GMAB
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	The place is so dirty, so run down and out dated it makes you question if you would be safe having care here
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	THERE ARE SOME DEPARTMENTS I WOULD AND OTHERS THAT IT DEPENDS ON THE TEAMS
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	To be honest, the stuff with ##### freaks me out, and made me a little leery (to get care or have my family get care at ORHC). But that is something that's more of a mental perception that I think can only get better with time, and the continued work to change that mental perception for myself and others. I have had an OP procedure this year, and had a family member admitted as an inpatient, and it was nothing but good.
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	I dread it when family needs to be seen, because I worry about the care they will get. I recommend my family go elsewhere, to outlying counties.
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	I was a patient here and was not treated very compassionately by some staff. I would go into the details ,but at this time it doesn't really matter anymore. I called the "complaint" line and never had a return call. When I received the survey in the mail I did not feel that it mattered as no one would even return a call so I did not return it.
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	depends on place
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	avoid the Er
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	

May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	I did not use to have concerns and I have always had good experiences with my family but, in the last few months its harder to say this is safe and now we have had another experience. How are such disgraceful people in healthcare?!!
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	Depending on the department
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	Labs are late or missing by lab. Care is delayed.
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	I would strongly recommend surgical services here
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	I would let my family have a one day surgery here. I would not want them to receive treatment in the ER or on the floors.
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	Only to surgical services
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	It depends on the the type of care they are needing.
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	as long as the nurses keep calling the shots in the er, without providers seeing patients, then no... get some docs that truly know how to access a patient, that uses common sense , not just trying to 'pay the bills'
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	I would choose this organization for surgery, not to receive inpatient care.
May 2023 CoSE	05/01/2023	I would recommend this organization to family and friends as a safe place to receive care.	Safety Referral - GPS	Ottumwa Regional	Retaliation no, someone actually caring about concerns... NO
May 2023 CoSE	05/01/2023	I can speak up about patient safety without fear of retaliation.	Psychological Safety - GPS	Ottumwa Regional	But I will anyways even if there is retaliation.
May 2023 CoSE	05/01/2023	I can speak up about patient safety without fear of retaliation.	Psychological Safety - GPS	Ottumwa Regional	On the spot issues about patient safety are handled directly. Sometimes a little harshly, but most of us in the Emergency Care setting are patient advocates and will speak up without fear of retaliation.
May 2023 CoSE	05/01/2023	I can speak up about patient safety without fear of retaliation.	Psychological Safety - GPS	Ottumwa Regional	

May 2023 CoSE	05/01/2023	I can speak up about patient safety without fear of retaliation.	Psychological Safety - GPS	Ottumwa Regional	Retaliation, not so much. But something actually being done about it, it is a laughable concept.
May 2023 CoSE	05/01/2023	I can speak up about patient safety without fear of retaliation.	Psychological Safety - GPS	Ottumwa Regional	Yes, because nothing really happens until something happens, Again reactive not proactive.
May 2023 CoSE	05/01/2023	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	Working short staffed and high nurse/patient ratios is definitely not safe without support is not safe
May 2023 CoSE	05/01/2023	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	The director of housekeeping allowed some of the clinics to go 3 business days (5 days including weekend) without being cleaned, this is not safe for our patients what so ever.
May 2023 CoSE	05/01/2023	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	If leadership cared about patient safety we wouldn't be driving ambulances with over 300,000 miles. Were constantly fixing them and its rare to have all three ambulances in service.
May 2023 CoSE	05/01/2023	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	Our past company administrators cared a lot about safety - This one care about money
May 2023 CoSE	05/01/2023	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	Everything seems to be focused on saving money. Pinching pennies. Not focused on providing the best care for the patients or trying to really work on the image of the hospital to the community.
May 2023 CoSE	05/01/2023	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	Not even a little bit. The AOC's have zero regard when requiring overworked and exhausted staff to jump in an ambulance with a non emergent transfer to Iowa City, just for the sake of saving a few bucks and not giving the trip to someone who can safely transport. But hey, maybe when someone who has been on the clock for 26 hours, wrecks a truck, and kills a patient that "matters" to the organization, maybe then will we change. Allowing EMS staff to work 36+ hours without the guarantee of sleep, then forcing short-staffed crews to take transfers, rather than calling another local service to take them. It's more about money than it is about safety. Again, administration shows their priority over and over again. Better pay would lead to more staff, which would lead to less long shifts, which would lead to better safety. But nothing will change until some catastrophe occurs and the change is forced.
May 2023 CoSE	05/01/2023	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	I beleive i pay close attention but i would not say the same for the leadership
May 2023 CoSE	05/01/2023	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	In my department I feel patients are completely safe. However in other departments, as proven by past actions, I feel like patients will be very skeptical about their safety.
May 2023 CoSE	05/01/2023	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	This place seems to be more about Re-action than action.
May 2023 CoSE	05/01/2023	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	We used to do safety briefings and pay close attention. With all the changes lately I think it has slipped through the cracks.
May 2023 CoSE	05/01/2023	Leadership's actions show that patient safety is a top priority.	Modeling - GPS	Ottumwa Regional	My manager and supervisor do a great job at promoting patient safety at all times. Not only do they care about patient safety, they too check in on their staff to ensure the nurses and other employees are physically and mentally safe to care for those they encounter each day.
May 2023 CoSE	05/01/2023	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	The ottumwa health group (clinics) does not perform yearly performance reviews (this is in the policy manual but they have never been completed as the employee is suppose to receive a copy of it)
May 2023 CoSE	05/01/2023	My manager provides me with feedback that helps me improve my performance.	Feedback	Ottumwa Regional	I would like more feedback on the specific job that I do. - more positive reinforcements or even shout outs to any of us doing a good job and why we are doing well. If we are doing something incorrectly we may never hear about it or know about it.

		My manager provides me with feedback that helps me improve my performance.			Only during annual reviews when it is required.
May 2023 CoSE	05/01/2023		Feedback	Ottumwa Regional	
		My manager provides me with feedback that helps me improve my performance.			haven't had a performance review in 4+ years and never receive raises because we have no money. I work hard but never told by upper management
May 2023 CoSE	05/01/2023		Feedback	Ottumwa Regional	
		My manager provides me with feedback that helps me improve my performance.			ONLY TIME YOU GET A TALK IS WHEN SOMETHING IS WRONG
May 2023 CoSE	05/01/2023		Feedback	Ottumwa Regional	
		My manager provides me with feedback that helps me improve my performance.			We have had several different leaders but I feel the last main leader supported me and provided me with feedback although sometimes I think she didn't see me for my potential. But my evaluations and 1:1 meetings were good and informative.
May 2023 CoSE	05/01/2023		Feedback	Ottumwa Regional	
		My manager provides me with feedback that helps me improve my performance.			She is amazing at communicating with us all and trying to find solutions to all of our problems, even if that means she sacrifices her own time here or at home! SHE IS THE BEST!
May 2023 CoSE	05/01/2023		Feedback	Ottumwa Regional	
		My manager provides me with feedback that helps me improve my performance.			i believe this to be true...
May 2023 CoSE	05/01/2023		Feedback	Ottumwa Regional	
		My manager provides me with feedback that helps me improve my performance.			He did when he was here
May 2023 CoSE	05/01/2023		Feedback	Ottumwa Regional	
		What do you love most about working for your organization?			Helping people.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			I enjoy helping the new mothers fille out paperwork for the Baby's Birth Certificate. It is the most important paperwork of the child's life. I want to make sure it is done correctly. I also help those that are not married to get the proper paperwork for the paternity affidavit. I enjoy seeing all the new baby's and seeing the joy on the new parents faces.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	I enjoy working with a great group of people.
		What do you love most about working for your organization?			The flexibility I have at my job with my schedule, an engaged director that I can talk and receive feedback from and the tight team dynamics on my unit.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			Where I work within the hospital, knowledge and experience I have to provide safe quality care, the people I work with are like a family with great teamwork.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			other staff interaction
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			I love making a difference in my patient's lives.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			The work I do.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			What I like most about working for this organization is the variety of patients I get to work with having different challenges amongst those patients. I also like working with most people in the facility.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	

May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Co-workers are great. Changes are being made for the better. It will take time
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	helping patients, empowering staff, learning
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	the team
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My Coworkers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Freedom to do things I need to get done
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Our new leadership, my coworkers, my team, and the support we get from our subject matter experts at the HSC.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love my patients
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have flexibility to work from home and onsite.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My co-workers in my department
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The team I work with at my clinic
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like the group of people I work with every day. I like the flexibility of my job.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have enjoyed building friendships with many of the nurses I have had the pleasure to work with.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I look forward to coming to work because I enjoy working with my team and I love what I do!
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Giving back to this community, a sense of pride at the place I work, being recognized for a job well done, and also getting feedback when a mistake has been made so that improvements can be made and the mistake will not happen again. I also appreciate my boss. She makes sure we are taken care including that we have had our breaks and food.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Team on my unit and leadership
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	We have a great team at Easy Care.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	SCHEDULE
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

		What do you love most about working for your			like being able to work prn due to aging and dibilitated parents, helps to only be able to work 1 to 3 days a week,
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			taking care of ill patients and feel rewarded
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			I love what I do, and my coworkers in my department. They are the reason I stay. My ormics crew is my family.
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			My team On BHU. I have worked with these individuals for awhile now and we work so well together when we get the opportunity to not be micromanaged
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			Good CEO
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			When I first moved here from a larger city 6.5 years ago, I was amazed how SE Iowa, as a whole, seemed 15-20 years behind even larger cities in the midwest. I often heard " This is just the way it is." I am disgusted by what happened last October, but our new CEO and his team are not only giving 150% to take care of the victims and families, but they are making the changes that so desperately needed to be made. I am excited about our future and new possibilities as a regional health center and very much want to be a part of the change.
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			I love working with my team
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			I work for the ambulance and I stay for my ambulance coworkers. I don't want to let them down.
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			The people I work with.
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			The people I work with in my department
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			The recent changes in administration have been a positive, I was worried to begin with, but change is happening in the best way possible. Transparency is better along with accountability. I'm excited for the direction things are going even though it will be tough.
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			everyone is friendly
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			Providing EMS care to patients in my community.
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			The people in the OR department. We have a great team in this unit and we all work well together.
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			I like the benefits that we have, my work schedule and my director is amazing to work for
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	
		What do you love most about working for your			the patients i work to take care of.
May 2023 CoSE	05/01/2023	organization?	Love Most	Ottumwa Regional	

May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the location of my employment. I believe my supervisor (#####) does everything in her power to get us help and things when needed but upper management does not help her
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people on my team are family.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I LOVE WORKING WITH MY CO-WORKER AND MY BOSS.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Flexibility. Open, honest, caring people.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	having a positive impact on the lives of my patients
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the opportunity for personal growth in my profession and to know that I am meeting the patients direct needs
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people in my department and a few of the directors that I get to work with occasionally.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love working for a large employer that is always working to make the health of others better and does it with the utmost of concern.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people and the work
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my immediate coworkers/team
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	THE TEAM I WORK WITH ON A DAILY BASIS. WE WORK WELL TOGETHER AND WATCH OUT FOR EACH OTHER. WE NEVER SAY THAT'S NOT MY JOB. WE JUST PITCH IN WHEREVER NEEDED
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The hours so I can be home with my family and leave work at work.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My co-workers always have my back. They help out when the load is to big or busy. everyone works together to get the job done.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	On
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love making a difference in the care of patients. I love being part of the diagnosis team that helps the providers treat the patients.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with on a daily basis are the best around
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	1.Making a positive difference for my patients and their families 2. Working on my team of coworkers 3. Autonomy to make decisions

May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworker #####.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My boss and co-workers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the work I do and helping out the providers to take care of the patients. I'm not proud of where I work though with all the negative drama stigma and then the lack staffing that has strained the rest of the staff to the brink of falling apart.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy pt care, and responding to emergencies. If there were another 911 service in our area, I would personally already be gone. My favorite part is clocking out.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Service to my community.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I Love my patients and my immediate co-workers. We are our own little team , but not part of the ORHC team. Haven't even met our new leader. Have needed help for 3 years..... Nothing yet.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Most days the people are friendly and cooperative
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The employees you get know are very good at working together in chaotic situations.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	As a whole we are trying to keep moving forward and supporting our community
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Working with my coworkers and the patients
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The patients I care for.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	It is close to my house and it pays most of the bills.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	coworkers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	the people I work wit
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	being outside on my runs
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the people I work with and that's it.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like that the 3 day work week gives me time with my family and time to decompress from this environment. I like that working in ARU provides me the opportunity to see patients succeed over a period of time. I like the size of our unit, it demands teamwork and cohesiveness.

May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love working with the night shift crew in the ER. The best nurses always going the extra mile and truly care about their patients. Night shift flow treats each other with respect and always work together through the rush of patients and stressful situations.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Flexibility in my schedule.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	On most days I enjoy coming to work because it's like family here and most staff will speak/acknowledge you in the hallway.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Caring for the patients in our community and working with amazing colleagues.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Team work
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My Doctors and most of my co-workers, honestly everything else needs a lot of work.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The thought that things might get better
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my team mates
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Team work, communication, caring supervisors
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Commitment to care for patients
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I LOVE WHAT I DO
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have the best managers ever, ([redacted]), they always listen to concerns and always willing to help if they can. Some decisions made by upper management don't always make sense to me in the everyday work that I do. I have worked here for almost 31 years and have seen a lot of changes in health care. Some are very good. I really would appreciate some physical presence from upper leadership on occasion. I never see that anymore. I appreciate knowing the people that I work with and their commitment to the hospital. They are amazing people.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love working with my coworkers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The friends I have made while working here.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The flexible hours my boss allows the people in our department to work.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people care about patients
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I ENJOY THE PEOLPE I WORK WITH
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	the benefit we provide to our community
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I LOVE MY JOB AND THE PATIENTS AND THE PATIENT CARE AND MAKING JOB/ EXAM MORE ENJOYABLE FOR EVERYONE- MYSELF AND PT AND FAMILY
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Challenged with special projects and tasks, always learning something new
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy my coworkers and providers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The ability to serve my community. Not only that, I love that I have co workers that really cares about the patients that are under our care, and directors that never fails to continously keep us updated as possible and the team work that we have, especially with emergency situations such as having access or system where we have assigned "rapid response team" that other hospitals may not possibly have.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Understanding if I have a need to switch my off days or if there is something I need to take care of at home.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love working on WFC and knowing that our team of nurses is truly a family
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love I have been able to change my schedule to meet my families needs.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love taking care of patients and feeling like I make a positive difference in their health care.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The patients I work with
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have seen significant improvements at our facility as a whole, especially in the last few months. I do appreciate the proactive administrative teams making ORHC feel great again. There is a sense of feeling cared for again, seen, and heard. I am seeing the sense of belonging from staff coming back and an uplift in workplace environment. I love caring for families on WFC, and grateful for the WFC team and leader! I am able to trust and confide in them. Our director empowers us to grow and learn which also helps us feel supported! We are beginning to see the smiles in the hallways from staff again. I do feel closer to this team and organization in these last six months. We are actively seeing the changes being made, and that is very hopeful!! Thank you!!
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My clinic feels like a family. We all work together to help each other, celebrate each others birthday and most importantly pick each other up if one of us is feeling down. I love my ORHC work family.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	team work
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

		What do you love most about working for your organization?			the group of employees I work with.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			Helping patients and growing staff. Seeing the staff grow and develop skills is rewarding.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			My team, growth opportunities and upper management.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			My coworkers.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			I love helping patients and volunteering.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			routine hours, consistency of where I will work
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			I love the people that I work with and being able to serve this community.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			The opportunity it gives to improve on patient care
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			My coworkers and my supervisor!
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			Being able to help people.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			My coworkers are the thing i love most about working at ORHC.
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			I really enjoy my coworkers!
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			personal interactions with peers
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			i have a job i like and i enjoy my coworkers
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			smallfamilylike atmosphere
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			the flexibility
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	
		What do you love most about working for your organization?			I like the fact that the person I am training with is through in making sure I have all the tools needed to be successful. I like the fact everyone gets along and works well with one another
May 2023 CoSE	05/01/2023		Love Most	Ottumwa Regional	

May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love helping our community, but most of all this place feels like a family to me. As I watch people come and go from here it saddens me that this hospital is so easily given up on.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	We do have a good manager for the clinics. I feel there is decent communication between staff members. There is behavior that is sometimes tolerated more than it should be. We do have providers that have unpredictable tempers.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	i love the people that i work with.they are who keep me comming back to work
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	i love a atmosphere we have here with the nurse we work together if we have trouble arising
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	THE STAFF IN THE HIM DEPARTMENT IS GREAT
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers, providers, and patients
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	working remote
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	that i am able to work from home so i can say what i want without anyone else hearing me
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Open communication, expectations set and acknowledged, core values
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel I am treated fairly and have been given opportunities to work in areas that I can excel.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with, and the bosses I have
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy working with the patients we have and being a part of a team that improves their lives by healing them and educating them on remaining healthy.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel I have great support from my director and co workers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel we have good co-worker relationships and teamwork, overall. I feel that most of the people I work with understand the importance of my specialty areas (plural) and usually show appropriate appreciation and/or respect for the depth and breadth of my profession (which is very significant).
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Working with dedicated employees daily that get little recognition and low pay, but still continue to try to do the best job that they can under the circumstances.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Hard working employees that get low pay for the jobs they do! But continue to come to work. Nurses always get raise. But hand on people don't..
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My department director, [redacted] is amazing. Any positive answers I have given are because of her leadership and teamwork with my co-workers in our department
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworokers and helping the community
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with everyday and the patients that I get to help.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Teamwork
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Enjoying the positive changes and friendly faces from the new administration. I love the variety of my job.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Patient Care.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The Nurse Practitioner I assist and the patients I care for.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my coworkers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Most fo my co workers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	CoWorkers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy the people I work with.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	That it's close to home.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	It is convenient and close to my home. I like my role in my department, but would be happier in this role in another facility if it was closer to my home.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Question 17 *Work order requests all available online -Includes maintenance, IT and BioMed -New maintenance system doesn't allow staff to see where in process request is, if it's been dealt with and if new issue or not. We need to see this. We need this for all work requests, especially IT that has notoriously poor follow-through.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My director is incredible and truly what I feel is holding the clinics together.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my coworkers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The job I perform
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	co workers
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Doing the right thing no matter what.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people that I work with.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	again, it's the dept 'family' for me... the abilities to help people...
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My job itself
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love a lot of my coworkers especially those that care about the community as much as I do. I love helping my community, and delivering care and comfort to patients and their families.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Teamwork in my Department !
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy the teamwork.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	like the people i work with
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I used to say the people I work with, however most of them have left.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love working for my specific department, ONE Day Surgery. I feel that we do a great job of communicating and helping each other out at all times.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like the team work at my department
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My unit and my boss
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I appreciate the support I feel from the organization, my coworkers and nurse manager. They are wonderful at communicating and working as a team to get things done.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like my team.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Night time providers and supervisors have been very helpful.
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Proximity to home
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people in my department are great!
May 2023 CoSE	05/01/2023	What do you love most about working for your organization?	Love Most	Ottumwa Regional	the people i work with
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	Everyone is losing their happiness here
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	I do not feel a sense of pride for this hospital. I am prideful in MY work with patients, but this organization only care about profit.
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	The lack of pay benefits is often discouraging. Especially when I can drive 20 minutes out of town and get compensated the way I feel I deserve for my years and experience.
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	I love my job and the people I work with the pay could be better
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	I am hopeful for the culture change that Admin is trying to introduce. However, I wonder if this is another flavor of the month. We have had so much change between RegionalCare and the Regional Care/Capella Health and now LifePoint. We have not had a stable environment and with each new administration, something big changes. We are all tired. We haven't recovered from COVID and we haven't been able to catch a breath. I belong to a great departmental team, but the job is rarely rewarding. I believe in William and his/LifePoint's vision and values, but I hope it's not too late to turn this place around.
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	I am happy to have employment
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	I am doing 3 peoples job as a single person due to short staff. Feeling very overwhelmed and unheard.
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	The only thing that keeps me here is service to my community as a paramedic. If there was another 911 service in town, I would have left years ago.
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	I love what I do, I love patient care. However, this place is toxic, and makes coming to work a dreadful experience.
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	I am not as happy as I used to be. There is too much turn over in employees, always working short so that people (some) have to work extra hours. Team work, and smooth work flow are it appears to be a thing of the past. This is partially due to the constant turn over (employees are not invested in this place because so many are not even from here).
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	My coworkers keep me coming back.
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	i feel that my voice is not heard at all
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	I enjoy my position and co-workers. I do not feel there is equality between nurses with pay scale or opportunities.
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	with all that is going on, it's hard to be happy, but at the same time 'happiness' is a state of mind, so with that said,, i'm grateful to have a job and to use my abilities to help others

					Short on staff, and being on call are facts that made me not feel so happy
May 2023 CoSE	05/01/2023	How happy are you working at your organization?	eSat	Ottumwa Regional	
May 2023 CoSE	05/01/2023	I feel empowered to make decisions regarding my work.	Empowerment	Ottumwa Regional	I answered this question higher last year. Decision making is slowly and silently being taken away. [redacted] is taking away almost all decision making in some relevant areas and tasks that used to be all part of the process are now done with questions and fear. I used to never feel micromanaged, and now I feel it more frequently. In other areas, I feel very empowered to make changes and to make a difference.
May 2023 CoSE	05/01/2023	I feel empowered to make decisions regarding my work.	Empowerment	Ottumwa Regional	See above. Administration has stripped away the ability for us to make decisions. I'm just thankful that they don't ride in the ambulance with me to micromanage the care I provide to my patients.
May 2023 CoSE	05/01/2023	I feel empowered to make decisions regarding my work.	Empowerment	Ottumwa Regional	Any decision that we do make usually gets overridden by admin because they have no clue what it is like to be in our shoes. Even if it means the safety of staff.
May 2023 CoSE	05/01/2023	I feel empowered to make decisions regarding my work.	Empowerment	Ottumwa Regional	I await the day that they decide they should come out into the field and tell us how to do our jobs in the box.
May 2023 CoSE	05/01/2023	I feel empowered to make decisions regarding my work.	Empowerment	Ottumwa Regional	To some extent. I can make work better for my co workers but don't feel like I always have the support I need for them.
May 2023 CoSE	05/01/2023	Employees who prioritize patient safety are appreciated here.	Recognition - GPS	Ottumwa Regional	I have not publicly seen this to be true.
May 2023 CoSE	05/01/2023	Employees who prioritize patient safety are appreciated here.	Recognition - GPS	Ottumwa Regional	i dont feel like we ever get recognized for anything we do. definetly dont feel appreciated
May 2023 CoSE	05/01/2023	Employees who prioritize patient safety are appreciated here.	Recognition - GPS	Ottumwa Regional	Patients need to be directed to the appropriate area of health to meet their needs safely and efficiently, not seen in the clinics to make their wait times easier.
May 2023 CoSE	05/01/2023	Employees who prioritize patient safety are appreciated here.	Recognition - GPS	Ottumwa Regional	No direct appreciation is shown, nor is it necessary. Doing what is right for the patient is just the standard.
May 2023 CoSE	05/01/2023	Employees who prioritize patient safety are appreciated here.	Recognition - GPS	Ottumwa Regional	When we do speak up, we are told it does not matter. Example; Staff is on a 36 hour shift, and there are not enough people to staff the ambulance. AOC- sends transfer---> sleep shift person then stays up to run calls ----> sleep shift person then exhausted, and nothing is done to alleviate this---> dangerous situations = NO APPRECIATION
May 2023 CoSE	05/01/2023	Employees who prioritize patient safety are appreciated here.	Recognition - GPS	Ottumwa Regional	Do we have anything in place to show that? Not that I am aware of.
May 2023 CoSE	05/01/2023	Employees who prioritize patient safety are appreciated here.	Recognition - GPS	Ottumwa Regional	I can see both sides of this statement. For a decent percent of time, yes patient safety is appreciated. However, there also seems to be a significant amount of time when the overall idea of patient safety is buried. For example, a patient is scheduled for a same day surgery, but ends up having to be admitted to the floor for observation overnight. The nursing supervisor gives a lot of push back because “this patient was scheduled to go home today, have you given them enough time to wake up?” or “we had no idea this would be a potential admit”. This attitude is unacceptable. I understand that certain surgeries are scheduled for outpatient, but plans change. Staffing is an issue currently and so is available beds, but if it’s the patients best interest to stay, that’s how it goes. I have felt like I am looked at as though I am stepping on other people’s toes for advocating for my patients.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	You need to figure out who should be doing what and make sure that they take over the task

May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Most of the time the OB department is the first experience many patients have in a hospital, This can build endearment towards the hospital, leading to trust that could make a patient choose the hospital for other reasons. People do have choices. It would be nice to see some care and investment in the OB unit. The team exists on the Unit. They are a team that has very low turnover and longevity in the hospital. It would be great to see that acknowledged.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better communication between departments especially with departments that are contracted.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Reward and recognition to staff that have endured and been here. It feels we are left behind to continue to pay high wages to travelers. It would be nice to be recognized with a gift card, money ets as we have saved the organization money.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	DEPARTMENTS NEED TO WORK AS A TEAM
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	wages, retention, recruiting, marketing
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Employee retention and recognition
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Give EQUAL opportunity to ALL employees. Higher pay. Remember ALL employees when giving out snacks to departments. Not all who are under a department are located in the same department and are forgotten.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I think the focus to make this organization a better work place would be the Behavioral Health Unit. I have struggled with getting patients on the unit for various reasons.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing. attitudes towards each other, especially between units
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	more staffing
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Our wages need to be competitive with our competition. Share the love, or praise, with all employees. There is a big focus on nurses and your other employees feel that they are not as important
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Improve communication Communication Ownership Leadership Cleanliness. I know it has improved but the areas I see are still very dirty. I want the floors to shine and the carpet look like it has been cleaned. Maybe the carpet on the main floor needs to be removed
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing. Pay people a competitive wage so that they want to come work here. Patient's cannot receive safe, proper and appropriate care without adequate staff

		Where should we focus to make this organization a better place to work?			everywhere out in the publics eye
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			Employee recognition, flexible schedules, pay increases/market adjustments
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			Higher wages to actually have nurses consider working here instead of temp employees that are only here for money and do not care of the long term goals of the organization.
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			employee recognition
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			pay scale
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			treat everyone fair no matter who they are or what they wrong with everyone here is entitled to work and not sit around doing nothing beside collecting a paycheck
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			Better wages for everyone not just nurses. It takes all of us to make a great hospital. We show up for work every day and do our job but we don't get the same treatment as nurses . They all got pay increase before the clerical staff and we all have bills to pay and do our best to make this hospital great
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			Eliminate all contract employees and outsourced services. In order to have a dedicated work force, we need employees that are employed by ORHC and live in the community.
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			Update systems to make staffs efficiency better. Examples would be a new documentation system, vital machines in every room, more computers for staff.
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			Pay me for what my job requires me to do. A 29cent raise?!?!?! GMAB.
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			Competitive raises for all employees not just nursing. Update technology ORHC is so behind in technology compared to Mahaska Health and Pella regional its embarrassing!
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			Regular raises - substantial raises. Getting compensated for BSNs and more education. Educational opportunities.
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			There seems to be allot of un-happy workers. Schedules changed frequently. Turn over in employees. Team morale is down. I wish there were something we could do to make everyone feel valued and appreciated. I believe in our mission to make communities healthier. I also believe in our team. We have so much talent here. When staff members leave, there is no communication as to why? What can we do to keep you? What happened to make you want to leave. I guess what I'm saying is we need to figure out why people are leaving and maybe turn that around and retain them. Communication is key!
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to work?			Continue to try to recruit full time staff. Staffing is our biggest issue right now. I think if we could get quality staff we could find our pathway back to greatness.
May 2023 CoSE	05/01/2023		Better Place	Ottumwa Regional	

May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Human Resources.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	SALARY
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	need to listen to staff concerns regarding help that is needed. and not take so long to brig staff on. whether travel personnel or regular staffing.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Very dirty carpet and bathrooms. Patients' family's complaining and nothing getting done. . Seems like no customer service anymore. Raises more than 3%, not working short staffed. Better computer systems.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	safe patient care environment with stable staffing
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Bring back our old culture and treat people like they are more than a number. Money is the only thing that matters to people and patient care is on the back burner. When a good employee asks for a raise as they work hard and go outside of their job duties, they are not appreciated.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	You need to work on communication, making your employees feel that they are valued, increase pay wages for employees that remain in your organization that are commiserate with the travelers that are paid quite a bit more for doing the same job, and when you say you are going to do something or help us, please do it.... we don't see the actions follow the promises that are made. We would not be here if we didn't want to help and care for the people of our community but when we are understaffed and overworked there is going to be a safety issue at some point with a patient, and we are here to keep our patients safe and make a difference.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Not focus on money. Think of the people and how you can help them. This place feels like it's all about money. Give them things they deserve and can use to do their jobs better, like an ambulance that doesn't have almost 300000 miles on it. Would you personally drive a car with that many miles on it? We have to pick up very sick patients and then if the rig breaks down we're stuck. They are very bumpy and not very comfortable for our pts. I like being recognized as departments for doing amazing things. Come visit departments and get to know who your employees are. Spend some time a couple days a week coming around asking how everyone is doing and if they need anything. Hold meetings to update us on things not just an email. Make time. We are coming here and working hard make this place a good place to work but some days I come here and I hate it. I hate the way my department gets treated as if we don't make the hospital money so we are the red headed step children who are lazy.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I feel we are on a new path of going in that direction. I think our biggest challenges are getting and replacing physicians, and customer service. I feel we need a program to bring customer service (not only to our patients, but to our team members as well) to the forefront. I have worked in hospitals that have such programs and it is difficult to put to words the positive difference it made.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Need more internal, positive communication between leadership and employees. Also need to market the positive things going on at ORHC within the surrounding communities
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better communication and competitive pay.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Start listening to employees. Stop letting management be management without knowing all aspects of the department. Bad attitudes prevail.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better communication and hiring local people versus contracted employees.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Finding a way to get core staff and keep them so we are not training travelers constantly
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Compensation- Not just wage increases but more with benefits that can adapt to the generation today. Not having the job description of "other duties assigned"
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	There's a lot. But be proactive to situations instead of reactive. Stop hiring outside sources that do not care about patients and start taking care of the staff that are here permanently. Stop caring about the money. I understand nonprofit but were in ambulances that are falling apart.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Transparency, follow through in promises, work conditions staffing, wages
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	HOURLY PAY AND BENEFITS SHOULD MATCH OTHER ORGANIZATIONS
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Increasing pay and incentive to retain staff and also on-board new staff. The appearance of the hospital should be assessed as well (i.e. new flooring in the entire hospital or potentially updating rooms in ODS; and cleanliness)
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We need more staff and the ability to hire staff in the clinic setting. We are being micromanaged ineffectively and our clinic employees are working hard but are extremely short staffed.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We need to pay better so we can get more people here to work. the staff we have can not continue to work the job of 3 people
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	better more effective equipment such as better scanners to scan ID bands and meds, cordless would be so much help, nurses who actually care and will help each other. so many staff anymore are rude and grouchy when you ask for help. no bed side manners
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	better competitive wages , better incentives for employees to pick up extra shifts
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

		Where should we focus to make this organization a better place to			In the employment management. We need more nurses and support staff in this hospital. We are getting rid of travelers but not replacing them while fulltime employees are getting the whiplash from it. People are not applying due to the pay ORHC offers them.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			WE SHOULD FOCUS ON LISTENING TO PATIENTS BEFORE TRANSFERING THEM TO THE WRONG DEPARTMENT MULTIPLE TIMES
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Consistent staffing & improved benefits
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Continuing to listen to the "small things", be transparent, and act upon feedback.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			updating equipment. cleanliness. treat employees equally. recognize contribution of employees who do not draw attention to the work they do, at the same time recognize intent of those who speak badly of or belittle co workers to inflate their own contribution. leadership should verify what they are told and get both sides of a story even if that information is coming from
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	a favored employee.
		Where should we focus to make this organization a better place to			Leadership lacks support of and for their employees and providers. Employees are not retained due to lack of poor working wages that are non sustainable to meet their needs for basic living.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Clear expectations, over communicate, clean it up and paint it, plant some flowers, promote it, hold people accountable, there should not be favorites, consistent evaluations and raises, bonuses for exceptional work, recognition that means something, brainstorming with staff on issues, empower, and give more time off. More community involvement, more community presence, more community outreach. More collaborations, defined goals
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	that anyone can work towards.
		Where should we focus to make this organization a better place to			Getting the staffing we need to provide safe care.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Hire more staff to reduce the work overload and stress. Then work to make processes with IT and anything that has been lacking brought to a better level.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Focus on raising moral of Core Staff so that they're happy to come to work.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			I think the stress of what is going on, when that is over I think it will be great
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			EMPLOYEE SALARIES. NOBODY WANTS TO WORK FOR WHAT WE ARE PAID AND NOBODY WANTS TO STAY BECAUSE THEY ARE NOT PAID ENOUGH. WE SHOULD BE GIVEN A RAISE AINCERTAIN AREAS AND MILESTONES WE HAVE REACHED AS WELL AS TIME OF EMPLOYMENT
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Hiring. As a single person doing the job of 3 people. It’s exhausting mentally, physically, and emotionally.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Give the right amount of pay to your employees and not below all the other hospitals in a 50 miles range. It's been talked about but is always shut down when you bring this amount to the table. ORHC employees are about $5-$7.oo hour below the Hospital 's around Ottumwa Regional
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	

		Where should we focus to make this organization a better place to			The people are spread thin in many clinics. Need more employees to backfill vacancies
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			To make this organization a better place to work, communication should be the focus.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Leadership- experienced and committed- not just hired from in-house because it is convenient. We need qualified leaders with great communication skills and a commitment to not just money or the organization but also our patients, staff
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Competitive wages
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Being transparent. Tired of hearing we don't have money. What money do we have? Where is the money going? What is the expense report? Getting and retaining staff. Communication. Raises for all the staff that have stuck it out during this very difficult times.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Sell us to someone who actually cares about the community and wants to treat staff well!
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			For starters, selling to an organization that actually cares about Iowa, and about OUR community. The people in Tennessee don't care about this facility. And as a result of their apparent indifference, our community suffers from poor quality healthcare. Stop hiring travel nurses and pay the organic staff what they deserve. Pay EMS staff better so people stop leaving for more pay at slower services. Hire managers who will enforce standards, and allow those managers to actually manage their departments without interference from administration.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Communication from management to workers, no friends working for friends
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Keepnig it cleaner & being more sincere. The public does notice. I haven't had a evaluation in over 2.5 yrs. no pay raise, no anything. It gets very hard to come to work when you feel like our leaders don't care ab
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			BETTER PAY
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			get a pulmonologist
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			wages - I hear it all the time we are lowest paid professionals in our hospital world causing staff to leave at a high rate. In the past loyalty kept people working here, but today after Covid the only thing that matters to many is the paycheck.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Invest in equipment & staff.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	

					Remove all upper management and start fresh. Also, make it a not for profit organization. I suggest selling to UnityPoint. They have multiple hospitals that are thriving.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Also, our insurance makes it to where if we need medical care it is cheaper to do it here since it is out of state the network is very small. Therefore, I had to get my care here and have never had such a bad patient experience. There's no excuse for such poor care. It's disgraceful.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Enough staff & better wages.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Need more staff and new equipment
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	On retaining the employees that have stuck around for the last 3 years and realize what we have done to keep ourselves going and continuing to help the patients. Give a sizable raise to these employees since you paid out so much for travelers and not your employees!!!
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Management. Raises!
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay, structure, technology. Pay: I honestly think that this current shortage in our hospital isn't going to change until we significantly outcompete nursing homes and other smaller hospitals in our wide area. To attract a young person to live in a somewhat rural area for any amount of time is going to take a serious pay commitment. Nursing homes in the area are starting to give PART-TIME nurses sign on bonuses of $5,000, and a recent LPN got hired at Ridgewood at a rate of $36/hr. Structure: our building is very dated and things are not kept in good running order. Patient's bring up the condition quite frequently. Chipped corners, stained walls, hanging curtain rods, water stains, broken glove dispensers, etc. Let;s face it, people are shallow, if they aren't in a professional looking place , they don't act it. Look good, feel good. Technology: it seems as though we are scraping by in terms of our tech. Down to one bladder scanner most of the time, an EMR that is not conducive to good work flow. Better pay to compare with other facilities, more employee incentives, and low staffing issues have taken a toll on everyone.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Recruitment and retention of staff and providers
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Motivating employees to stay and having the needed and properly working equipment and Supplies.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay local employees a good wage that will encourage them to stay employed. There are surrounding hospitals that have a smaller volume of patients (less work) that get a higher wage and also get IPERS. I understand a for profit has to make money however that should be shared with the folks at the bottom not just the top of the chain.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Becoming the top competition for other organizations in regards to staff wages, benefits, culture, diversity, and inclusion.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Need to work on changing the culture of wanting people to come here and make a career out of it here at the hospital. We shouldn't be loosing people to other places because of pay incentives or increase. We need to work on keeping good staff here, replacing staff instead of piling more work on staff and not getting any pay increase for it or have any training or licenses for it.

May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Departments/inidividuals that aren't liging the new culture
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Corporate and local administration.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay Vs. Inflation, Pay vs work load, Pay in general, Managment, Appreciation, Moral, Environment, Pt Care above all else, overall well being and mental health of staff, work load, communication, Appreciation, Compassion, Heart, feels like a dictatorship, Acknowledgment. Pay the staff who have stuck it out.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	COMMUNICATION. ASK THE EMPOLYEES WHAT CAN BE DONE TO IMPROVE. UP DATE INSTRUMENTATION.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	pay
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Making patient/nurse ratios safer so we can provide quality safe care
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	WAGES
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing, wages, keeping staff, marketing to get a better name for ourselves
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Less hostility displayed by coworkers towards other coworkers
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	PAY SCALE!!
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Keeping nurses and units managers and supervisor communicating with everyone better
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Occasional physical presence of upper leadership so we can actually get to know each other and appreciate the work we all do and why we are here. It's much more than making money.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Taking care of the employees that have stayed and worked through all of the crap. If you continue to take care of your current employees, you wouldn't constantly be searching for new ones.

May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better pay
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	THAT IS A MANGERS JOB- I HAVE TRIED UNTIL I HAVE BEEN ASKED TO SILENCE MY THOUGHTS AND PERSONALITY- GOOD LUCK
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	TREATING EMPLOYEES BETTER WITH ANNUAL REVIEWS TOPPED OFF WITH A WAGE INCREASE TO RETAIN THE EMPLOYEES. ALSO RECONITION WITH THE COMPANY
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Increase wages; increase staffing; better equipment.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better communication from the top down, better sense of team and that we are not just "bodies to work" but valued employees, improved quality of care
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	having more coverage
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I think what's more important is HAVING A BETTER AND COMPETITIVE WAGE for staff, cleaner facility, and having accountability where concerns are not just being acknowledge but taken into action especially with variance reporting and staffing issues (call offs). Cosmetics and structure wise, we are pretty outdated and improvements on this can increase the confidence patients may have with our facility and staff competency. Hr needs to be more organized especially with job applicants where they take MONTHS before getting back to them and it leaves those amazing potential employees to move on to another organization. I think staff may also want to receive items that represent orhc (jackets, pens, shirts, etc) Although pizza and icecream are great, we also have other great food in this town to such as BUBBA Q, JIMMY JOHNS, Ashbys, etc that staff may also like :)
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing we are short staffed and it puts a lot of extra work on everyone.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Wage- pay your full time staff instead of travelers
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Physician recruitment and upgrading the WFC floor to make it look more up to date
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Morale across all departments is low and really needs to be improved. I feel like we work to do our best for the patients and get little to no recognition that we are trying our best. I don't mean a sign that says "your a hero" or "we appreciate at our staff". I mean stopping by and pitching in when we need it. Helping us get the materials we need to do our jobs, without us having to beg and send 42 emails to 5 different people to get our supplies. All most everywhere is working short staffed, so stop expecting increased results or everyone will find new jobs.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Employees

May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Giving the employees opportunity to grow and learn. I have been “transitioning” to a different position for 3 months and not been able to move.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Continue to help us feel supported! Building the trust of the team will help us grow trust within the community again too. Thank you!!
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Annual reviews with raises.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	when an employee has question or comment or an answer for a concern, the person or dept that the concern is addressed to does need to be much better at follow through.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staff feel very strong with staff retention. We are also not competitive enough with wages. We also have to work on the face of the organization and get more updates. Sometimes it feels like it would be cheaper to build a new facility than to continue to bandaide what we have. Last continue to provide resources of positive outcomes for things like BSSR which we sometimes struggle with from other facilities that have had successes and how they were able to keep it hardwired.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Adequate staffing
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Appreciating staff more than travelers.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Employee recognition such as employee of the month, employee spotlight, recognizing years of service, etc Competitive wages for all staff ORHC attire such as nursing jackets, scrub tops, etc
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Continued support of employees, active retention of current employees, and not keeping negative employees.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	More staff for workload, update ancient equipment and computers, better pay, MUCH better communication
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Software: Meditech is antiquated and not user friendly.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	More staffing, more pay, more PTS
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Make promises and actually keep them. Pay raises have been promised and have not been received. Also, I have applied for a part time position and haven't heard anything about that. Our ambulances are falling apart and need replaced.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	There are too many to list, a but a few things to make ORHC a better place would be quicker and more aggressive improvements to equipment and the facility especially the emergency room and the ambulance service. Show the community that ORHC cares about there experience and health more than just words!

		Where should we focus to make this organization a better place to			Pay and benefits. Value employees and don't just dump everything on them
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Wages and benefits.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			physical appearance of the facility. it is dirty and worn. not appealing to patients or potential employees
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			More CNA help. Many jobs can be done by CNA that are not being relied upon for
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			On current employees. Recognizing those that have been here and continue to stay here. Whether that be by pay, verbal appreciation
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Continue to be open and honest with staff. Strive to continue with transparency. Show employees they are appreciated.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Get your manager for the clinic's assistance if needed. The turnaround time to start is far to great and help getting all the CAQH accounts and credentialing done and to help the providers.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Nurse retention and front desk retention. Wages are not comparable to the area and therefore we are not retaining good staff. Housekeeping is paid more than front clinic desk staff.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			more competent staff and open icu,more ancillary staff.more staff period
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Getting more staff in here!
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Having enough staff.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			faster at getting upgrading aesthetics of the facility like pictures, furnitures our rocking chairs on wfc our old wooden rockers that are uncomfortable to breastfeed in. the cots we have our fathers sleeping in our just springs yes we have a foam mattress to put on them but i feel its just a bandaid on a bigger problem so getting couches that turn into a bed would be more pleasing to patients and family
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			1. Pay 2. Good, competent employees 3. Maintenance upkeep
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Praise to do better, employee recognition, staff pay increases instead of paying traveling staff loads of money
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	

May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	BETTER PAY BETTER WITH COMMUNICATION LISTEN TO ALL COMPLAINTS FROM EMPLOYEES AND DON'T JUST SAY I HEAR YOU, ACTUALLY PROVE IT AND DO SOMETHING ABOUT IT THAT SHOWS
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	better wages,communication
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Infrastructure repairs of older building needed
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	One of the areas that needed desperate attention were salaries which was for me taken care of over a month ago. The next area of improvement should be transparency and communication. Recognition of a job well done is also a very important part of feeling valued at work. I really think the Quint Studer Hardwiring Excellence has many great ways to improve organizations and I was previously employed at a hospital that hardwired the methods covered in the book. Pt. satisfaction scores rose and employee satisfaction was and still is high. It isn't an overnight fix but once hardwired, it is very effective.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Supporting your staff.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I feel we should focus on communication, not only with in the hospital with staff but with patient's and their families as well. I believe providing more staff to be available for patient cares and maintaining the patient's room would be of benefit as well.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	To continue trying to get the staffing needed for each department
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	By listening to employees in the areas that need improvement. Management has a way of only focusing on the bottom line, employees that are working the floor see and hear a lot of things that would give the hospital over all a better reputation and these things need to be acknowledged. By using incentives to retain current staff and encouraging staff to join the hospital is very important. All departments are terribly short staffed and need to be recognized and they need to know that the hospital truly appreciates their hard work and dedication. Unappreciated employees, especially in this trying time will not stay.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We need to be able to successfully and efficiently REACH people in the administrative side of Lifepoint, for example Payroll, Human Resources, Benefits, etc., and we need to know that they will actually call us back or reply to an email. Far too many questions are left "unanswered" because there is literally nobody to call/reach out to (that will call us back or help with the situation, etc.). There have been 2-3 topics/issues that I have sent emails and left voicemails about, but did not get the help I very sincerely/urgently needed.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better pay!!!!!
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Wages!
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Focus on pt care, and the processes that make pt care better. More staff at the point of care, instead of more management, The staff are in survival mode, we cannot make improvements, if we are barely hanging in there to give basic care. We have antiquated charting and documentation systems that are labor intensive. Management, including corporate management, give knee jerk reactions to problems that occur. Staff end up with even more charting and more rules to follow and less time for patients.

		Where should we focus to make this organization a better place to			more staffing and better benefits
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			More competitive salaries,
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Happy employees = happy patients. Focus on raises that actually mean something and make them across the board don't pick and choose that causes angst among staff. Recognize nurses week, ems week etc. don't lump it all in on hospital week. When you have events don't staff it with staff. Truly cater it so everyone can enjoy themselves.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Giving everyone a raise
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Communication.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Wages. We need to be competitive with surrounding areas so we don't lose good employees and/or applicants due to pay,
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Pay, not all RN staff received a pay increase. It's frustrating to know someone else with your same title, fewer departments, and less seniority is making significantly more per hour than you are.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			More employees, better pay
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Communication efforts and making those accountable for their actions when they need to be. Not just saying, "Well that's just them." If being rude and disrespectful is ok, I guess we have that down. However, I feel strongly in being as kind to your co-workers as to your patients.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			When you say you are giving across the board raises, then you should give them to all and not just Nurses
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Giving raises and incentive to employees that go above and beyond. As well as raises to attract more people and better benefits. Update equipment to make things run smoothly
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Better benefits for part time employee
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Management and taking provider concerns more seriously when they are brought forward.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	
		Where should we focus to make this organization a better place to			Should pay permanent workers more so we want to stay and there will be less travelers.
May 2023 CoSE	05/01/2023	work?	Better Place	Ottumwa Regional	

May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	*Safe staffing levels *Clean work environment *Lunch breaks -Having other staff that have their own full load of patients in a dept take on unsafe load of someone else's patient in order to facilitate a break in acute setting is not a lunch break. Staff care about each other and their pts so need to forgo lunch because this is never a solution *Don't have students/preceptees/orientees w/ staff if not fully staffed -Preceptor can't teach/orient when have more than full patient load -A burnt out preceptor isn't beneficial to teaching, orienting or recruiting new staff *Follow-up with staff who address concerns so we know mgmt is dealing with these -This includes all variances &learning board issues *Have supplies we need to provide great care -Don't cut corners and say it's a supply chain issue when we can look up items online and see they're available but the hospital choses to order inferior, at times unsafe, products. E.g. 2-part needles that need tightening before use
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	better communication, proper supplies needed, proper pay, proper time off
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	return to a non profit organization
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better pay and opportunities to grow. Equality between nurses. Recognize a bachelors degree.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Adding educational offerings (CEUs).
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	unsure
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Continue to focus on the culture
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	like before mentioned- there has been alot of positive things that have been said... thats the easy part... and i think there needs to be continuous action to strive to make this a better place, which it will be extremely hard to dig out of this slump, but no matter how hard it is, the words 'i give up' cannot be used... this is a VERY delicate time, but this is a time of growing and going...
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Caring about the patient wants and needs who are coming here.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication, respect, retention, praise
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication, open conversations. Don't make it feel like there is a secret alterative motive. Help us to feel some appreciation for what we are trying to do for this community and ultimately your patients. It is really hard to look at a patient who is scared and convince them that ORHC will take amazing care of them, knowing that some people wont because they are tired and over worked and feel like no one cares any way because as long as that money is being made then it doesn't matter how much further we go for patient care.

May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Having a more positive moral instead of having a negative work environment
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	getting enough employees
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Retaining staff, not travelers. Keeping the same upper management.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better salary compensation, so we have more people applying , that way we are not short on staff.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Holding people accountable for their actions/ inactions.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	More competitive wages. More opportunity for continuing education. Bigger push for BSN prepared nurses, with pay increase for those that are.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Literally every department all the time needs to be accountable
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	More resources for continued patient care. Limited resources slow down and/or hinders what we can do for our patients.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Safety culture, removing fear of reporting mistakes, make the focus on process improvement and not individual punishment for lack of process and procedure.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better staffing
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Teamwork/comradery is lacking. There are several units/areas that need more upkeep. Wax the floors and better cleaning as an example.
May 2023 CoSE	05/01/2023	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication and consistency
May 2023 CoSE	05/01/2023	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	Rarely recognized unless its by patients or their families (which is quite frequent)
May 2023 CoSE	05/01/2023	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	I feel like our department and many others are out of sight, out of mind. We once had two nurses work in the storeroom for the day so that they didn't have to go home due to low census. They said they would never do that again as the work was too hard. One of my supervisors said to me once, "thank you for not being stupid" after I had to prove to them the issue that was raised was under control and not truly an issue. Every single day we make things happen that are almost near impossible, yet no one knows or acknowledges.
May 2023 CoSE	05/01/2023	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	I do not recall the last time I was given any sort of thanks for working to almost two FT lines that I cover regularly. We used to be thanked with Pizza parties, because that's the most that the organization would do. And now, we don't get that! Sometimes administration brings us donuts, and hands them out to us, like they are the rich feeding the poor, and trying to feel good about it.

					What praise?? What recognition? I've been here since 2006 and I make as much a medic who's been here for 2 years. My time and experience mean nothing.
May 2023 CoSE	05/01/2023	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	
					Not acknowledged
May 2023 CoSE	05/01/2023	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	
					I try to stay under the radar at this moment so I wouldn't expect any praise. I just do my job to the best of my ability and take care of my patients and make sure that they feel taken care of and safe. I don't try to get anyone to notice my work. I just want my patients to know that they are cared for.
May 2023 CoSE	05/01/2023	I feel satisfied with the recognition or praise I receive for my work.	Recognition	Ottumwa Regional	
					Short staffed. unskilled temp employess
May 2023 CoSE	05/01/2023	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	
					Coworkers do... managers do not
May 2023 CoSE	05/01/2023	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	
					Staff here on BHU do that , not management.
May 2023 CoSE	05/01/2023	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	
					In our department we try and advocate as best as we can but are usually over rid. Whether its what's best for the patient health or finance wise.
May 2023 CoSE	05/01/2023	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	
					Our unit is great about watching over each other
May 2023 CoSE	05/01/2023	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	
					Depends on the department, and whether administration is a part of the equation. Most staff to staff interactions when situations are explained are well received. When admin is involved, they care about the money.
May 2023 CoSE	05/01/2023	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	
					employees yes
May 2023 CoSE	05/01/2023	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	
					Our department takes care of each other and team up to give great care to our patients. I do not see that in other areas of the hospital
May 2023 CoSE	05/01/2023	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	
					Depends on where you are.
May 2023 CoSE	05/01/2023	We support each other in caring for patients safely here.	Teamwork - GPS	Ottumwa Regional	
					Everything in this organization is a quick fix mindset, NOTHING LONG TERM
May 2023 CoSE	05/01/2023	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	
					Thats exactly what we do. The organization is reactive instead of proactive and it is just enough to get by, not sustainable soluations.
May 2023 CoSE	05/01/2023	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	

May 2023 CoSE	05/01/2023	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	No one has ever followed through with recommendations for improvements or transitions that need improvement. It is a patient-dominated organization that needs further evaluation and a balance of expectations that are to be seen in the clinic, eg. paying copays, not allowing patients to monopolize resources, and demanding work excuses and treatments from providers.
May 2023 CoSE	05/01/2023	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	All we've been doing is quick fixes which is why now we are only focusing on the money aspect. No really problems have ben solved.
May 2023 CoSE	05/01/2023	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	As stated above..... JEANS DAY. This is a slap in the face to the individuals across the hospital that are clinical staff, running themselves into the ground, and actually feeling the strain. But hey, jeans, which they cannot wear! Supe exciting.
May 2023 CoSE	05/01/2023	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	No. We do knee-jerk reactions when something happens, then hope that it resolves on its own. Like staffing and pay...
May 2023 CoSE	05/01/2023	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	We try but often have to do quick fix and then have issues with follow up to sustainability
May 2023 CoSE	05/01/2023	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	We just keep adding paperwork and more rules instead of thinking through problems and coming up with new improved processes. We keep our old processes, and add new mandatory tasks to fix things.
May 2023 CoSE	05/01/2023	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	Feel we are just in time for a lot of things
May 2023 CoSE	05/01/2023	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	Again, offering pizza parties or prizes is nice occasionally, but stop sugar coating issues that need resolved indefinitely instead of quick fixes. Hold people accountable for their actions/inactions.
May 2023 CoSE	05/01/2023	At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'	Root Cause - GPS	Ottumwa Regional	Only when reported to governing bodies, not within the organization
May 2023 CoSE	05/01/2023	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	

May 2023 CoSE	05/01/2023	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	The only change has been a knee jerk reaction to one individuals very very poor choices.
May 2023 CoSE	05/01/2023	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	I agree. However, once a variance is entered, the person reporting is left hanging and isn't told the resolution. For example: Reported finding a medication vial in a hallway. Did the variance and then was never asked another question about it. My employee asked why she wasn't questioned or interviewed about it. She had no closure and stated to me, that what's the point of the variance if nothing is done about it. Again, I think this goes back to communication
May 2023 CoSE	05/01/2023	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	I would like to think so, but I really can't speak to this.
May 2023 CoSE	05/01/2023	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	Sure, the DEA has been here to make certain that things in that department change.
May 2023 CoSE	05/01/2023	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	Not to my knowledge
May 2023 CoSE	05/01/2023	Actions taken based on safety event reporting have led to positive changes here.	Change Willingness - GPS	Ottumwa Regional	still working on this as new leadership roles emerge...
May 2023 CoSE	05/01/2023	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	I do not believe that this will matter, I am not even sure that a real person will be reading this. I often wonder if these are "weeded out", after admin realize which departments answered the questions.
May 2023 CoSE	05/01/2023	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	I've spoke my issues in the past and never saw anything done about it
May 2023 CoSE	05/01/2023	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	LMAO... No...
May 2023 CoSE	05/01/2023	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	I would be surprised if anyone actually reads these responses or takes any measurable action to correct these complaints. Administration doesn't want to hear (or see) the things we have, but instead they want to "blow smoke" and try to get us to believe that everything is fine. Either they are truly blind and they don't see how bad it is, or they are lying to everyone and they know the ship is sinking but can't admit the truth. Question 17 (not enough room) *Listen to staff with repeated concerns about the behavior issues and pt safety issues regarding the same provider or staff member -We have lost many staff due to inaction regarding unsafe and repeated unprofessional situations -How much more bad press do we need before staff are heard? -Don't ask in exit interview why people leave that have repeatedly tried to fix problems -Don't ask people that are leaving to stay when repeatedly ignore their concerns
May 2023 CoSE	05/01/2023	I believe meaningful action will be taken as a result of this survey.	Action Taking	Ottumwa Regional	We have performed this survey every year for the past three years that I have been here. I have seen only decline in safety, communication, moral, and patient care. It makes me scared and sad for this community.

Glint Report for Lifepoint Health
Exported: 11 Sep 2024

Report Template Tit Comments
Filters:
Culture of Safety an Hospital Name Ottumwa Regional
Date: 25 Feb 2024
Responses: 282 of 342
Response Rate: 82%

Section Name Comments
Comments ALL

Survey Name	Pulse Date (mm/dd	Question	Question N	Team	Translated Answer in English
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	KNOWING THAT I HELP MAKE A DIFFERENCE EVERYDAY
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The staff I work with
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love my job and helping find out what is potentially wrong with our patients. The lab is the back bone of the hospital. I know that we impact our patient care and I take that very seriously. We love being a part of Life Points Mission of "Making Communities Healthier"!
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love my co workers here in Surgical Services
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	We have an administrative team that cares about this organization.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Being able to help people
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The staff I work with at my location
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Feeling of family and friendship.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I am honored to help those around me and I am appreciative that I work where people are making patients healthier.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers caring attitudes
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my coworkers
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love my co workers and how they make my job worth coming to. I have never found a job that my co workers become my family but the ones I've met here, have!
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the people I work with. I enjoy that my job is flexible with things I may hav going on in my personal/home life. There is always room to grow with support from my co-workers.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have some of the most amazing coworkers to work with. We work together. We are all here for the same reason: to help the community
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Comfort in working here for several years.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I have worked with.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The leadership and my coworkers. I feel this is the best, most invested senior leadership team we have had since I started working here years ago and it's motivating. Looking forward to the continued positive change.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I am from this area and proud we can service people who may not be able to drive far.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The patients I serve is the most rewarding. I love my main nurse she is awesome
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy the challenge of solving complex problems and collaboration with the people I work with.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The leadership in the O suite is amazing. They are always willing to help. My team here has been one of the best I have ever worked with.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The Patients
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My one up does a great job dealing with many issues but still able to be calm and still cares about everyone under her, she is the reason I have stayed here because I trust what she is trying to do.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I work in a small outreach clinic, I love the people I work with on a day to day basis.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Helping people and families connect with resources
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	i love the environment and the people here.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love making a difference and caring for people in my community. I also care about the people I work with. They keep me coming back each day.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Our patients, helping people. The flexibility with my hours. Great coworkers & weekends off.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	MY COWORKERS
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have been with ORHC for 27 years, I feel the admin team we have in place has made a big difference in the hospital setting I wish they would look in the clinic side
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the patient care.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	good leadership
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Ensuring the pts are scheduled for the services they need in a timely manner, to the best of my ability. The positive feedback from the pts. Knowing I am making a positive difference n the pts we serve with empathy and compassion, and understanding.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I am allowed to do my job without someone looking over my shoulder most of the time.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers and the teamwork to make ORHC an even better place to work.

February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel I have a great communications with the patients and I truly feel they would state the same about me. I have been told by serval patients I go above and beyond.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The best thing about working for ORHC is the opportunity to get experience in my field with the high amount of patient volume
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy helping the community.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy my co-workers, they are easy to work with and helpful
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I LOVE THE PEOPLE AT THE EDDYVILLE CLINIC. THEY ALL HAVE HELPED ME AND WE ALL WORK TOGEATHER TO GET THINGS DONE
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love working with my team at the Eddyville Clinic but I also believe there are many things that need fixed and not just put off to the side. Things tend to get put to the side and never get done
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my co worker
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love that I get to come to work and be surrounded by what has now become my second family. I feel so close to the people I work with and know that any call we go on, someone will have my back if I need it.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love being able to be an OB nurse full-time and care for my patients, but I do not love having to shift my attention to other floor patient's (ortho and med-surge overrides) instead of providing excellent care for laboring/postpartum/newborn/ill newborn/ pediatric patients. We don't have enough time on day to educate our patients and parents like we should be able to prior to sending them home with a new infant.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My team at Easy Care
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my co-workers
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My team and growth opportunities
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	There are opportunities to move into leadership roles within the organization.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My collogues & co-workers
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Friend ship with my coworkers. the patients
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Here recently the recognition has been vastly improved upon and it has made working here better than it used to feel.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people that I work with really make working for this organization better than most and it makes the long days worth it.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Now that I am in the Gastroenterology clinic, I feel more comfortable and valued as an employee.

February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My schedule
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	i feel i have the support to make the ORHC building more safer and look better to public
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the people I work with on a daily basis.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Having the opportunity to grow and learn.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with! Kind and most are here for the community and to improve patient health!
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My co-workers
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I ENJOY MEETING THE PATIENTS THAT COME THROUGH. ALSO WORKING WITH MY CO-WORKERS.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love my coworkers and taking care of patients and their families.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Our patients. Our team care about our patients. It isn't just clinical staff that care. Our CEO cares, our Plant Ops team, the housekeepers. They all look out for our patients and their needs.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The patients!! I also love the teams I work with!
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel like I make a difference with what I do. I always try to help others with a good perspective in what is going on.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love what I do and that I get to help those in need.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	How much people help each other throughout the work day.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Helping the community I live in
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy the people that I work with, and taking care of our community
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love that I have learned several modalities since being here. I love that I have been given more responsibility, which shows I am trusted to do a good job.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	On most days I feel like I work with family and friends that care about one another. It's a place I can come enjoy my time and not watch the clock tick by. It's a pleasure to work with a great department that has a team that works together, looks out for each other and have other staff from other departments that care for one another also. The job I have allows me to work independently. I am happy to serve the people in my community by living and working in this area.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Helping the patients and families
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy working with my co-workers.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers are my second family. If i need ANYTHING they are right there to help, whether it be work or personal life related.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers and bosses
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The friends I have made. The difference the organization attempts to make to improve the community and facility.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The staff I work with.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people that I work with and serving my community.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy working with my co workers and provider. My provider takes time out of his day to explain, teach, and advise us if we have questions or do not fully understanding something. I couldn't ask for a better office/provider to work with
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Consistent co-workers ED Director & ED interim director
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	People I work with
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the teams I work with. For the most part every department and ormics work well together.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have a great director that I work for, she works hard and jumps in when needed. She is trying hard to show us that we are valued and that we can be a good team. She is trying hard to make this a better place to work and change the downers of our department.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I trust the majority of my coworkers and providers to provide quality care
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Helping people and growing in my position to better do that
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The team work and support
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I work in a small department that has a great team. We all work well together and help out wherever needed.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	coworkers
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the staff in one day surgery. We have an amazing team.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My boss and coworkers
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my patients
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	i enjoy working with my patients
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	it's close to home and my immediate coworkers feel like family
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Taking care of our community
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The Paramedics and EMTs work through adverse conditions with old out dated and unsafe ambulances and do an outstanding job treating the citizens that call Ottumwa home and provide quality care.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Going home at the end of the day; feeling like I made a difference
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people and department I work in.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	flexibility of work schedule
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The team relationships, sense of group effort to get work done and great patient care. It takes the whole village.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have moved up in this organization and feel that if you have the drive that anything is possible.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Tiffany does a great job as a leader to communicate and help however she can. I think the lab does well with helping everyone however they can.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	my great coworker
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Semi retired, I work as needed, and am appreciated and respected when I do work
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I have received better pay. I try to choose shifts to work with people who have better attitudes and work ethic.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I really love the one-on-one patient care. I love getting to know our patients, and helping them heal.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love that I am learning so much. I am supported in the decisions I make and encouraged to grow my department.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Feeling like I belong and always have and opportunity to learn new things. You can express ideas and concerns.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers and schedule.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The satisfaction I feel in a job well done. Believing that I make a difference by coming to work. I greatly appreciate the health insurance offered to employees and their families.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	taking care of patients
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like that our hospital once had the opportunities to work in many different areas. That we had services that weren't available at critical access sites. It seems we are losing services due to staffing and we don't have a plan in place to turn that around.

February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My patients and their families being able to interact with them and hoping I make a difference in their lives.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	For the most part I love the people I work with. I love how as dysfunctional as we can feel at times that there is still a family atmosphere and we protect each other especially in the field.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	People I work with and the fact we take care of people in this community.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Positive attitudes.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Helping patients to have healthy lives.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Sense of belonging to an organization with a mission to make a difference.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers and the salad bar.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Teammates/Co-workers. I do like that we have done multiple family oriented events and hope for it to continue
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the people I work with in my department. We work well together as a department and genuinely care about one another and the work we do for our patients.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the people I work with.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love caring and educating my patients and their families.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Frankly - at this point the paycheck is the only thing I enjoy about working at ORHC.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I appreciate my coworkers and manager very much. I feel that my manager does her best to work with me so that i can have a good work life balance.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The patients and the staff that I work with
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	That I am serving my community that I live in. I think the new administration team we have is more invested in making connections in my community, where the previous administration was more stagnate in that area. Although we have lost many long time staff members, we have also retained some long time staff members and that is reassuring and provides some connection. I think at this time, we do have the best administration team that I have ever experienced here.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love my patients and other staff in my department, Everyone I work with are very good and take excellent care of our patients.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel useful
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My team and patients make it worthwhile.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The staff!
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Schedule
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	i love the actual job and helping the patients. im embarrassed when people of the community ask why i still would work here.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I enjoy the spontaneous potlucks and get togethers at work.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I still feel there is huge disconnect between corporate management and the real patient care that happens here. It still feels like corporate is only about making a dollar or saving a dollar, at the expense of our patient care and safety. This has turned our previously thriving regional health center into a shell of our former providership.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people in my direct unit
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the ability to take care of my patients as I feel they should be, with the ability to spend quality time during their visits while being efficient with time. We are able to connect with our patients on personable level, due to their being here for multiple visits. I like the fact that we are a small team u here and that we are able to work together as a team to make things run efficiently.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My patients and team
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	That I can get help patients and help my co-workers with anything they need.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	the people and the work I do
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like helping patients. I want the patient to leave a little bit happier than when they came in.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The kindness, thoughtfulness, the staff is here.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I used to love how valued and appreciated I was. That hasn't been the case in the past 1-2 years.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I do love the people on my team. I get along with every single one of my close coworkers and I do enjoy coming to work and being able to be around them, to work together with them towards our common goal of trying to improve the hospital. Sadly, that does not transfer out to the rest of the organization, it often feels like we are alone on a sinking ship, trying to keep it afloat. The people on my team all care, and we all work hard to do our best, help those around us, and try to improve, but once we leave our doors behind, it feels like an entirely different work place.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The few co-workers that have been with ORHC for several years.

February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Working with the crew I work with
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The department I work in. The individuals in the department are great to work with! They have become my second family
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people!! The new administration is very engaged, the most I have seen in almost 6 years of working here. It helps create a positive, comfortable work environment.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Our unit is very passionate about the care that we care that we provide for our patient's experience, which also makes it easy to love this career here!
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	co-workers
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love that I am able to stay in my community and help then.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with, family atmosphere we care about each other
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The pay is great
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	We are able to provide safe and compassionate care to the community.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	the learning environment
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love the nursing staff that I work with. Especially as a younger nurse I have always felt welcomed and that they were all extremely supportive and helpful when I need it.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Nothing
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Flexibility and teamwork
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My schedule is flexible with my ability to go back to school. My director is easy to bring issues to and I know that will be addressed in an appropriate way.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The patients
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The ability to learn and grow
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	like the people but need more employees. we are spred to thin to cover all areas
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I feel my patients deserve the experience and knowledge I have acquired
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My co-workers, my department.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	

February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Working with [redacted] under their good leadership
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	the new leadership
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people in the department are a great team that care about the patients they provide care to.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	On
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	.y team
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Our culture is changing for the better every day. It makes me proud to work here.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I am here for my patients and especially enjoy taking care of those who continue to come see me year after year.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love our Midwestern values of nice.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	My coworkers
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I like the interaction I get to have with patients, most of the time it is pleasant, but there are sometimes when it is not.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	I love working with the team of people I work with.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	the patients i take care of and some of my coworkers.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with, their kindness, friendliness and support of one another. I value their support. I believe we give very good care.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	The people I work with.
February 2024 CoSE	02/05/2024	What do you love most about working for your organization?	Love Most	Ottumwa Regional	Hiring staff instead of getting Travel personnel
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	THE ORANIZATION AS A WHOLE IS DOING GOOD AND ALREADY WORKING TOWARDS THE RIGHT DIRECTION.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	THIS DEPARTMENT NEEDS TO COMMUNICATE BETTER AND PEOPLE IN THIS DEPARTMENT NEED TO BE LESS CLICKY AND MORE TEAM PLAYERS. Communication
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better pay and benefits. I also feel like there is allot of talk about FET etc. I'm not for sure how they measure what it takes to get QC in range on some days, the daily, weekly and monthly maintenance that is required. The short staff of trying to run multiple departments but yet still be expected to stay on top of all other duties. There never seems to be enough hours in the day.

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Nursing
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	staffing
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	PAY! More PTO Clean the place up- the entire hospital and clinics are gross looking Bonuses for medical staff including clinic staff, retention bonuses for staff that have been with company over 2yrs Better internet and phones for outreach clinics Advertising for providers (include the clinics not on campus)
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communicate before reacting. I continually fight to stop people from making assumptions. Generations react differently from each other, and we need more generational understanding.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication and consistency
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Continue to provided resources and improve on equipment and vehicles.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better communication
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	staff retention. organization is focused on hiring. no incentive to stay as an employee.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better Benefits, listening to things we need to do our jobs to the best of our ability. Come and visit our departments and see how we are doing, and if we need anything.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	The equipment.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	better pay, less travelers
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Benefits - improved 401k match and increased fertility benefits. It is sad to work for a healthcare organization and have all of my friends have better fertility benefits than I have (they are not in healthcare.)
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Morale - continued team bonding events/activities. Focus on recruitment.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication for sure would be #1 on my list. Not waiting until the last minute when certain things have a deadline to let people know that those things need to be done then have an issue with certain people having overtime or getting sent home because of overtime when noone else can do the things that are expected to be done. BENEFITS
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better communication, feedback, rules that everyone follows and expectations.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Our nurse wages are not competitive with other nursing opportunities in the area. A clinic nurse should not make more than a floor nurse does here.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Get Providers, and regular staff.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Work from home options for salary and just flexibility to get the job done, more ways to pay staff by maybe helping with student loans and make sure we have a better understanding about raises. There is no rhyme or reason to them and it's beneficial to just move around every 2 years and then comeback for a significant raise.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Large sign on bonuses (10k+) are red flags of desperation and terrible working conditions. It's sending an unintentional message. It would be better to put a good portion of this money towards retention and then offer a moderate sign on bonus. This shows we value our current staff and we want you to work here too.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Actually care about the employees. Stop being fake!! Employees need a liveable wage!!
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Supervisors/directors need to tell their employees when the staff are doing something well and not just pointing out what they did wrong. We also need to make sure that directors/supervisors aren't picking favorites within the departments and leaving out other staff members.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	invest money into the right things
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Higher pay
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication between units
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	LIKE TO SEE MORE COMMITTEES GEARED TOWARDS NURSING WITH NURSING STAFF INVOLVEMENT IN MAKING DECISIONS THAT AFFECT OUR JOB - POLICY/PROCEDURES, ETC. EXAMPLE - UNIT BASED COUNCILS
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication. Better pay & Benefits. Enough staff.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Ottumwa Health Group clinics in general
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	A weekly newsletter keeping employees informed of what is going on throughout the organization. For instance, what is going on with laundry, are we going to outsource? etc. Stressing follow through from the departments that support the departments who perform direct patient care. Our department has experienced many issues that are left unresolved for very long periods of time during which time we make multiple reminder phone calls to get the issue addressed. Phone calls/email messages are often not returned and in general, better communication would be helpful.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Regular (quarterly) one on one rounding between management and staff - asking what is working well? where is there room/need for improvement? etc.

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Becoming an employer of choice. Culture/atmosphere, leadership, reputation, benefits, etc.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication and follow-through.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	communicate more effectively with the public
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Improve communication, realize that we are human and can/will make mistakes from time to time. Focus on acknowledging staff positively, for a job well done. Not just focusing on mistakes.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Wages, retirement plans, flexibility in scheduling, holding people accountable, improve the cleanliness and improve the appearance of the hospital (a little paint would go a long way).
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Upgrading equipment such as MRI Updating the clinics, example: flooring and furniture
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	The biggest area of focus should be updating the equipment we have to use for the patients. With such a high volume, equipment gets worn out. We need new rigs, cots, small equipment, and we need an upgrade to the ER for appearance issues
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	CARE ABOUT YOUR EMPLOYIES
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	personnel
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	equipment
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Employee retention
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I feel as though EMS wise needs a few more things to effectively do our job. We have been going in a great direction with the new managers and medical director and I am thankful for all they have done
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We should replace the floors in OB and upgrade the department to draw in the newest generation of patients having infants. If we do not change our department then we will continue to lose them to different closer facilities that have new tech savy labor and delivery suites.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Create a hospital wide recognition program, so patients, visitors and other employees can easily recognize employees that provide excellent service.

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	On the employees. Make sure there is adequate staffing and the tools to do their job. Replace equipment that is broken or at end of life.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	In a dream world, 1-2 more people to help administration, who have so much on their plates. Even if it was just temp help.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I feel like there is a major lapse in communication between teams sometimes and it feels like it hurts my department more than the others.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	unsure
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	#1: Get it cleaned. The physical building is filthy. The public areas are filthy. I am ashamed 2# Our hardware is failing. Replacement is crisis management. Situation existant prior to COVID-19 3# Use vendors that don't create more work with less efficacy. I'm not unrealistic in believing that contracting hospital services will go away. That said, contracting services in this institution has generally degraded quality. 4# We desperately need marketing staff. It's hard to believe that you are valued when you learn about the free Thanksgiving lunch at 10 am & the cafeteria opens at 11.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communicating with your employees. I feel as if the higher up the person the less they feel the need to listen to people that are actually working on the floor or that are a "lower" rank than them. We come across a lot of things that are no okay or that are unnecessary in the workplace and I feel that no matter how may times we raise concern or speak up about a situation whether it is about the safety of patients or concern for or about employees nothing gets done. I feel as if people are also scared to say anything because they feel as if it's going to be a waste of time because nothing ever gets done or because whoever you're reporting to makes you feel dumb or as your concern does not mean anything to them. I feel as if they are constantly putting employees at risk and in sticky situations that could easily be avoided if they were just to listen to the people actually working on the floor.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I feel that to make this organization a better place to work, would be to value all employees better. Pay increases would be a great way to get good employees to stay. I feel that offering sign on bonus' is difficult for current employees as they have been working through very difficult times and deserve to have a bonus as well. Improve the hiring process to get more permanent staffing.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	The administration in the lab needs to be changed.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication between departments, between teams.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	BETTER PAY FOR EVERYONE NOT A SELECT FEW, QUIT OUTSOURCEING JOBS, USE YOUR OUTRAGEOUS SIGN ON BONUS TO UP PAY SO YOUR NURSES AND SUPPORT STAFF WONT LEAVE
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	have all employees be accountable for there job duties
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	WE NEED TO FOCUS ON BETTER PATIENT CARE.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	To much traveling staff, we have staff that does not care about our hospital or our community. So many good people were lost with new policies, with no effort to keep them.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Continue to work on hiring nurses.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Try to get pay better so that people want to stay. To many travelers working. They take no pride in working here. They seem to do as little as possible. I don't like it when I go to them about something and your answer is, I don't know, I am a traveler.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	It would really great if we could get all the physicians on CPOE as well as physician accountability for the orders they put it. Sometimes there are no orders or conflicting orders. Sometimes the physicians tell the patients care that is different than what the orders say. Especially with cardiology.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Removal of long-time department heads and managers, replacing with new staff who is not stuck in "old ways."
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Our pay is on the low side compared to other neighboring hospital's
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication is a big thing, streamlining processes
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Increase pay so workers want to stay.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Sense of teamwork, making employees feel like a team not just a number
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay. We are constantly losing staff because they can go elsewhere and get more money for less work. We have been told for 1 year that we would get market adjustments and have yet to get them.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	1. I don't feel you give recognition to long-term employees. 2. Make it a fair place to work. I have been told all nurses were brought to the same wage scale. I found this is not true. A nurse with less years of experience makes more than a nurse with more. I saw her paystub she left out. 3. It feels like you don't want long term employees, but prefer prn staff and travelers. 4. I think it is ridiculous that the mail room is an area that won't allow some people access, It's just to drop off mail and use the copy machine! Lighten up!!
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	One thing that needs focused on is the cleanliness of the hospital being a cleaner place to work at from floors, windows, to patient's rooms, front entrance, ER/Admitting, 2nd floor and bathrooms looking clean and smelling nice. It would be nice to have a monthly newsletter that has information on of what is happening in the hospital from events we hold, to new staff, Director/Manger starting or transferred to other departments, etc. Have the main hospital website up to date with doctors, ARNP, NP and what we have to offer. Have recognition for staff that goes above and beyond, not just for nurses. One thing to work on is the retention of keeping good staff here by offering them better wages or hours, so they don't leave to go work somewhere else. The hospital needs to be promoted that it's a great place to work at, so staff feels like they can invite family and friends to work here with everyone.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Collaboration from ancillary services

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Need better communication between departments, and for us linen needs to be a priority.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	communication
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We need to work on getting more staff. I understand we don't have the best reputation but we have a cath lab, thats brand new that we don't get to use. We have an OR that again doesn't see the traffic we use to see. I do see med surg is keeping more patients but we use to have a fully functioning ICU. I do know were giving sign on bonuses but I feel theres more that can be done.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better compensation. Less negativity by team leaders.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Continue working on getting staff in, retention is key, continue working on the appearance. If we can get things looking better all departments which takes time people will want to work here and patients will choose. Continue to communicate and encourage Direcfors to communicate and keep staff abreast of our plans and focuses.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Bring on more staff, purchasing new ambulance so we can effective do our jobs.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We really need to get actual staff in all of our inpatient departments. We could be so much more successful with an ICU and Cath Lab.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better Communication. Be fully staffed. Everyone be on the same page.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Retaining consistent employees, whether permanent or temp contract Cleaner work environment Proactive vs reactive feedback from admin
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Get more help, better pay especially for the ones who are on call not just certain area's.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication works both ways but saying something and doing something else isn’t good communication. Managers need to be honest with us. If something can’t be done or changed, just tell us.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Making sure that we are being paid adequately for the jobs that we are doing That when there is a survey, that things are followed up on Instead of bringing us a snack, give us gift cards or bonuses
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	More staff to patient ratio ex. MS to provide better quality of cares for patients and their families. This would also allow for call lights to be answered in a timely manner. Staff would feel like they are providing better quality of care and able to do the job they signed on for.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Retention of staff, facility maintenance, facilty cleanliness and updating equipment.

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Continue to provide good communication; look for additional resources for pt care
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Work on recruiting, which we are
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	we really need to look at the insurance for our medicine we can only use mail order there awful to work with meds get lost or get delivered weeks later. It would be awesome to be able to use our local pharmacy's please help.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We need to hire and retain new hires in all departments. Our department has been short staffed for the past year.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	'-Number one of all is staffing and better wages. -Staff needs to feel like their license is not at risk working in our facility. -We also need to make sure the facility is always clean and we lack on that. -One day surgery is an amazing unit but the hospital lacks the promotion of it. There's still no open position posted online! -Surgery schedules need to be adjusted so staff gets off work on time. -Many have reported that the reason they left one day surgery is because of being on-call. Although we have it gone, the uncertainty of it coming back makes people hesitant on going full time.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Higher pay
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Investment in people and investment in facility
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	getting ful time help and not paying for temp people make sure the people that are here and have been for the organization feel appreciated
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication at all levels. Ownership and making sure all stakeholders are communicated to prior to change.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	N/A
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Effective communication from the top down to every staff member
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Management. It is not a pyramid the base does not make us stronger. It needs to start at the top. Poor management, specifically unit based, has led to poor work performance and poor staff retention
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	New equipment and more staff
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Providing new ambulances to the ORMICS crew that will be safer for staff and patients.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	communication, staffing
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Connections! Just a simple directory listing department extensions would be so helpful. There are people who have worked here for years and we don't know each other's first names. We used to have a weekly one page flier that was posted in all the units, break rooms and bathrooms; it noted general updates, unit changes, birthdays (unit and first name only), welcome to new employees and general accomplishments. (i.e. "Thanks to the facilities management crew for keeping the ice down in the parking lots!" or "Lots of good comments about the cafe menu! Thanks, [redacted]", "Thank you for your service to our veteran employees: [redacted] etc") This little, inexpensive gesture really made people feel connected.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Equal pay with surrounding communities and the equipment needed to do our job correctly.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Updating the facility's equipment and maintenance of rooms and hallways. A lot is worn out and not even able to be cleaned anymore.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Make it a more personable place to work. I have team members that feel it is more of a corporate run facility and it is but we need to find a way to make our employees feel valued and respected for what they do no matter how small or big their role here is.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Medical care for the patients
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I think this is talked about a lot, I try not to complain about it but pay. It definitely affects our staffing and attitude towards work as I have seen throughout my couple months. I know [redacted] has been working hard on it which is another thing I appreciate her for. I think ordering needs to be trained more, seems like a lot of orders are put in wrong or late and blamed on the lab.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Getting more core staff hired, and incentives to keep current core staff motivated to stay. Working to better consistently maintain safe staffing levels for each shift. One cna on med. surg. for OVER 10-12 patients (depending on acuity) is too much.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	hire more local staff that care about the community.stop keeping bad help (coming in late,lack of caring of phone usage,facetime,dont care about how many call offs they have)because they know they wont get fire and its hard for the good help that shows up and is ready for work daily
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Only hire high Quality staff.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Need better follow through when a concern is voiced.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	We have to continue to focus on updating equipment and moving into the 21st century. It would be great if we could offer better benefits and retirement. We are not comparable to other companies.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	COMMUNICATION. Also having a central scheduler to make employees schedule so there's no confusion on who is supposed to be where.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	competitive place to work

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staff retention/recognition as well as staff recruitment. Rewarding, incentivizing longevity. Ensuring the right employee "fit" for the most "fitting" position. (If not working out well in one dept., encouraging trying a different position within the organization)
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better pay, more competitive.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	don't put full time employees on stand by unless they want to...
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I believe first and foremost, have to come up with a means to staff this building. We,in my opinion are at a tipping point that has already started typing the wrong way. Hospitals are competing with each other and staffing agencies for nurses. There aren't enough to go around it seems. Hospitals have to lead the way and be part of the solution to increasing nursing numbers in training programs. Kids quite frankly don't expect to grind out a meager living for years until they are finally financially stable in their late 40's like generations before them. There are competing ways of making a good living from home, obvious a staff nurse can't. Our hospital has had staffing issues well before Covid and covid really just exposed the pre-existing issue. We want patients to think about prevention, while hospitals I feel still have reactionary plans. We have been paying contract help in nursing every since I started at ORHC. I have heard the whole time that things will change, it hasn't.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Listening to all employees. Everyone has a right to be heard. Follow up with them if they have questions and you don't know the answer. Follow up with them if they have a complaint / problem . Don't say I will look into that and not share a solution or resolution.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication. It had gotten better at first with the department meetings and such but I feel as if we are not communicating very well. Especially those that do not work the 8-5 hours. I also think that new hires need to be treated better or we are never going to catch up on staffing.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Collaboration between departments. Collaboration between leadership and employees to create and enforce new protocols.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Making sure we have the things we need to do our jobs efficiently.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication. Especially about raises.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Continuing to move in the right direction toward getting the community to believe that ORHC is a great place to work, and a safe place to seek care.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Respect and understanding from administration for frontline workers.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Care less about saving money focus on quality of organization.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Comparable wages Sign on bonus and referal bonuses that are in place are nice, maybe something more for people who have been here. I think I remember when I first started there was something for people who had no call offs but I don't think we do that anymore

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Besides offering huge sign on bonuses to new hires, offer a retention bonus to current employees. Other hospitals in this area have done this.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Capital requests granted
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	re=open the ICU. We manage ICU patients on the MedSurg floor, with nurses who are not ICU trained. This puts the patients and the nurses at risk. Nurses are often caring for patients with critical needs with 4-5 other patients. This is not SAFE.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	The main issue I have is with one department in particular and I don't feel that it's appropriate to call out a particular department in survey.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Safe staffing, listening to staffs concerns and actually take the time to understand their point of view and make changes accordingly. Stop with the mindset that a nurse is a nurse - so many nurses are trained to their specific area (which to become proficient and safe can take months or years) yet are being asked to take patients that are not appropriate based on training and experience. Accountability (for everyone- not just those chosen with excuses made for others), Consistency, Fairness.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I feel like more needs to be done to invest in the facilities, updated units but more importantly updated tools so that we can do our job the best that we can. I have head talk in the community about how people like to go to Pella or Osky because the facilities are better. I also feel as though there needs to be done for employee retention. The sign on bonuses are nice for new hires, however you have employees that have stuck by the organizations side through covid and everything else and they are getting paid pretty much the same as new hires. This makes it hard to stay especially when one can go to another hospital or clinic and get paid more. Housekeeping for a start. Overall, we are a dirty facility. It is hard to maintain pride when the facilities are not maintained. Communication is lacking. Processes are rolled out with little notification. There is poor delineation of management roles and who things should be directed to. Adequate staffing in all areas would be helpful but if that is not provided the staff doing 2 jobs should be compensated. Staff advocacy
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Updating equipment and the environment within the departments. If the hospital looked better perhaps we could attract more permanent staff and physicians. Having old equipment and even some of the materials in the environment such as wallpaper and carpet can hold germs and not be cleaned as easily. Old equipment can lead to work injuries for employees and patients. Better communication, communication about changes is very poor from upper management, My immediate supervisor is very good but leadership does not invest in this organization. Most are not from this area and do not want to take up residence and invest in our community. There positions are very temporary. We also are staffed primarily with traveler's whom have no vested interest in our organization. I have been here for many years and have seen many changes. This environment if very difficult to work, with little real commitment as I have devoted to this organization. This has to change in order for our community to trust us to care for them and there loved ones. Need a good surgical director
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Productivity is not a measure of success. It should hold little to no value in decision making. It is not accurately reflective of a department's needs and prohibits growth.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication. Addressing voiced concerns
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Up to date, properly working equipment. Cleanliness and holding people accountable for their work.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Increase pay and benefits to keep staff. It is frustrating to see new staff get such huge sign on bonuses but old staff can't get a cost of living raise. Maybe you should focus on keeping staff instead of trying to constantly find new staff to replace staff that has left ORHC.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	thats a management question
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	the drama
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	This organizational needs to expand Family Medicine opportunities in the organization by allowing Family Medicine with OB physicians to manage OB patients and deliver OB patients, including being able to offer IUDs and implants. This would be a win for the community and help reduce the number of patients going to Oskaloosa or Pella for consistent OB care and delivery. I think this would help with recruiting physicians and reduce our specialists care burden.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Hire quality directors. Hire quality staff. Reopen the closed departments. Update our facility to meet todays patient needs for our region.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	more follow up, every week there is somethingdiferent. I have no idea who half the administration is because it changes all the time.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Cleanliness of our facility seems to be of importance only when an executive is due for a visit.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I feel like not all the departments are recognized as being part of the hospital. I have had several of our patients coming to us for the first time saying they didn't even know we existed. I feel disconnected from the res of the hospital in a lot of ways because we are a small department and most of the focus is on the larger departments of the hospital.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Get it little bit cleaner on the units. Work orders that have been placed in computer need to be done a little bit faster. There are places that need fixed and the public see it not done every time they come to this unit.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	on the scheduling process and how it works or lack there of with each department, or modality within departments.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Listening to us more then acting on our patients complaints that we are telling you about. We are only trying to make us a better place that our patients have expressed dissatisfaction over.

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Take value in the quality of nurses you have and all staff. Find local leaders to step up in the organization so we can actually be Ottumwa Regional and not a bunch of people who do not have any ties to the community or care about the long standing of Ottumwa.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Pay and not outsourcing all of our jobs to different companies. So many of the employees who work here daily do not actually work for the hospital. They work for a different company that works for the hospital, and as such the standards we try to hold for our employees does not apply. Even though Ottumwa Regional has done alot to try to improve pay at this facility, a simple google search can show you how poorly they still compare to the surrounding community. The constant rotation of new staff/travelers makes it next to impossible to be working along side people whom are competant in their position here, and this along with the continuous low staffing has forced patient safety to be at risk.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Treat employees with respect and equality.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	communication
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Making sure we have equipment that works
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Employee retention
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Getting rid of negative people in different departments. Also, showing more appreciation for staff. Regular staff should be recognized and appreciated more, whether its a simple thank you or small gift. Just knowing that you appreciate what they do and how hard they work.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	increase staffing
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I think that we should focus more on our new grads coming out of college. Make this place look like a great place that it is to work.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication Meaning what you say. Not saying one thing and doing another. Getting us the things we need to be able to do our jobs to our satisfaction. Encouraging the team to focus on the positive aspects of their job and the team remembering that our patients are real people.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Bullying
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Focusing on growing the core staff, maintaining safe staff ratios among units to provide safe care for patients
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	improve communication with each other
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better patient to staff ratios
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Everywhere is obviously short staffed, but floating med-surg aids to different departments on nights makes our med pass extremely difficult to complete in a timely manner.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Making a teamwork together. Not having job silos (nurses,cnas).
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Newer equipment,
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Employee satifaction
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing, working equipment, positivity, collaboration, checking on employees, obtainable expectations, understanding, communication, more feedback.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	higher wage more employees
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I greater emphasis on staff motivation. There has been a general attitude focusing on negatives with minimal acknowledgement of positives.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Better wages
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication and trying to keep the people here that have been here for a long time.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Respectful communication for everyone. Increased hourly pay
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Clear expectations for certain roles
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication between supervisor and staff
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	BETTER PAY/WAGES THAT MATCH THE SURROUNDING AREAS
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Hiring full time nursing staff
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	I believe we need more management so our management team is not spread so thin. I also believe we need a full FTE in HR to handle the amount of things that need to be done.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	add an employee wellness room so we can do light exercises or stretching, provide adequate staffing especially during busier periods.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Communication between the Hospital and Corporate.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Education and workload/stress
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	The inclusion of the clinics is lacking. Our voices/concerns do not feel heard or acknowledged. The decision to hire clinic assistants off the street to "train on the job" when there is no medical background is dangerous and lends to the belief of "what we do in these clinics is not important to this organization." Hiring of certified personnel who can perform blood draws, injections and have basic medical terminology knowledge is greatly needed and should not be ignored in leu of a warm body.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Compensation and a sense of community.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Recruit community OBs
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	On making sure other parts of the hospital treat each other well.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Wage increase
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	having less travelers so that regular staff actually get their hours instead of standby. reward those who have stuck around through everything and continue to fight for this place. i feel so undervalued and underappreciated most days
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	giving more raises, bigger holiday bonuses and better 401k matching.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Continue to be open and supportive to staff.
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	Staffing
February 2024 CoSE	02/05/2024	Where should we focus to make this organization a better place to work?	Better Place	Ottumwa Regional	

Ottumwa Regional Health Center
Income Statement
YTD ending December 2022 - Actual
All Entities

	Ottumwa Regional Health Center Consolidated
Routine Revenue	23,891,920
Ip Ancillary	53,650,221
Op Ancillary	270,001,140
Other Oper Income	232,573
Gross revenues	347,775,854
Medicare Current Yr	71,447,624
Medicaid Current Yr	2,589,680
Champus Contractuals	4,454,095
Py Contractuals	(10,487)
Hmo/Ppo Disnts Inc Me/Ma Mgd	168,150,017
Charity Discounts	122,103
Other Deductions	11,268,931
Total deductions	258,021,962
Revenues before provision for doubtful accounts	89,753,891
Provision for doubtful accounts	9,090,682
Net Revenue	**80,663,209**
Salaries	34,631,652
Contract Labor	4,268,690
Employee Benefits	5,819,609
Supplies	13,414,945
Professional Fees	6,629,422
Contract Services	11,886,714
Repairs & Maintenance	3,743,804
Rents & Leases	576,510
Utilities	1,544,004
Insurance	1,020,740
Non Income Taxes	2,590,621
Other Oper Expense	1,112,776
Total operating expenses	87,239,488
EBITDA	**(6,576,279)**
Depreciation	4,804,022
Interest Expense	5,539,847
Management Fees	2,610,011
Total capital and other expenses	12,953,880
Income before income taxes	(19,530,159)
Provision for income taxes	-
Net income	(19,530,159)

Ottumwa Regional Health Center
Income Statement
YTD ending December 2021 - Actual
All Entities

	Ottumwa Regional Health Center Consolidated
Routine Revenue	27,693,887
Ip Ancillary	59,277,793
Op Ancillary	265,996,738
Other Oper Income	395,378
Gross revenues	353,363,796
Medicare Current Yr	77,462,220
Medicaid Current Yr	2,102,939
Champus Contractuals	4,460,966
Py Contractuals	20,037
Hmo/Ppo Disnts Inc Me/Ma Mgd	156,881,853
Charity Discounts	101,496
Other Deductions	13,426,135
Total deductions	254,455,646
Revenues before provision for doubtful accounts	98,908,150
Provision for doubtful accounts	9,236,212
Net Revenue	**89,671,938**
Salaries	33,094,578
Contract Labor	5,467,272
Employee Benefits	6,852,643
Supplies	14,265,529
Professional Fees	4,976,189
Contract Services	11,371,944
Repairs & Maintenance	3,339,768
Rents & Leases	609,909
Utilities	1,568,740
Insurance	1,313,343
Non Income Taxes	2,022,007
Other Oper Expense	1,052,111
Total operating expenses	85,934,033
EBITDA	**3,737,905**
Depreciation	4,973,793
Interest Expense	7,005,435
Management Fees	2,463,360
Total capital and other expenses	14,442,588
Income before income taxes	(10,704,683)
Provision for income taxes	-
Net income	(10,704,683)

November 25, 2024

DELIVERED VIA EMAIL

Ottumwa Regional Legacy Foundation, Inc.
935 Pennsylvania Avenue
Ottumwa, Iowa 52501
Attention: Chairman

Re: Amendment to Asset Purchase Agreement

Dear Ladies and Gentlemen:

Reference is made to that certain Asset Purchase Agreement, dated as of April 30, 2010, as amended (the "**Purchase Agreement**"), among Ottumwa Regional Legacy Foundation, Inc. (f/k/a Ottumwa Regional Health Center, Incorporated), an Iowa non-profit, non-stock corporation (the "**ORHC**"), Regional Retirement Living, Inc., an Iowa non-profit, non-stock corporation ("**RRL**"), Regional Enterprises, Inc., an Iowa corporation ("**RE**" and, collectively, with ORHC and RRL, the "**Sellers**"), RCHP-Ottumwa, LLC (f/k/a RCHP-Ottumwa, Inc.), a Delaware limited liability company ("**Buyer**"), and RegionalCare Hospital Partners, LLC (f/k/a RegionalCare Hospital Partners, Inc.), a Delaware limited liability company ("**RCHP**"). Subsequent to the closing of the transactions contemplated by the Purchase Agreement, RRL and RE both dissolved and distributed their respective assets to ORHC, as the sole shareholder and successor in interest to each of RRL and RE. Pursuant to Article X of the Purchase Agreement, the parties agreed to certain post-closing covenants in connection with the operation of the Hospital, and the parties now desire to enter this letter agreement (this "**Letter Agreement**") to amend certain provisions of Article X of the Purchase Agreement in accordance with the following:

1. Background.

   (a) The parties previously amended Section 10.7 of the Purchase Agreement pursuant to that certain letter agreement dated September 19, 2024 (the "**First Letter Amendment**").

   (b) Based on operational developments at the Hospital, the parties desire to further amend the Purchase Agreement in order to reflect certain agreements of the parties regarding the Capital Projects and other commitments set forth in Article X of the Purchase Agreement. Section 10.20 of the Purchase Agreement provides that any deadlines for the completion of the projects may be changed by mutual agreement.

2. Amendments and Acknowledgements.

   (a) Capital Projects. The current status of the Capital Projects and Infrastructure Projects pursuant to Section 10.6 are set forth on Attachment A. The parties acknowledge and agree that the current status and completion dates of each of the Capital Projects and Infrastructure Projects, as detailed on Attachment A, are acceptable and agree to the rationale for any projects not completed or completed after a completion deadline as set forth on Attachment A. Sellers hereby waive any requirement to complete such outstanding projects identified as "Not Completed" on Attachment A, provided, that Buyer agrees to continue to assess the need for such projects and will complete such projects at such times as required to maintain the Hospital in good working condition.

(b) Physician Recruitment and Development. The parties acknowledge that, pursuant to Section 10.8(a), during the first five (5) years following the Closing Date, Buyer was required to expend $7,500,000 in its efforts to recruit at least twenty-five (25) physicians to the Hospital, with an initial focus to recruit three (3) to five (5) family practice physicians. Buyer represents that it has recruited at least twenty-five (25) physicians to the Hospital with the initial focus on recruiting family practice physicians, and has expended $6 million in physician recruitment efforts and approximately $40 million in physician losses in connection with recruiting physicians to the Hospital. The parties agree that Buyer's expenditure of $40 million in physician losses together with the $6 million in physician recruitment efforts satisfies Buyer's recruitment commitment pursuant to Section 10.8(a) of the Purchase Agreement. Buyer further represents that it is currently working to recruit and will continue to use good faith efforts to recruit physicians to the Hospital, including but not limited to one (1) to two (2) general surgeons, one (1) obstetrician/gynecologist, and one (1) to two (2) primary care providers within the next three (3) to five (5) years.

(c) Residency and Hospitalist Programs. The parties acknowledge that, pursuant to Section 10.9 of the Purchase Agreement, Buyer has an obligation to work with Iowa training programs to establish a resident rotation program at the Hospital. Given the size, status of operations, and capabilities of the Hospital, the parties agree and acknowledge that the establishment of such residency rotation program at the Hospital is not feasible nor practicable at this time. As a result, the parties agree to waive the requirement to establish a resident rotation program at the Hospital pursuant to Section 10.9 of the Purchase Agreement.

(d) Outpatient Substance Abuse Program. Pursuant to Section 10.16(f) of the Purchase Agreement, the parties agreed that Buyer would establish and implement an outpatient substance abuse treatment program in Ottumwa, Iowa, affiliated with the Hospital. The parties acknowledge that such program has not yet been established given certain operational practicalities and the financial feasibility of establishing such program, and in substitution of the requirements of Section 10.16(f) the parties hereby agree to use good faith efforts to explore, support, and establish within two (2) years of the execution of this Letter Agreement a viable behavioral health service line for the treatment of adult behavioral health needs, substance use disorders, or other similar program as determined by the Hospital in consultation with ORHC based on community need.

3. Capitalization. Capitalized terms used but not otherwise defined herein shall have the meanings set forth in the Purchase Agreement.

4. Conflicts/Ratification. This Letter Agreement will constitute an amendment to the Purchase Agreement pursuant to Section 13.29 thereof with respect to the matters set forth herein. The balance of the terms of the Purchase Agreement shall remain in full force and effect.

5. Counterparts. This Letter Agreement may be executed in two (2) or more counterparts, each of which will be deemed to be an original copy of this Letter Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement. The exchange of copies of this Letter Agreement and of signature pages by facsimile or Portable Document Format (PDF) transmission shall constitute effective execution and delivery of this Letter Agreement as to the parties and may be used in lieu of any originals for all purposes.

[*Signature Page Follows.*]

IN WITNESS WHEREOF, the parties have caused this Letter Agreement to be executed as of the date first above written.

OTTUMWA REGIONAL LEGACY FOUNDATION, INC.

By: _____

Name: Kelly Gennerg

Title: President / CEO

RCHP-OTTUMWA, LLC

By: Signed by: Charlotte Lawrence B92A4AD58CE5427...

Name: Charlotte Lawrence

Title: Secretary

REGIONALCARE HOSPITAL PARTNERS, LLC

By: Signed by: Charlotte Lawrence B92A4AD58CE5427...

Name: Charlotte Lawrence

Title: Secretary

[Signature Page to Letter Agreement]

320664946.4

ATTACHMENT A

Capital Projects and Infrastructure Projects

Capital Projects			
	Project	**Completion Status**	**Rationale/Response**
Buyer shall undertake the following capital projects:			
1.	As soon after the Closing as is practicable, commence the design and construction of a permanent building to house a catheterization lab in accordance with the specifications described on Exhibit O-1, purchase equipment therefor and recruit a cardiologist (subject to Buyer's receipt of any required Certificate of Need approval which Buyer shall use reasonable commercial efforts to obtain expeditiously).	Completed	This project was timely completed.
2.	Immediately after the Closing, commence the process to build a new medical office building with a minimum of Fifteen Thousand (15,000) square feet ("MOB") in accordance with the specifications described on Exhibit O-1.	Completed	This project was timely completed.
3.	Complete a remodeling of Hospital's nursing unit and intensive care unit in accordance with the specifications described on Exhibit O-1 within one (1) year following the Closing Date.	Completed	This project was completed, but was completed in 2012 after the one-year deadline.
4.	Complete a remodeling of Hospital's emergency department in accordance with the specifications described on Exhibit O-1 within two (2) years following the Closing Date.	Completed	This project was timely completed.
5.	Commit to investment in the following projects: (i) $750,000 for purchase of the CLS Interests, (ii) $1,246,000 for the purchase of a PET scan (subject to Buyer's receipt of Certificate of Need approval, which Buyer shall use reasonable commercial efforts to expeditiously obtain), or, if Buyer is unable to obtain a required Certificate of Need approval for a PET scan, a CT scan, (iii) $2,000,000 for expansion of services and ownership in the cancer center, and (iv) $305,000 for the purchase of a lithotripter.	Completed	These projects were timely completed.
Infrastructure Projects			
	Project	**Completion Status**	**Rationale/Response**
1.	Due to the age of the chilled water plant equipment and its reliability it is proposed to replace three of the four oldest existing chillers with two larger new 500-ton chillers keeping the existing 350-ton chiller in service at an estimated	Completed	This project was completed, but was completed in 2018 after the five-year deadline because there was available life remaining in the prior equipment and replacing it before 2018 was premature.

	cost of $1,000,000. This work is required when any new construction is developed.		
2.	Replace portions of the oldest roof sections with a new membrane roof flashing of roof equipment and repair the exterior masonry walls where cracks are evident including recalking the exterior windows at an estimated cost of $512,000.	In Progress	Approximately 75% of the old roofs have been replaced. Buyer continually assesses the need for further roof replacements while also getting remaining useful life out of the remaining roof sections.
3.	Repair and replace as needed the parking areas at the front of the hospital at an estimated cost of $250,000.	Completed	This project was completed timely.
4.	Relocate the existing Step Down Unit from the second floor to the third floor and replace the existing 2 pipe fan coil units with a 4 pipe fan coil unit or an all air system at an estimated cost of $2,585,000.	Completed	The Ottumwa Regional Legacy Foundation Board of Directors consented to adding the new da Vinci Surgical Robot as an infrastructure project on September 21, 2011, with an investment amount of $1,474,350.34. The da Vinci Surgical System installation was completed and subsequently an additional investment in an advanced da Vinci Surgical System was made in 2023 in the amount of $1,126,724.75. Buyer spent a total of $2,601,075.09 towards the da Vinci capital investments. As a result of adjustments Buyer made in 2023 to accommodate step down patients on the Hospital's Med/Surg floor, relocating the stepdown unit is not necessary. The parties agree that the relocation of the stepdown unit is no longer required and that the da Vinci Surgical investments are substitutes for the relocation of the step down unit.
5.	Replace the existing chilled water air-handler-units that are over thirty years old as needed with new units over the next five years at an estimated cost of $500,000.	Completed	There are a total of 18 chilled water air handlers in the building. Three units were fully replaced in the years 2002, 2004, and 2023. The remaining units have undergone extensive upgrades, including transitioning from pneumatic to electronic controls, ensuring modern and efficient operation.

			Routine maintenance and upkeep are diligently performed, with coils regularly replaced to maintain optimal performance. Any issues are promptly addressed by HVAC professionals, ensuring the building consistently maintains appropriate and comfortable temperatures.
6.	Replace ground fault protection on five existing feeder breakers at the service entrance to provide two levels of ground fault protection at an estimated cost of $40,000.	Not Completed	The ground fault protection on the five existing feeder breakers has not been completed, as it has not posed a significant operational concern.
7.	Provide an electrical system study to determine the correct settings for the adjustable breakers on the normal and essential electrical system at an estimated cost of $50,000.	Completed	We conduct Arc Flash testing biannually, utilizing advanced infrared technology to proactively identify any hot spots in the electrical panels. Our on-site electricians are always present during these tests, ensuring that any identified issues are promptly and effectively resolved, maintaining the safety and reliability of our electrical systems.
8.	Replace the existing 208V electrical switchboard which is near the end of its service life at an estimated cost of $275,000.	Not Applicable	The Hospital does not have any 208V electrical switchboards to replace. Instead, Hospital has a total of 8 electrical panels. One of these electrical panels was replaced in 2014 at a cost of $163,478.46, but otherwise Buyer has not identified any needed replacements of electrical panels.
9.	Replace the existing electrical transfer switches and the essential system distribution panels and locate into new electrical rooms at an estimated cost of $300,000.	Completed	This project was completed timely.
Other Projects			
	Project	**Completion Status**	**Rationale/Response**
1.	Following the Closing Date, should any of the mechanical or electrical systems, equipment or elements identified on Exhibit O-3 be broken or in disrepair such that safe, reasonable operations	Ongoing	There have been updates to mechanical or electrical systems as needed. To Buyer's knowledge, everything is operating consistent

	of the Hospital are affected, Buyer agrees that it shall also fund such projects (in addition to, and not in lieu of, the Capital Projects described in Section 10.6 and the routine capital expenditures described in Section 10.7), provided further all such expenditures shall be credited against the Note (to the extent it remains outstanding).		with current codes that regulate these systems. Nothing currently represents a safety issue.
2.	Buyer agrees to: (i) build, subject to any required Certificate of Need approval, a second catheterization lab equal to the quality and size of the first catheterization lab if patient volume and usage of the first lab makes it necessary to provide a larger service capability; and (ii) expand the MOB to up to Thirty Five Thousand (35,000) square feet if there is sufficient demand for such an expansion.	Completed	Buyer has built a new catheterization lab that is equal to the quality and size of the first catheterization lab, which opened in August 2023. There is no need for an MOB expansion at this time.

Ottumwa Regional

State of the Hospital Update

December 2024

Reflections: Thank You

- Our hospital has weathered challenges and changes, and our team is deeply grateful for the support we continue to have from our community

- Our employees take great pride in providing excellent healthcare to our friends and neighbors – we have a strong, caring team

- We are committed to being a true partner and to enhancing and expanding the services our community needs the most

Our Guiding Principles

Our Mission

Making communities healthier®

Our Vision

We want to create places where:

- People choose to come for healthcare
- Physicians and providers want to practice
- Employees want to work

Our Core Values

Champion patient care

Do the right thing

Embrace individuality

Act with kindness

Make a difference together

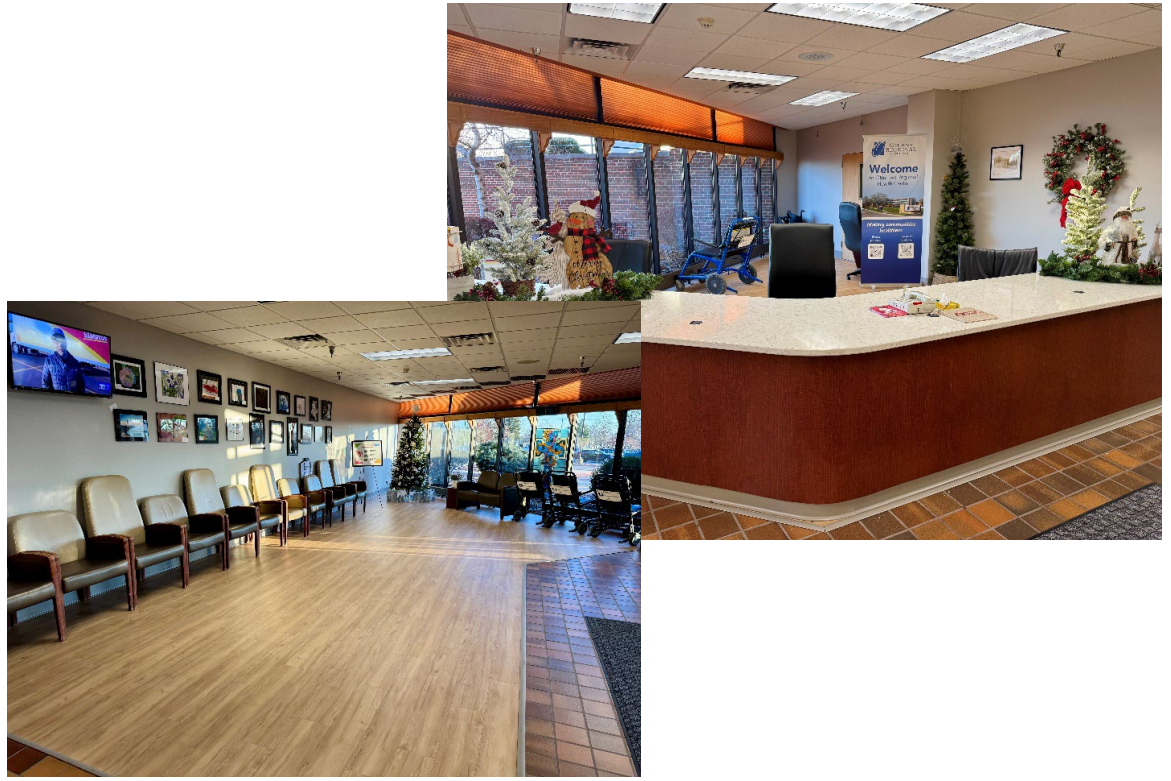
Ottumwa Regional

Ottumwa Regional

Operational Updates

Enhancing Our Campus

- Renovated our reception area
- Patient room enhancements
- More to come in 2025



ORHC by the Numbers in 2024

404 team members (+ contract labor)

15 employed physicians

52,763 outpatient visits

11,434 ER visits

8,656 patient days

1,807 inpatient admissions

589 cath lab procedures

211 babies born

**As of October 2024*

Ottumwa Regional

Welcome New Leaders

Scott Avery
Executive Consultant

Gary Thompson
Director, Plant Operations

Ronda Crump
Director, Pharmacy

Issues Update: SBC Report

- Appreciate Senator Grassley's commitment to the health of people throughout our region
- Provided extensive data and information in response to questions from Senator Grassley's office
- Expect a report from the Senate Budget Committee; will continue to share updates with the community as we have them
- Look forward to a continued partnership with Senator Grassley and all of our state and local leaders

Issues Update: Ownership

- Being a part of a system protects us from many of the challenges facing rural hospitals
  - Nearly 200 rural hospitals have closed in the past 20 years (30% at risk of closure in Iowa)
  - No service line closures at ORHC, committed to expanding services
  - Only 38% of Iowa hospitals (including ORHC) offer OB services
  - Only 24% of Iowa hospitals (including ORHC) offer BH services

- Our tax status allows us to invest back into our hospital community
  - Invested more than $20 million in our hospital and in expanding services (2019-2023)
  - Provided nearly $50 million in charity care (2019-2023)
  - Paid more than $27 million in taxes (2019-2023)

Ottumwa Regional

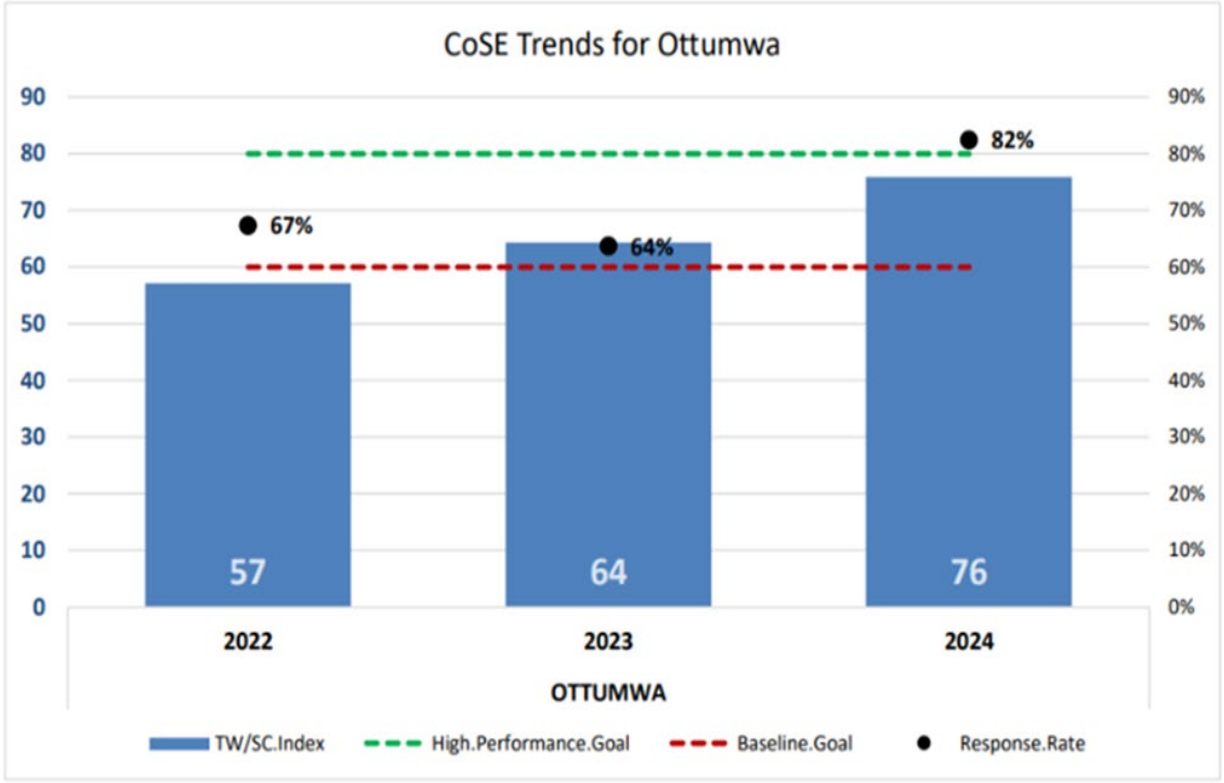
Ottumwa Regional

Investing in Our Team

Our Focus Areas

- Building culture and strengthening employee engagement
- Retaining and recruiting excellent team members and skilled providers
- Reviewing market data and investing in employee compensation increases for identified roles

Culture of Safety and Engagement Employee Survey



Building Employee Culture

- New employee communications tools
- Encouraging community event participation
- Employee and service awards
- Fun activities and events
- Employee engagement committee

Culture & Community Building

Recruitment

- **New Providers & Staff**
  - Dr. Alan Billsby – General surgery (12/24)
  - Dr. Nedal Alkhatib – Orthopedics (2/25)
  - Dr. Jessica Zaret – OB/GYN (1/25)
  - Abigail Storto – Certified Nurse Midwife (12/24)
  - Scotlan Peterson – Certified Nurse Midwife (7/24)

- **Open Provider Recruits**
  - OB/GYN
  - General surgery
  - Nurse practitioners (primary walk-in care)

Investing in Our Team

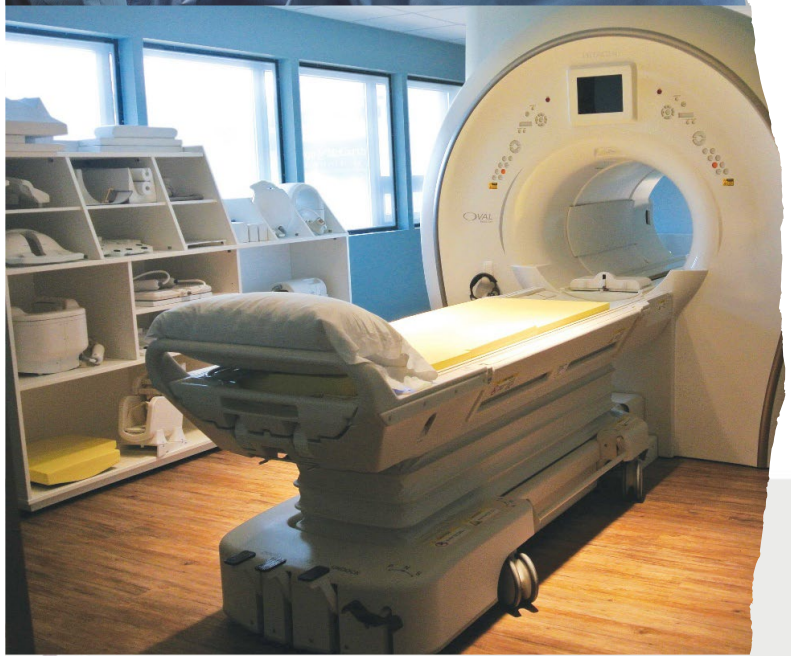
- Committed to being an attractive place to work and reducing contract labor
- Nearly $800,000 in compensation increases in 2024
- Continuing to evaluate other positions and needs in 2025

Ottumwa Regional

Advancing Quality & Services

Strengthening Our Quality

- 13 quarters with no catheter associated urinary tract infections (CAUTI)
- 10 quarters with no central line associated blood stream infections (CLABSI)
- 7 quarters with no hospital acquired MRSA infections
- 0 NHSN harms 2024 to date (National Healthcare Safety Network)
- Overall c-section rate: consistently below goal of <33% (2023 and 2024)



Investing in Services & Equipment

- Provide 911 EMS services to Ottumwa and Wapello County
- New exam tables, EKG machine replacements, nerve stimulator, AED and more
- Aquablation: the first robot in Iowa to support men with prostate issues
- A second Da Vinci robot
- New cardiac cath lab in 2024
- New MRI coming in late 2025

Ottumwa Regional

October 2024 YTD Capital

Project	Approved Amount
MRI	2,591,003
Aquablation	501,450
Ambulance Cots	177,127
Generator	150,068
Medical Vacuum System	128,342
BHU Nursing Station Enclosure and Room Renovation	117,891
Various Purchases(nerve stimulator, AED, exam table, code zero button,etc)	103,437
ScottCare System and Interface	48,655
Bladder Scanner and Carts	46,744
Fire Pump	42,035
EKG Machine Replacements	32,797
Temporary Pacemakers	20,119
Futrex- Body Composition Analyzers	18,094
Engine Replacement-Ambulance	14,277
Floor Machines	14,036
	4,006,075

Ottumwa Regional

Investing in Our Community

2023 Community Benefit Report

- Added 78 employed and independent providers
- Made more than $5 million in capital improvements
- Distributed a payroll of $42 million to 400+ employees
- Donated more than $10 million in services to those in need
- Paid $6.5 million in taxes

Enhancing Services for Our Community

Breast Cancer inspections are down 10% in Wapello County

October 2, 2024

20 People at Ottumwa Regional Hospital celebrated their fight against the leading cause of death in America

October 18, 2024

Ottumwa Regional Health Center to Celebrate Grand Opening of New $4.6 million Cardiac Catheterization Lab

July 26, 2023

Ottumwa Regional is the only Hospital in Iowa offering a new solution to BPH or Benign Prostatic Hyperplasia

October 17, 2024

Ottumwa Regional Health Center hosts fourth annual Breast Cancer Awareness Walk

October 14, 2024

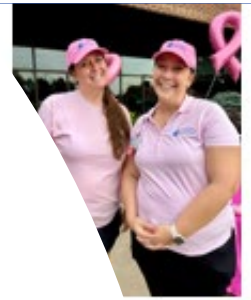
Ottumwa Regional has added a Midwife program to increase availability of OB-GYN care

November 4, 2024

Ottumwa Regional In the Community

Community Outreach

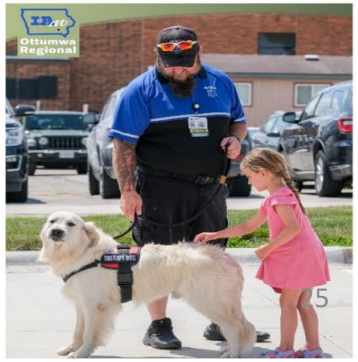
- Oktoberfest Parade
- Eddyville Homecoming Parade
- Hot Dog Day
- Alzheimer's Walk
- Shop With A Cop Basket Auction
- Family Fun Fest Exhibitor
- RAGBRAI Medical Crew Volunteers
- Breast Cancer Walk
- Blood Drives
- Annual Be The Glow Walk









Thank You for Your Support

"Ottumwa Regional Health Center and its team of caregivers provide essential care to the community and surrounding region. At a time when many rural hospitals face an uncertain future, it's great to see ORHC investing in its team members and working to expand access to maternity and behavioral health services. The Iowa Hospital Association appreciates ORHC's contribution to our state's healthcare landscape and we look forward to the hospital's future success." – ***Chris Mitchell, President and CEO, Iowa Hospital Association***

Ottumwa Regional

Thank You

We take great pride in caring for our friends and neighbors.

We are committed to being a strong community partner and to meeting our community's healthcare needs as we move forward together.

Year	Month	ED Visits	Admit %	OBS %
	Goal:		na	na
2024	**September**	1,181	7.0%	3.5%
2024	**October**	1,208	9.9%	3.3%
2024	**Nov**	1,208	10.1%	3.8%

Transfer %	% Left AMA	% LWOT	Arrival to MSE
na	1.0%	1.0%	14.0
4.1%	4.2%	4.7%	30.1
5.0%	2.2%	2.8%	24.1
8.3%	3.0%	3.4%	27.5

LOS- Overall	LOS- Discharge	LOS-Admit	% EMS Arrivals
127.0	112.0	184.0	na
311.8	281.0	610.6	16.9%
252.6	227.4	476.8	23.5%
305.0	248.0	542.0	24..8%

Ottumwa Action Plan

Last updated: 12.5.24

Service Line	Improvement Focus	Observation	Solution	Notes	Owner(s)	Start Date	Due Date	Completed Date	Status	Updates:
Emergency Dept	Case Management	Providers are not utilizing Case Management to their full potential for their Obs vs. Inpatient decisions	Review Interqual criteria with the providers and set expectations regarding when/how to contact Case Management. We will schedule a ZOOM meeting with Case Management prior to our 10/9 on site meeting.	[redacted]	Team	9.20.24	Ongoing	10.9.24	Completed	Feedback was positive from [redacted] team regarding usage of Case Management resources and Obs/Inpatient status. We will continue encouraging the team to use these resources, and [redacted] will reach out to [redacted] with any future issues
Emergency Dept	Documentation	There is no consistency in the order sets used or the way that providers document core measure issues (sepsis, trauma, etc.)	Review order sets with our TeamHealth Documentation Specialists, and provide training/feedback to the providers	Our internal meeting has been scheduled for 10.29	[redacted] TeamHealth Documentation Team	9.20.24	Ongoing	11.6.24	Completed	10.18: Our internal group is pulling records to review any trends or specific educational topics for the physicians, before making changes to order sets. 10.25-The internal meeting has been scheduled for 10.29. 11.7- [redacted] is adding a Provider in Triage note and working with our internal team to make additional verbiage changes after the chart review by both parties.
Emergency Dept	Documentation	Restraint documentation is not consistent among providers	Review order sets with our TeamHealth Documentation Specialists, and provide training/feedback to the providers	Our internal meeting has been scheduled for 10.29	[redacted] TeamHealth Documentation Team	9.20.24	Ongoing	11.6.24	Completed	10.18: Our internal group is pulling records to review any trends or specific educational topics for the physicians, before making changes to order sets. 10.25-The internal meeting has been scheduled for 10.29. 11.7- [redacted] is working with our internal team to make additional verbiage changes after the chart review by both parties.
Emergency Dept	Metrics	There is a potential issue with the EMR double counting LWOTs/AMAs	Review EMR issue with [redacted]	[redacted] met with [redacted] on 9.5.24 and the issue is currently being fixed at the HSC level	[redacted]	9.4.24	Ongoing	Ongoing	Completed	[redacted] is working on determining the root cause of this data issue
Emergency Dept	Metrics	Patients are not receiving full discharge instructions	We will send the facility a discharge review resource that would be driven by the nursing department	[redacted] have already discussed this strategy, and we will put [redacted] into these conversations.	[redacted]	9.20.24	Ongoing	Discharge document sent 9.20.24; ongoing education	Completed	10.25: We will obtain an update from the provider group during our meeting on 10.29. 11.7- We will discuss how this process is continuing to work in our 11.13 ED meeting
Emergency Dept	Metrics	Sepsis fallouts are a big miss	Mandy will provide TeamHealth with monthly core measure data to include in the Physician Scorecards, and to be discussed in the monthly ED Operations meeting	We will work with [redacted] to obtain core measure data; Meeting scheduled for 10.7.24 @ 1130 CST via ZOOM	[redacted]	9.20.24	Ongoing		In process	[redacted] is working on giving TeamHealth access to the secure documents in the share drive; 10/18/24-still pending access to these documents. 11.13- We will begin reviewing these as a team via a Sepsis Workforce group, similar to the Chest Pain Work Group. [redacted]ves are TBD from the facility.
Emergency Dept	Metrics	Increased LWOTs	Discuss implementation of a PIT process for the APCs on shift each day	We will discuss this with [redacted] during our rounding call this month.	[redacted]	9.30.24	Ongoing		In process	[redacted] has been able to staff a dedicated Triage RN, and the providers are discharging patients from Triage as the census allows. We will continue to discuss the APC PIT process with the staff. 10.25-TH will have an internal meeting discussing next steps on 10.25. We will present our Triage process plan with [redacted] for additional input. 11.7- We have mapped out a PIT plan that we will discuss with the APCs on 11.8 and then bring forward to the Administration/Provider groups for additional feedback. 11.13- Awaiting completion of the PIT note to be placed into the EMR. 12.5- Following up with [redacted] on anticipated completion date
Emergency Dept	Metrics	Low Press Ganey Scores	APEX education	We will share monthly APEX "bite sized" education with all departments, and provide in person training once we have a core group of providers in place	[redacted]	9.20.24	Monthly		Ongoing	10.18- October education will be sent to the facility by 10.21.24 (COMPLETED) 11.15-Next education will go out the week of the 18th. 12.5- Education will be sent out next week due to the holidays.
Emergency Dept	Radiology	MRI usage is stated to be abnormally high	Obtain Radiology reports and schedule a ZOOM meeting with Radiology prior to our on site 10/9 meeting.	We will work with [redacted] on obtaining specific reports/numbers. We have a meeting scheduled on 10.9.24 @ 1030 CST.	[redacted]	9.20.24	Ongoing		In process	10.9 [redacted] is gathering MRI data for us to review. CT/Plain film orders are within normal volumes, with the exception of increase contrast usage. Once the data is available, we will review for next steps. 11.15-Will round back with [redacted] on expected date. 12.5- Still awaiting data for review
Emergency Dept	Staffing	Quarterly staff meetings need to be conducted	Begin quarterly ZOOM staff meetings (MD/APC) beginning in October	Team metrics will be reviewed, Press Ganey scores/goals, facility news, Quality Goals, etc. Each individual provider will have their own scorecard for review as well.	[redacted]	9.30.24	10.31.24	October Provider meeting scheduled for 10.29.24	Ongoing	10.25-Provider meeting scheduled via ZOOM for 10.29 [redacted] will be providing nursing information for the agenda as well. 12.5-The next provider meeting is in the process of being scheduled; awaiting best dates for scheduling.
Emergency Dept	Staffing	There is a concern that our APC shift times do not cover our patient volume by hour needs	We will run a Cognition report to review the ideal staffing model times based off of the current patient volumes	The current APC staffing model is 10-10 (M-F). There is feedback that it feels like the staffing times need to be pushed back to 12-12. After running the Cognition report, the APC staffing is scheduled appropriately; we can review at our Goals Progress meeting on 10.9.24	[redacted] Performance Improvement Team	9.20.24	9.24.24	9.24.24; we will discuss further during our 10.9 Goals Progress meeting	Completed	10.9- There is still facility concern that the APC shifts should be pushed back, as this is when a large number of LWOTs are taking place. We will discuss pushing the shift back to 11-11 with the APC group.
Emergency Dept	Staffing	There is no consistency in shift report from Day to Night Shift team	We will educate the providers and supply a shift report template if needed	We have a one on one meeting scheduled with [redacted] on 9.30.24, in which we will add this topic to our agenda.	[redacted]	9.30.24	Ongoing		Ongoing	10.18- This topic will also be on our staff meeting agenda. 11.13-Obtaining update on how the shift report is going from the FMD
Emergency Dept	Staffing	FMD Opening	Pro-actively recruit	[redacted] will be attending ACEP in October	[redacted]	9.20.24	Ongoing		In process	10.25-No current updates. 12.5- Recruiting is screening a potential candidate that was looking for leadership positions within our group.
Emergency Dept	Staffing	Core provider openings	Pro-actively recruit	TeamHealth will meet with our Recruiting team to develop the best strategy for the area. A new Locum search has been opened pro-actively, until core providers are onboarded.	[redacted]	9.20.24	Ongoing		In process	[redacted] has confirmed that he will still be joining the provider team FT; we are following up on his pending Credentialing items so that we can provide a new EPD 11.13- [redacted] is still pending licensure, so we are treating this position as open. 12.5- We are reviewing (2) other potential Locum providers for staffing needs.
Emergency Dept	Staffing	Provider Concerns	Removal of Dr. [redacted] (Locum)	The facility has requested that Dr. [redacted] be removed from the schedule due to a numerous amount of issues	[redacted]	9.13.24	10.1.24	9.13.24	Completed	Feedback was given to TeamHealth Locum Leadership and his Locum agency.
Emergency Dept	Team Collaboration	There is no collaboration between EM/HM physician leaders	Conduct monthly EM/HM Leadership meetings	These meetings will include EM FMD/HM FMD [redacted]	[redacted]	We will discuss on 9.30.24 during our rounding call with Dr. Murdock	Ongoing		In process	10.18- We discussed opportunities for this collaboration during our 10.9 on site meeting; date TBD

Emergency Dept	Education	Obstetrics Education needed for the facility	An on site obstetrics simulation training has been scheduled for 11.4.24 & 11.5.24	The dates/times were provided by [redacted] to encourage our providers to join in person. Online materials have been requested for those that are unable to attend in person.	[redacted]	We will discuss on 9.30.24 during our rounding call with [redacted]	Ongoing	11.5.24	Completed	10.9- We will encourage in person training but understand the travel restrictions that most of our providers would encounter. A online education option will be available through Healthstream. 10.18- This will also be a topic of discussion during our team meeting
Emergency Dept	Metrics	HEART score utilization is needed for Chest Pain Workgroup	Obtain individual HEART scores and provide education	Next Chest Pain Workgroup meeting is scheduled for 10.10.24	[redacted]	9.27.24	Ongoing	10.10.24	Completed	10.10- Individual provider HEART scores were shared with the Chest Pain Workgroup for reference; we are also removing the TIMI score from documentation templates and placing HEART score information on the providers computers as a reminder.
Emergency Dept	Metrics	Individual Provider Scorecards	Create individual provider metrics scorecards to share with each clinician as an educational tool for improving throughput		[redacted]	10.24.25	Ongoing	11.6.24	Completed	10.25- Provider scorecards are being created to share with the providers after our staff meeting next week; these will be updated monthly. 11.7- We will send the scorecards out to each individual providers for their review. The scorecards have been back dated to the beginning of the year. We will update them monthly.
Emergency Dept	CMS Action Plan	Action Plan submission to CMS for EMTALA	[redacted] will review 10 charts per week for 16 weeks; weekly updates will be provided by the Quality group	[redacted] sent a list of completed EMTALA training for the providers on 11.4.24.	[redacted]	11.4.24	Ongoing		In process	11.4 [redacted] will send out the accepted CMS Action Plan to the group for awareness and to determine a start date, and provide [redacted] emote access in case he is needed for chart reviews. 11.14 [redacted] was sent the paperwork to complete for remote access; no start date for chart review information has been shared by the facility at this time. 12.5- [redacted] is completing (10) chart reviews a week per the CMS Action Plan. He does not have internet access when he is not on site, so alternatives will be made for chart reviews if he is unable to complete them onsite. [redacted] is still

Strategic Plan 2025

Ottumwa Regional Health Center

August 12, 2024

Lifepoint Health

Facility Profile

YTD June 2024

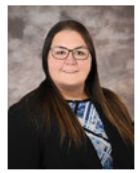
Key Statistics	Current Year	Budget	Performance Current Year vs. Budget	Prior Year	Performance Current Year vs. Prior Year	Main Driver Comments
Admissions	1,017	1,019	-0.20%	915	11.15%	Misses to budget are OB (35), ICU (24), ARU (15) Compared to PY- declines are ICU (24), OB (17), and ARU (13). Growth is in Med Surg (99) and BHU (59)
IP Surgeries Excl	92	119	-22.69%	151	-39.07%	Lack of on-cal staff, (-) ortho provider,
OP Surgeries Excl	799	875	-8.69%	1,275	-37.33%	(-) ortho provider, G.S. winding down practice
OP Endo	810	815	-0.61%	814	-0.49%	
OP Visits	20,358	22,192	-8.26%	21,716	-6.25%	Referring MRI out of mrkt, sleep lab down, lab equip. down – micro
Obs Visits	466	365	27.67%	363	28.37%	
Deliveries	124	166	-25.30%	145	-14.48%	Loss of FT OB, Locums coverage
ER Visits	6,834	7,247	-5.70%	6,898	-0.93%	
ER Admit Rate	9.0%	-	-	7.7%	18.14%	Woo Hoo!!
Avg Daily Census	28	29	-5.97%	26	4.80%	YES!!

Financial Metric	Current Year	Budget	Performance Current Year vs. Budget	Prior Year	Performance Current Year vs. Prior Year	Main Driver Comments
Net Revenue	$40.9	$43.8	-6.59%	$36.9	10.80%	Variance to budget is volume driven. June 24 YTD DPP payments are $6.7mil
OpEx	$45.2	$45.9	-1.45%	$43.4	4.19%	No major key driver to budget other than low volume. Drivers to PY is pro fees, insurance (DPP), and CL. Offsets in SWB, and CS.
EBITDA[1]	($4.3)	($2.1)	-105.03%	($6.5)	33.37%	Budget drivers are volumes and DPP is driver to PY
EBITDA Margin[1]	-10.6%	-4.8%	119.49%	-17.6%	39.86%	DPP!

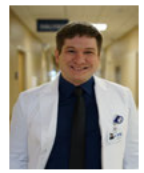
1 References Hospital/Internal EBITDA and EBITDA margin only

Site Executive Team

William Kiefer - CEO
Years of Service: 1.8
Industry Experience: 15



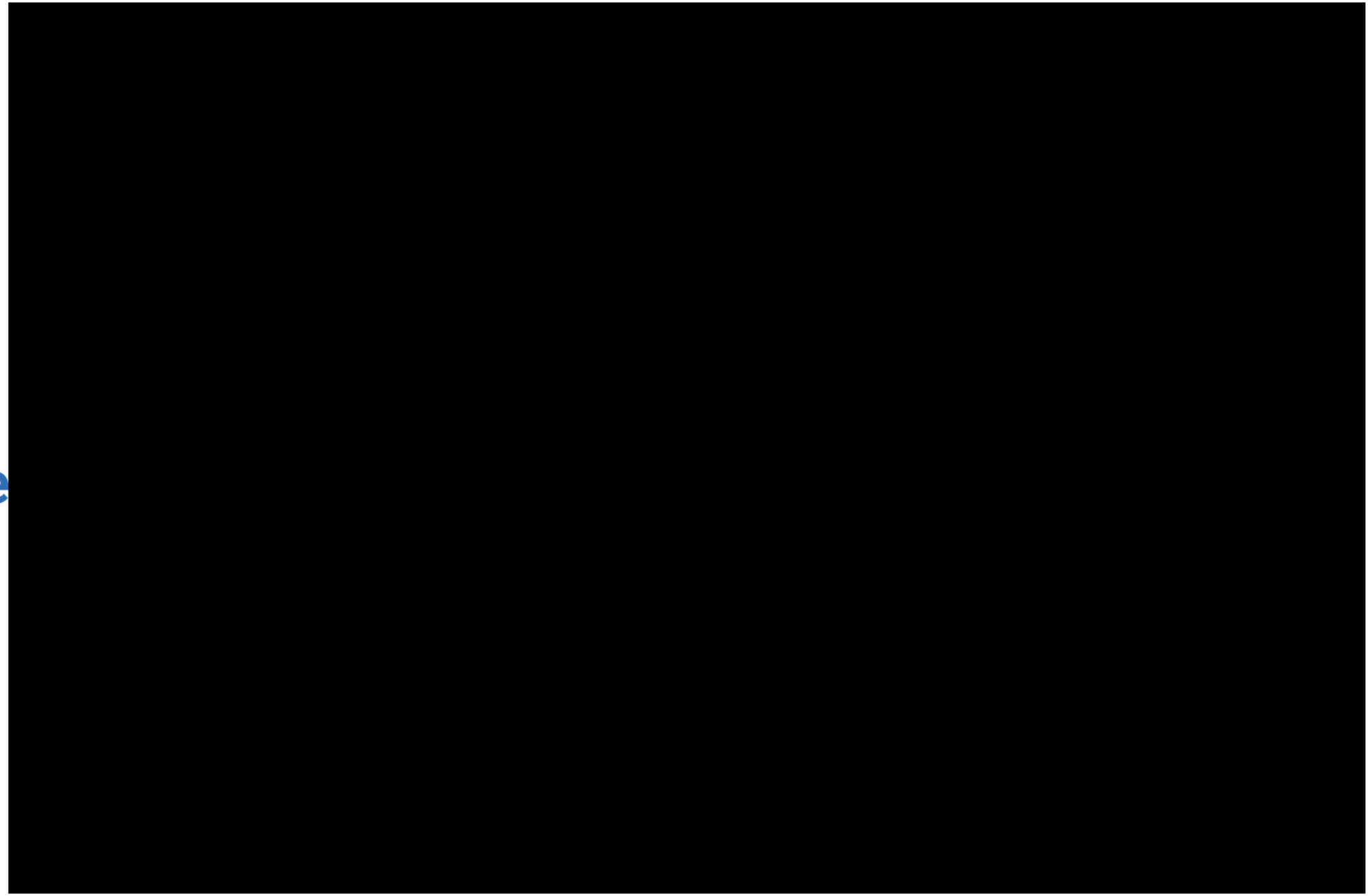
Kristy Lee - CFO
Years of Service: 6
Industry Experience: 15



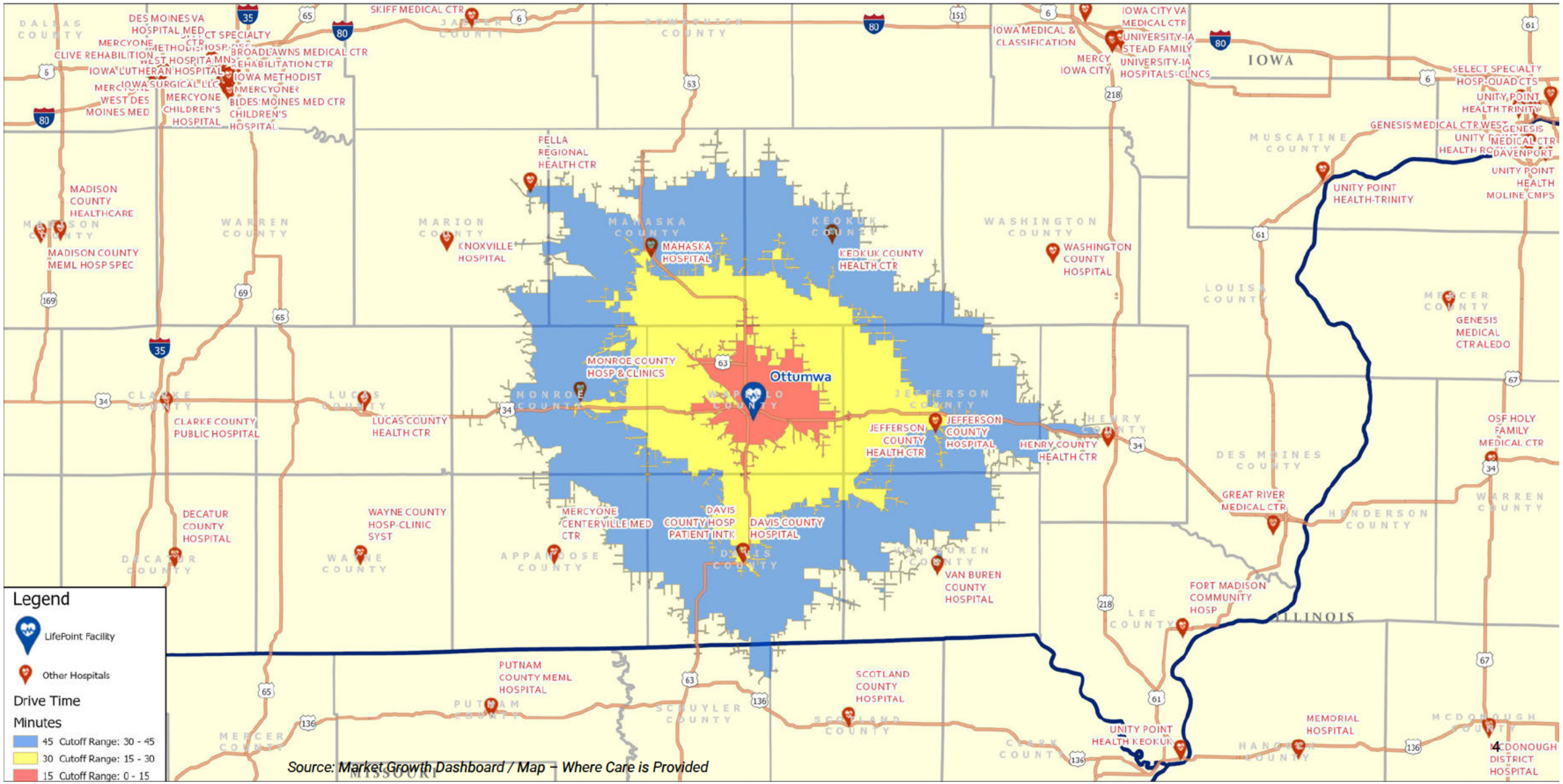
Bryan Harkness - CNO
Years of Service: 1.5
Industry Experience: 12

Justin LeMoine – AA
Years of Service: 1
Industry Experience: 4

Facilit
Profile



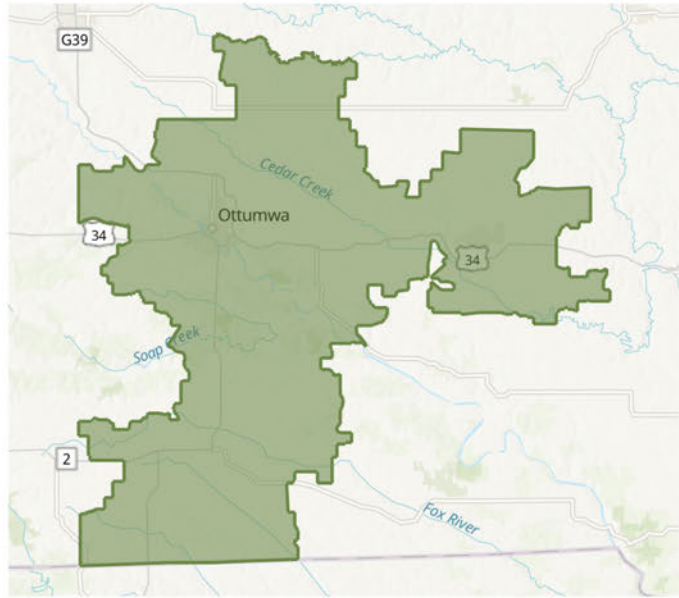
Market Profile



Source: Market Growth Dashboard / Map – Where Care is Provided

POPULATION TRENDS AND KEY INDICATORS

Ottumwa PSA
Geography: ZIP Code



55,463	22,502	2.38	40.7	$61,244	$155,641	67	143	45
Population	Households	Avg Size Household	Median Age	Median Household Income	Median Home Value	Wealth Index	Housing Affordability	Diversity Index

Unemployment Rate

3.7% ↑

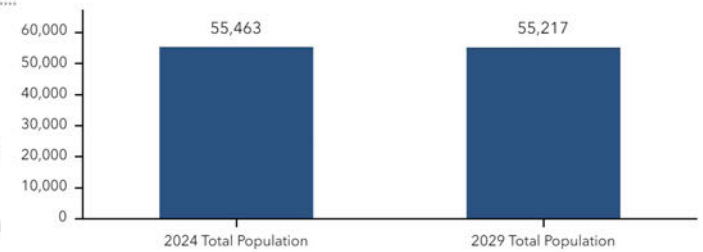
Unemployment Rate
This is 24% higher than **Iowa**.
Iowa has a value of **2.8%**.

5 Yr Population CAGR

-0.09% ↓

Population: Compound Annual Growth Rate
This is -367% lower than **Iowa**.
Iowa has a value of **0.24%**.

5 Yr Population Growth Estimate



2024 Households by income (Esri)

The largest group: $50,000 - $74,999 (18.3%)
The smallest group: $200,000+ (4.0%)

Indicator ▲	Value	Diff
<$15,000	11.4%	+5.6%
$15,000 - $24,999	8.6%	+2.4%
$25,000 - $34,999	7.1%	+3.3%
$35,000 - $49,999	12.9%	+2.1%
$50,000 - $74,999	18.3%	-1.2%
$75,000 - $99,999	14.8%	-4.7%
$100,000 - $149,999	15.5%	-2.7%
$150,000 - $199,999	7.4%	-0.4%
$200,000+	4.0%	-4.3%

Bars show deviation from Davis County

2024 Median Household Income

for this area

$61,244 which is less than the average for United States

Area	Value ▼	$0 $80,000
United States	$79,068	
Davis County	$78,742	
Iowa	$74,738	
Keokuk County	$63,496	
This area	**$61,244**	
Wapello County	$60,421	
Jefferson County	$56,416	

5 Year Population Growth by Age Category

Age Group	2024	2029	% Variance
0-19	13,978	13,288	-4.9%
20-64	29,198	28,478	-2.5%
65+	12,287	13,451	9.5%
Female 15-44	9,549	9,400	-1.6%

esri THE SCIENCE OF WHERE

Source: Esri
Esri forecasts for 2024, 2029

Facility

Ottumwa

Site of Care

HOPD

Service_Area

All

Inpatient Projections

Service_Line	Est Current	Est 5 Yr	Est 10 Yr	Growth 5 Yr	Growth 10 Yr
Cardiac Services	1,130	1,074	1,056	-4.9%	-6.5%
ENT	86	69	62	-19.0%	-27.6%
General Medicine	3,802	3,648	3,567	-4.0%	-6.2%
General Surgery	739	695	684	-6.0%	-7.4%
Gynecology	84	60	52	-28.5%	-38.3%
Neonatology	1,042	937	905	-10.0%	-13.2%
Neurology	483	464	449	-3.9%	-7.0%
Neurosurgery	80	84	85	5.1%	6.7%
Obstetrics	907	848	864	-6.5%	-4.7%
Oncology/Hematology (Medical)	300	280	265	-6.4%	-11.6%
Ophthalmology	11	11	11	-6.3%	-7.2%
Orthopedics	559	502	488	-10.3%	-12.7%
Other Trauma	93	90	92	-2.3%	-0.9%
Rehabilitation (Acute Care)	9	9	10	6.0%	11.7%
Spine	206	182	163	-12.1%	-20.9%
Thoracic Surgery	57	50	47	-11.6%	-17.8%
Urology	148	137	134	-7.2%	-9.0%
Vascular Services	172	156	145	-9.3%	-15.3%
Total	**9,906**	**9,296**	**9,080**	**-6.2%**	**-8.3%**

Market Profile Overall Growth Projection

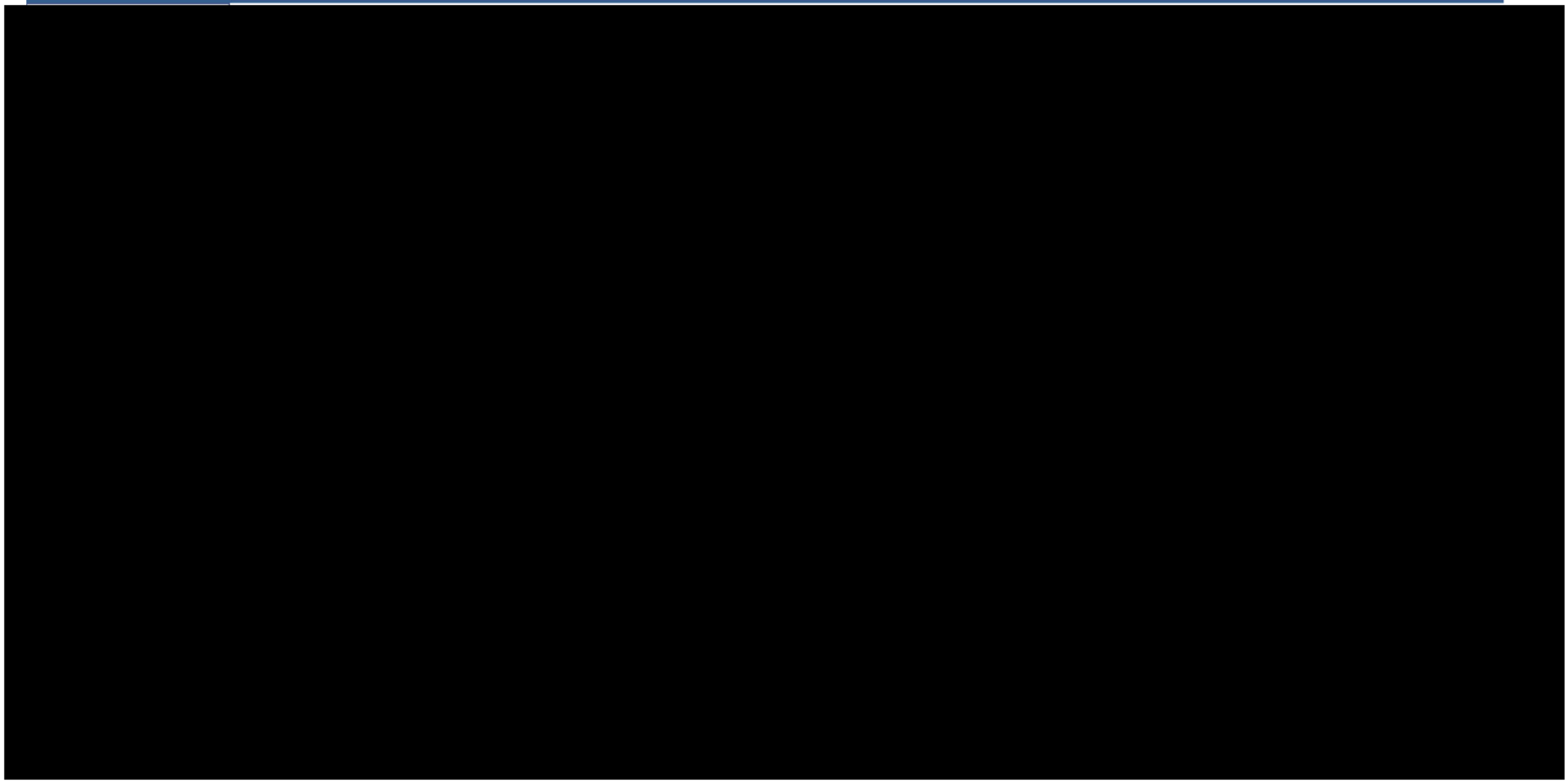
Hospital-based Outpatient Projections

Service_Line	Est Current	Est 5 Yr	Est 10 Yr	Growth 5 Yr	Growth 10 Yr
Cardiology	10,985	11,492	11,830	4.6%	7.7%
Cosmetic Procedures	154	145	140	-5.7%	-9.0%
Dermatology	544	557	566	2.4%	4.1%
Endocrinology	122	119	115	-2.8%	-6.1%
ENT	1,063	960	856	-9.7%	-19.5%
Evaluation and Management	30,733	29,019	28,727	-5.6%	-6.5%
Gastroenterology	3,399	3,022	2,723	-11.1%	-19.9%
General Surgery	1,144	1,102	1,075	-3.6%	-6.0%
Gynecology	494	486	483	-1.6%	-2.2%
Lab	11,731	11,890	12,015	1.4%	2.4%
Miscellaneous Services	3,340	3,429	3,569	2.6%	6.8%
Nephrology	324	280	237	-13.7%	-26.9%
Neurology	871	730	646	-16.2%	-25.8%
Neurosurgery	56	54	53	-3.7%	-5.2%
Obstetrics	301	253	219	-15.9%	-27.2%
Oncology	2,200	2,293	2,526	4.3%	14.8%
Ophthalmology	1,621	1,545	1,489	-4.7%	-8.2%
Orthopedics	2,131	2,127	2,129	-0.2%	-0.1%
Pain Management	928	684	479	-26.3%	-48.5%
Physical Therapy/Rehabilitation	2,717	2,917	3,253	7.4%	19.7%
Podiatry	119	116	117	-2.7%	-1.9%
Psychiatry	1,330	1,519	1,578	14.2%	18.7%
Pulmonology	645	604	558	-6.4%	-13.5%
Radiology	42,631	42,680	43,481	0.1%	2.0%
Spine	422	447	438	6.0%	4.0%
Thoracic Surgery	129	130	126	0.3%	-2.6%
Trauma	835	823	815	-1.4%	-2.4%
Urology	575	547	531	-4.9%	-7.6%
Vascular	1,986	2,061	2,129	3.8%	7.2%
Total	**123,530**	**122,030**	**122,903**	**-1.2%**	**-0.5%**

Performance Summary

Ottumwa

Data Recency	
Inpatient	2023Q4
Outpatient	2023Q4



Service Line Scorecard

Ottumwa

Data Recency | Inpatient | 2023Q4

Episode Visit Type
- Select all
- Inpatient
  - IP Medical
  - IP Surgical
- Outpatient
  - OP Medical
  - OP Surgical

Patient Origin
- Select all
- IP PSA
- IP SSA

Where Care is Provided
- Select all
- IP Facility - in Near-Mar...
- IP Facility - in Out of Re...
- IP Facility - in PSA
- IP Facility - in SSA

Service Indicator
Y

Site of Care
- Select all
- Inpatient
- Outpatient
  - HOPD

Service Line: All

Sub-Service Line: All

DRG/Product Line: All

Service Lines	Market Size	Market CAGR	Facility Size	Facility CAGR	Internal Profitability	Market Share	Addressable Market	Addressable Mkt %	Referral Integrity	Indexed Score
Inpatient	**6,350**	**-2.7%**	**1,704**	**-8.1%**	**($614)**	**27%**	**2,628**	**41%**	**41%**	
IP: Cardiac Services	646	-3.3%	209	-8.9%	($217)	32%	237	37%	14%	51
IP: ENT	25	18.6%	7	51.8%	($6,147)	28%	9	37%	33%	20
IP: General Medicine	2,402	-6.5%	567	-12.9%	($1,514)	24%	1,027	43%	44%	100
IP: General Surgery	310	1.9%	56	-5.3%	$3,982	18%	85	27%	23%	34
IP: Gynecology	7	-14.0%	4	10.1%	$1,514	57%	3	43%	0%	58
IP: Neonatology	393	-0.2%	136	-0.7%	($1,075)	35%	192	49%	0%	43
IP: Neurology	349	0.0%	115	-0.6%	$1,711	33%	121	35%	71%	52
IP: Neurosurgery	4	26.0%	1	0.0%	($736)	25%	1	35%	100%	32
IP: Obstetrics	943	0.5%	265	-9.9%	($1,256)	28%	472	50%	40%	60
IP: Oncology/Hematology (Medical)	110	2.9%	28	13.8%	$3,401	25%	42	38%	36%	38
IP: Orthopedics	485	3.8%	148	9.4%	$1,372	31%	238	49%	43%	53
IP: Other Trauma	35	24.8%	4	-100.0%	$1,058	11%	8	22%	0%	4
IP: Psych/Substance Abuse	471	-3.1%	121	-15.1%	($3,774)	26%	146	31%	43%	32
IP: Spine	33	-7.7%	5	-14.5%	$2,002	15%	15	46%	27%	20
IP: Thoracic Surgery	6	26.0%	1	-100.0%	($2,879)	17%	1	20%	0%	0
IP: Urology	77	-4.0%	27	1.3%	($707)	35%	18	24%	58%	39
IP: Vascular Services	54	3.3%	10	18.6%	$9,305	19%	12	23%	26%	41

Note that the amounts are based upon hospital data only

*Please select one Episode Visit Type at a time

Patient Origin

- [x] Select all
- [x] IP PSA
- [x] IP SSA

Where Care is Provided

- [x] Select all
- [x] IP Facility - in Near-Mar...
- [x] IP Facility - in Out of Re...
- [x] IP Facility - in PSA
- [x] IP Facility - in SSA

Service Indicator

Y

Site of Care

- [ ] Select all
- [x] Inpatient
  - [x] Hospital IP
- [ ] Outpatient
  - [x] HOPD

Service Line Scorecard

Ottumwa

Data Recency | Outpatient | 2023Q4

Episode Visit Type
- Select all
- Inpatient
  - IP Medical
  - IP Surgical
- Outpatient
  - OP Medical
  - OP Surgical

Patient Origin
- Select all

Where Care is Provided
- Select all
- OP Facility

Service Indicator
Y

Site of Care
- Select all
- Outpatient
  - Advanced Imagi...
  - Ambulatory Sur...
  - Endoscopy Cent...
  - General Office/...
  - HOPD

Service Line: All

Sub-Service Line: All

DRG/Product Line: All

Service Lines	Market Size	Market CAGR	Facility Size	Facility CAGR	Internal Profitability	Market Share	Addressable Market	Addressable Mkt %	Referral Integrity	Indexed Score
Outpatient	**103,144**	**1.6%**	**15,215**	**-2.6%**	**($241)**	**15%**	**36,661**	**36%**	**55%**	
OP: Radiology	40,166	1.9%	6,597	0.0%	$94	16%	14,737	37%	53%	100
OP: Evaluation and Management	28,813	0.3%	3,364	-8.0%	($1,398)	12%	9,247	32%	51%	70
OP: Cardiology	9,185	2.5%	1,452	-2.1%	($263)	16%	2,564	28%	49%	45
OP: Lab	7,354	2.5%	15	-65.9%	($27)	0%	3,594	49%	7%	30
OP: Gastroenterology	3,131	2.3%	826	-1.1%	$513	26%	1,131	36%	86%	48
OP: Physical Therapy/Rehabilitation	2,207	2.4%	70	-13.7%	$71	3%	1,048	47%	69%	32
OP: Oncology	2,112	2.7%	372	-3.4%	$1,105	18%	865	41%	46%	40
OP: Orthopedics	1,838	2.5%	654	-0.7%	$3,697	36%	566	31%	88%	58
OP: Vascular	1,644	2.8%	91	-15.4%	$105	6%	642	39%	31%	28
OP: Miscellaneous Services	910	1.5%	264	-15.2%	($294)	29%	183	20%	44%	38
OP: ENT	840	0.2%	270	18.6%	$788	32%	303	36%	67%	46
OP: Ophthalmology	814	2.6%	126	2.0%	$1,037	15%	342	42%	38%	36
OP: Trauma	787	1.6%	370	-0.8%	($524)	47%	192	24%	97%	52
OP: Pain Management	701	3.0%	75	-6.6%	$346	11%	307	44%	28%	30
OP: General Surgery	684	2.0%	216	6.3%	$2,135	32%	210	31%	52%	47
OP: Neurology	371	2.5%	86	-9.9%	($85)	23%	139	37%	40%	35
OP: Urology	348	2.1%	132	71.3%	$436	38%	128	37%	45%	48
OP: Dermatology	344	1.6%	46	-19.5%	($36)	13%	139	41%	85%	34

Note that the amounts are based upon hospital data only

Service Line Stratification

Ottumwa

Data Recency | Outpatient | 2023Q4

Episode Visit Type*
- Inpatient
  - IP Medical
  - IP Surgical
- Outpatient
  - OP Medical
  - OP Surgical

**Please select one Episode Visit Type at a time*

Patient Origin
- Select all

Where Care is Provided
- Select all
- OP Facility

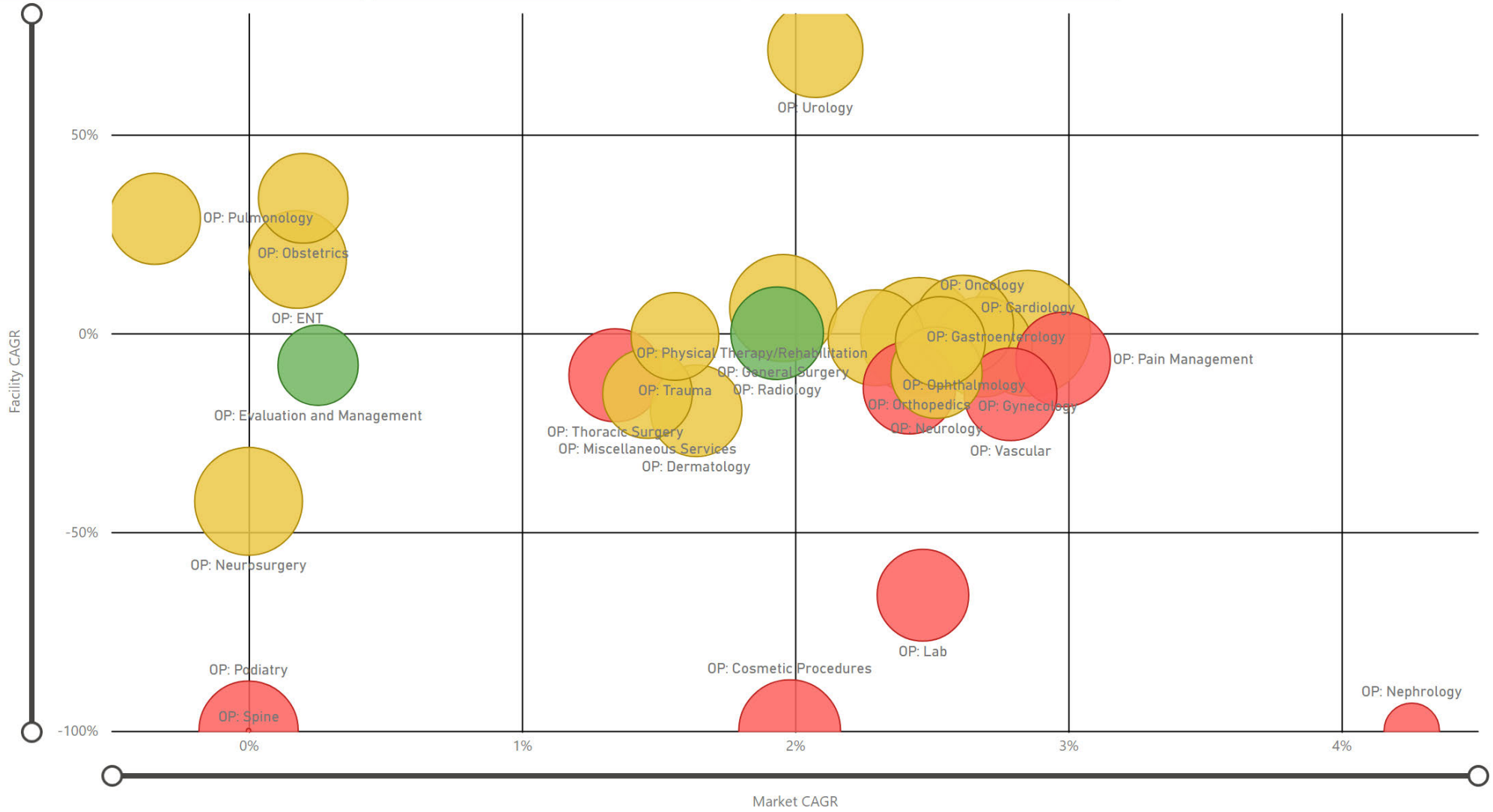
Service Indicator
- Y

Site of Care
- Select all
- Outpatient

Service Line: All

Sub-Service Line: All

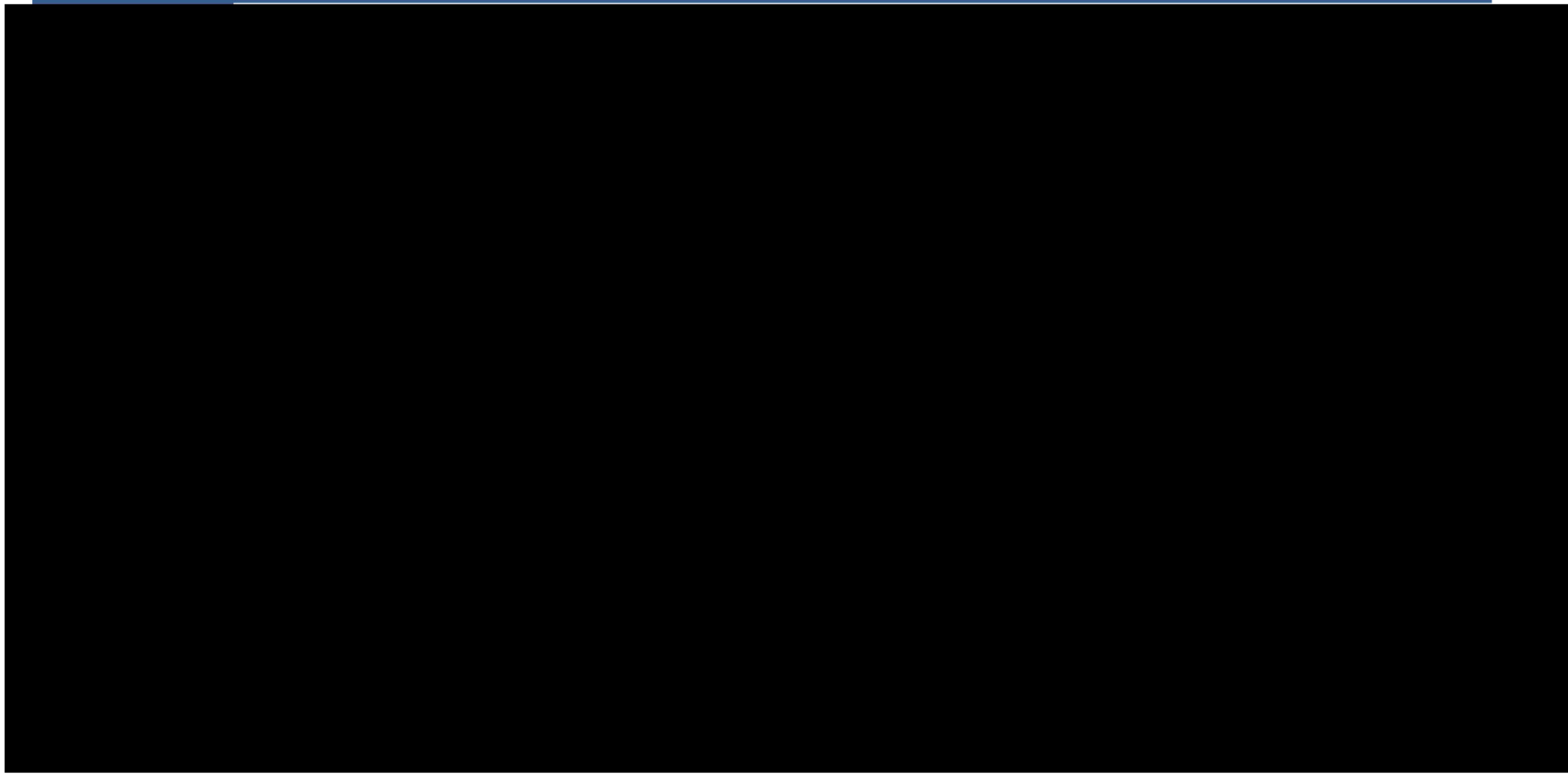
DRG/Product Line: All



Performance Summary

Ottumwa

Data Recency | Inpatient | 2023Q4



Executing on Key Growth Strategies

Growth Strategy	Existing 2024 Growth Strategy Y/N?	Approach	Needs	Expected Results	Milestones
Growth Strategy #1: **Cardiac Services**	Yes	Collaborate w Iowa Heart to recruit FT Ottumwa Cardiologist Work to maintain current volumes despite losing local Cardiologist As situation develops, constantly evaluate for opportunities/risks	[redacted]		
Growth Strategy #2: **Orthopedics**	Yes	New Ortho to start 12/1/24 G&O visits to introduce and begin forming relationships w referral sources and community Establish Ortho Center of Excellence Team			
Growth Strategy #3: **OB/GYN**	Yes	Partner with local FQHC as a referral source New Nurse Midwife starting Q3 2024 Convert PSA OBGYN to Full Time Market all-female OB team to community			
Growth Strategy #4: **Implement Adolescent Inpatient BHU**	No	Collab w Lifepoint BH on project **& future of ORHC** Access Tele Psych to provide care Collab w local, state elected officials to help with CON and possible funding			

Existing Growth Strategy #1: Cardiology

Executive Summary

Continue building ORHC cardiology services:

- [redacted]
- Improved relationship w Iowa Heart in 2024
- [redacted]
- Continue working relationship and volumes based upon provider availability from Iowa Heart

Financials

Year	One-time Costs (e.g., CapEx)	Expected Returns	Actual Returns YTD	Forecast (Full Year)
2025	$50K	[redacted]	[redacted]	[redacted]
2026	$50K	[redacted]	[redacted]	[redacted]
2027	$50k	[redacted]	[redacted]	[redacted]

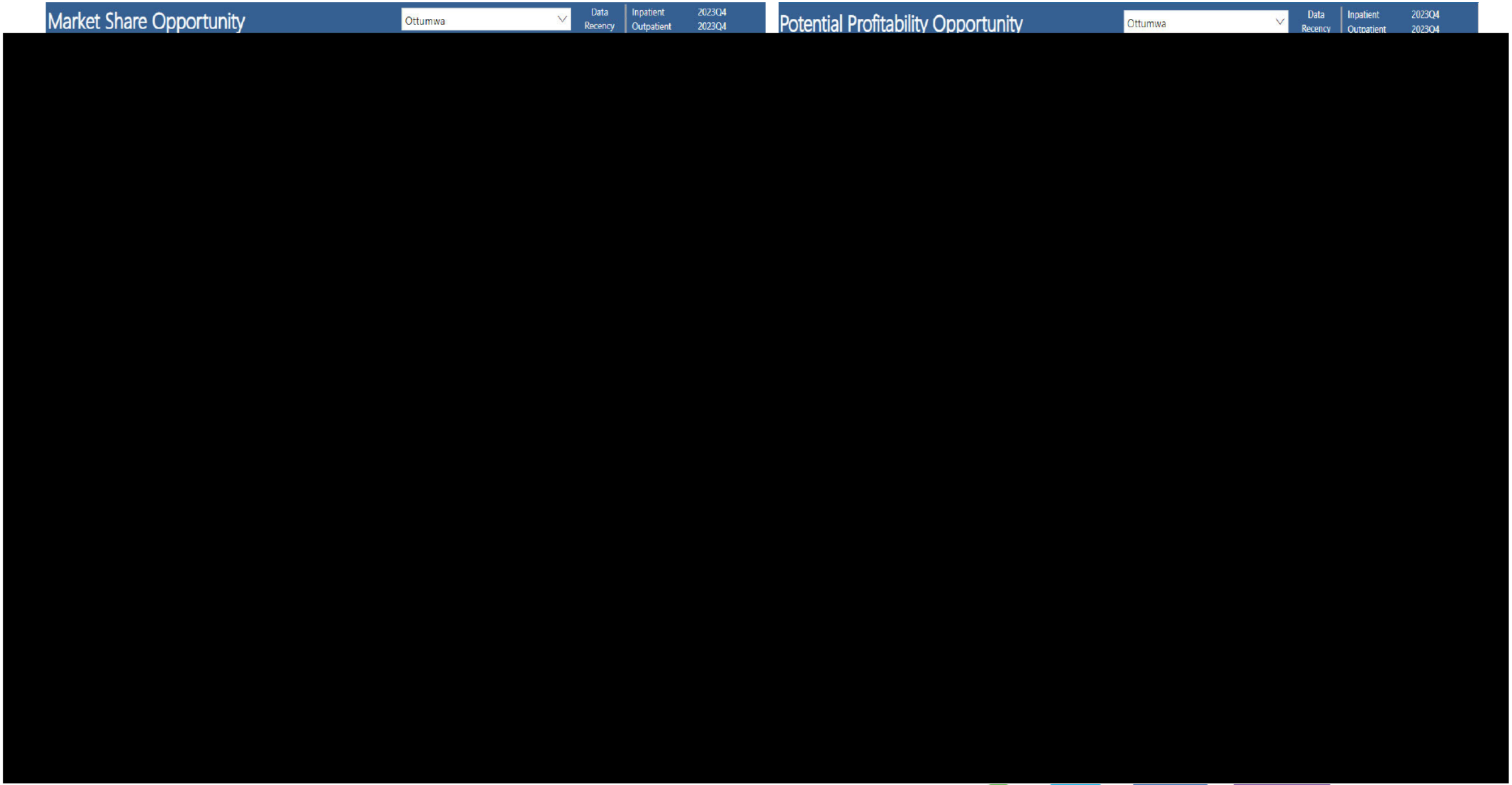
Date	Milestone / Activity	Completed Y/N
Q3 2024	• Obtain division approval for supplemental recruitment agreement for local cardiologist for Ottumwa, $150k over 3 years	N
Q1 2025	• Successfully recruit cardiologist, decrease locums expense, increase profitability	N
Q1 2025	• Build Cath lab volumes: diagnostic & interventional cath's, loop recorders, pacemakers and ICDs	N

Key Risks to Timeline & Value Capture

[redacted]

KPIs / Metrics to Measure Success

KPI	Target	Actual YTD	Forecast (Full Year)
Recruit local Cardiologist	[redacted]	N/A	N/A
Maintain & Grow Vol.'s	• '24 BUD- 683 [redacted]	• June YTD – 368 • Adj. EBITDA $1,740	• '24 Proj – 736 • $64,380
Cardiac Quality Improvement	Improve: • Door to EKG • Door to troponin	• Door to EKG 13% • Door to troponin 18%	• >50% • >50%


Market Share Opportunity
Ottumwa
Data Recency
Inpatient 2023Q4
Outpatient 2023Q4
Potential Profitability Opportunity
Ottumwa
Data Recency
Inpatient 2023Q4
Outpatient 2023Q4

Existing Growth Strategy #2: Orthopedics

Executive Summary

[redacted]

Financials

Year	One-time Costs (e.g., Capex)	Expected Returns	Actual Returns YTD	Forecast (Full Year)
2024	N/A	[redacted]	$0	$186,040
2025	N/A	[redacted]	[redacted]	[redacted]
2026	N/A	[redacted]	[redacted]	[redacted]

Date	Milestone / Activity	Completed Y/N
Q3 2024	Ortho arrives, begin marketing and G&O visits to local referral sources, host provider seminars, meet & greets	N
Q1 2025	Establish Ortho Center of Excellence Team, monthly meetings- SWOT analysis, establish KPIs, implement EBPs, evaluate outcomes	N
Q3 2024	Re-establish Surgical Dept. mtg to ensure that block times are utilized effectively in anticipation of Ortho start, control costs	N

Key Risks to Timeline & Value Capture

[redacted]

KPIs / Metrics to Measure Success

KPI	Target	Actual YTD	Forecast (Full Year)
Ortho Volume Growth	• 2024: 13 IP / 65 OP [redacted]	N/A	• 13 IP/65 OP
Center of Excellence	[redacted]	• Perform GAP analysis • Est. KPIs	[redacted]

Market Share Opportunity

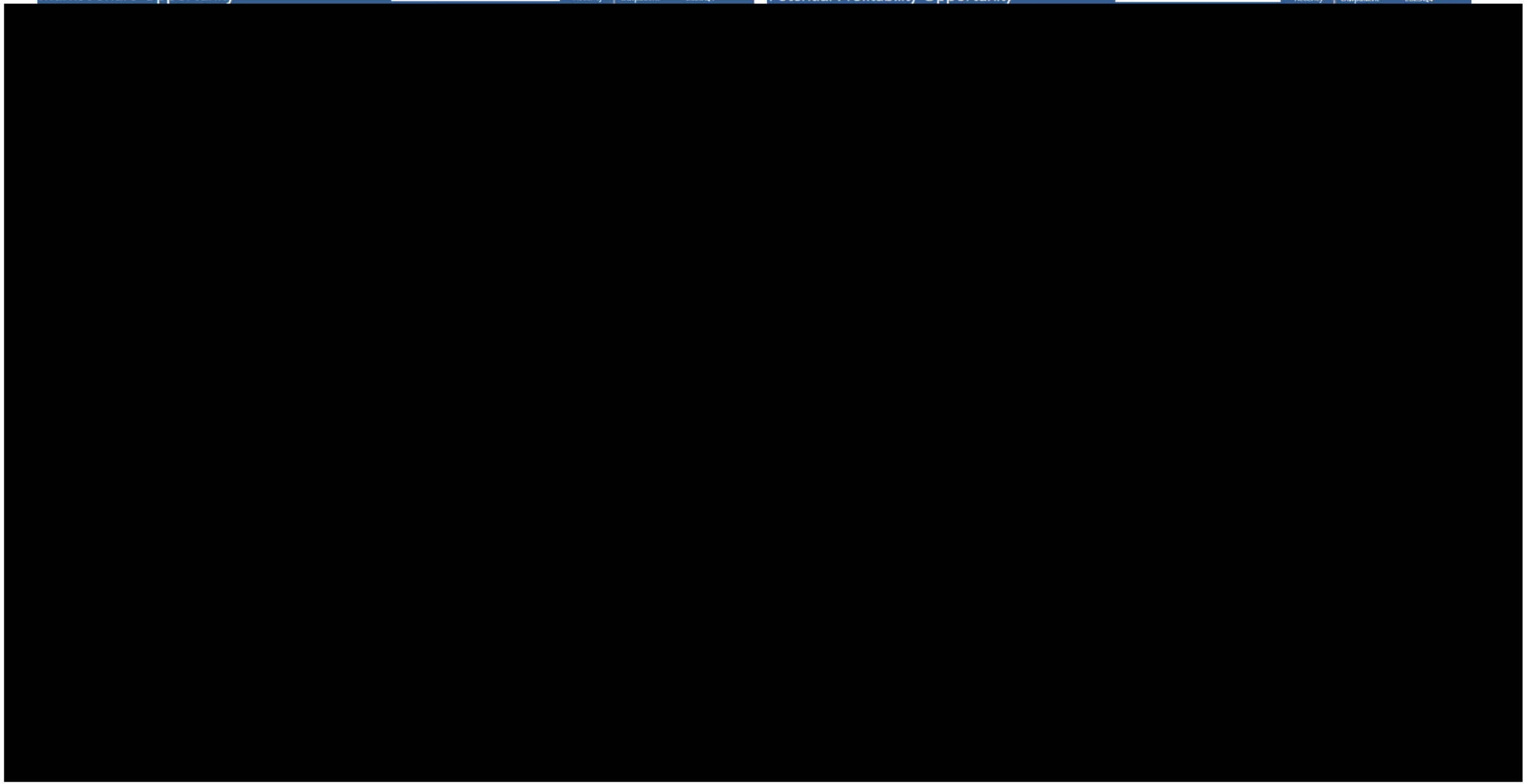
Ottumwa

Data Recency | Inpatient 2023Q4 | Outpatient 2023Q4

Potential Profitability Opportunity

Ottumwa

Data Recency | Inpatient 2023Q4 | Outpatient 2023Q4



Existing Growth Strategy #3: OB/GYN Services

Executive Summary

- Supporting important community need builds trust in ORHC
- Partner w local FQHC as a referral source to reverse years of referring out of community for OB and GYN care

[redacted]

Financials

Year	One-time Costs (e.g., Capex)	Expected Returns	Actual Returns YTD	Forecast (Full Year)
2024	N/A	[redacted]	$0	
2025		[redacted]	[redacted]	[redacted]
2026		[redacted]	[redacted]	[redacted]

Date	Milestone / Activity	Completed Y/N
Q3 2024	• New nurse Midwife starting	Y
Q1 2025	• Convert PSA OB/GYN to full time	N
Q1 2025	• Market all-female OB team to community	N

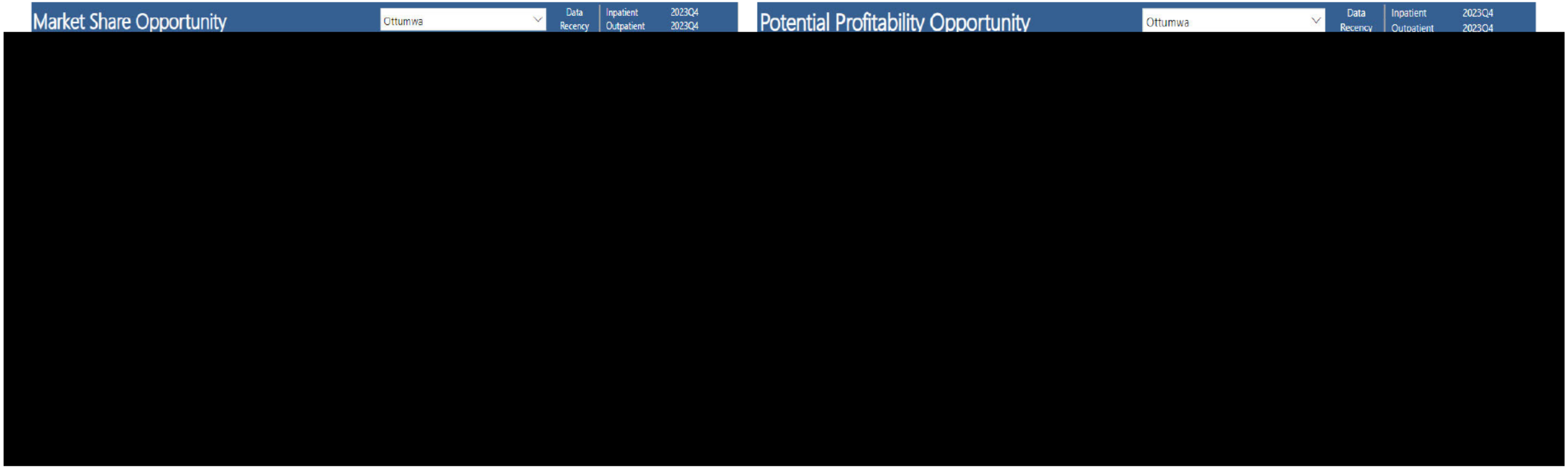
Key Risks to Timeline & Value Capture

Benefit: All female team with the addition of midwives for those looking for alternative deliveries

[redacted]

KPIs / Metrics to Measure Success

KPI	Target	Actual YTD	Forecast (Full Year)
Increase Deliveries	[redacted]	N/A	[redacted]
Increase GYN Surgery	[redacted]	N/A	[redacted]
Locums expense reduction	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]



Lifepoint Health

New Growth Strategy #1: Inpatient Adolescent Psych

Executive Summary

- Ottumwa faces significant behavioral health (BH) needs, currently offering only adult inpatient psychiatric care.
- Adult BHU ADC increased from 5.5 to 9 YOY
- 94 Adolescent ED BH visits/month Q2 2024
- Data reveals a need for 44 psychiatric beds, yet only 12 are available.
- Collaborate with Lifepoint BH, and local and state elected officials, to secure support and funding for expanding these essential services.
- This initiative will also generate significant goodwill, as we provide a much-needed solution for a community, region and state in crisis.

Financials

Year	One-time Costs (e.g., CapEx)	Expected Returns
2025	[redacted]	[redacted]
2026	[redacted]	[redacted]
2027	[redacted]	[redacted]

Options Considered

- Insufficient adolescent beds in region and throughout state, likely receive patients from large geographic region
- Monthly adolescent psych ED visits 16/month at ORHC alone
- BH needs are projected to increase 14% then 18% in 5 and 10 years
- **Potential to parlay into outpatient BH services in the future**

Benefits and Contribution to Business Strategy

- Lean further into BH space which is one of only 2 major service lines projecting growth in next 5/10 years in Ottumwa
- Consider Adult IOP & Adult IOP SUD
- Per diem reimbursements

Key Risks to Timeline & Value Capture

[redacted]

Date	Milestone / Activity	Completed Y/N
Q3 2024 Q4 2024	• Obtain approval of project concept • Develop budget and submit CAMS • Receive final project approval • Obtain CON	N
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

KPIs / Metrics to Measure Success

KPI	Target
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

New Growth Strategy #2: Intensive Outpatient Program (IOP)

Executive Summary

- Ottumwa faces significant behavioral health (BH) needs, currently offering only adult inpatient psychiatric care.
- Market data shows significant need for outpatient substance abuse/behavioral health programs
- Available space for IOP with minimal construction needed
- Collaborate with Lifepoint BH, and local and state elected officials

Financials

Year	One-time Costs (e.g., CapEx)	Expected Returns
2025	[redacted]	[redacted]
2026	[redacted]	[redacted]
2027	[redacted]	[redacted]

Options Considered

- Insufficient outpatient programs in geographic region
- Opportunity to bridge gap between adult inpt BHU and outpatient services
- BH needs are projected to increase 14% then 18% in 5 and 10 years
- **Potential to parlay into outpatient BH services in the future**

Benefits and Contribution to Business Strategy

- Lean further into BH space which is one of only 2 major service lines projecting growth in next 5/10 years in Ottumwa
- Consider Adult IOP & Adult IOP SUD
- Per diem reimbursements

Key Risks to Timeline & Value Capture

[redacted]

Date	Milestone / Activity	Completed Y/N
Q3 2024 Q4 2024	• Obtain approval of project concept • Develop budget and submit CAMS • Receive final project approval • Obtain CON	N
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

KPIs / Metrics to Measure Success

KPI	Target
2025	[redacted]
2026	[redacted]
2027	[redacted]

Primary Service Area Ottumwa Regional Medical Center
Adolescent data ages 12-17 Behavioral Health

Trilliant data reflecting number of adolescent patients seen in ED's in Q2 2024 for Mental health primary diagnosis	Patient Age 12-17
Name	Total
OTTUMWA REGIONAL HEALTH CENTER	**37**
UNIVERSITY OF IOWA HOSPITAL & CLINICS	38
MERCYONE DES MOINES MEDICAL CENTER	29
UNITYPOINT HEALTH - ST LUKES HOSPITAL	56
UNITYPOINT HEALTH - ST LUKES HOSPITAL	37
MERCYONE NORTH IOWA MEDICAL CENTER	14
GENESIS MEDICAL CENTER - DAVENPORT EAST RUSHOLME STREET	16
MERCYONE WATERLOO MEDICAL CENTER	16
IOWA LUTHERAN HOSPITAL	14
IOWA LUTHERAN HOSPITAL	15
JEFFERSON COUNTY HEALTH CENTER	12
IOWA METHODIST MEDICAL CENTER	17
CHI HEALTH MERCY COUNCIL BLUFFS	25
BERKELEY MEDICAL CENTER	16
UNITYPOINT HEALTH- TRINITY MUSCATINE	14
CHILDREN'S MINNESOTA HOSPITAL-MINNEAPOLIS	15
BOONE HOSPITAL CENTER	15

Lifepoint Health

Referral Patterns - Specialist to Facility

Ottumwa

Data Recency

Inpatient	2023Q3
Outpatient	2023Q3

Report

- PCP to Specialist
- Specialist to Facility

Ref Provider Affiliation: All

Rendering Specialty: All

Is Hospitalist: All

Patient Type: All

(>80%)	(50% - 80%)
(30% - 50%)	(<30%)

Referring Provider Stats

59	34,406
ProviderCount	Visits

	1 OTTUMWA REGIONAL HEALTH CENTER	3 DAVIS COUNTY HOSPITAL	4 MERCYONE DES MOINES MEDICAL CENTER	5 MAHASKA HEALTH PARTNERSHIP	6 JEFFERSON COUNTY HEALTH CENTER	7 OTHER SYSTEMS
⊞ EMPLOYED	87.2%	1.4%	0.6%	0.2%	1.4%	9.3%
⊞ AFFILIATED	49.7%	2.5%	1.8%	0.1%	23.9%	21.9%
⊞ DAVIS COUNTY HOSPITAL	0.9%	15.9%	3.3%	0.1%	0.0%	79.8%
⊞ MERCYONE DES MOINES MEDICAL CENTER	3.0%	0.6%	72.5%	0.1%	0.1%	23.8%
⊞ MAHASKA HEALTH PARTNERSHIP	4.6%	1.7%	2.7%	63.5%	0.2%	27.4%
⊞ JEFFERSON COUNTY HEALTH CENTER	12.1%	2.9%	0.9%	0.9%	38.8%	44.4%
⊞ OTHER SYSTEMS	4.8%	2.0%	9.6%	1.1%	2.3%	80.3%
⊞ UNAFFILIATED	20.2%	13.2%	17.8%	8.9%	0.8%	39.1%

Referral Patterns - PCP to Specialist

Ottumwa

Data Recency

Inpatient	2023Q3
Outpatient	2023Q3

Report
- (●) PCP to Specialist
- ( ) Specialist to Facility

Ref Provider Affiliation: All

Rendering Specialty: All

Is Hospitalist: All

Ref Provider is Different: All

(>80%)	(50% - 80%)
(30% - 50%)	(<30%)

Referring Provider Stats

59	52,419
ProviderCount	Visits

	1 EMPLOYED	2 AFFILIATED	3 JEFFERSON COUNTY HEALTH CENTER	4 MAHASKA HEALTH PARTNERSHIP	5 DAVIS COUNTY HOSPITAL	6 PELLA REGIONAL HEALTH CENTER	7 OTHER SYSTEMS	8 UNAFFILIATED
⊞ EMPLOYED	31.2%	14.5%	3.8%	5.3%	0.8%	4.8%	39.0%	0.5%
⊞ AFFILIATED	23.2%	21.1%	4.4%	6.2%	2.2%	3.3%	38.9%	0.7%
⊞ JEFFERSON COUNTY HEALTH CENTER	3.1%	6.0%	18.4%	1.6%	0.5%	0.6%	69.1%	0.8%
⊞ MAHASKA HEALTH PARTNERSHIP	2.6%	2.5%	0.5%	40.9%	0.4%	8.9%	43.4%	0.8%
⊞ DAVIS COUNTY HOSPITAL	8.3%	8.0%	4.3%	3.6%	20.2%	5.2%	47.4%	2.9%
⊞ PELLA REGIONAL HEALTH CENTER	10.0%	6.9%	2.3%	3.9%	1.8%	38.6%	35.7%	0.8%
⊞ OTHER SYSTEMS	4.2%	5.7%	1.4%	3.2%	4.7%	4.4%	75.5%	1.0%
⊞ UNAFFILIATED	8.0%	7.6%	1.4%	3.3%	7.5%	5.1%	66.4%	0.8%

Ottumwa G&O Strategic Initiatives

Service Line	Focus Providers	Current Mkt Alignment - Focus Providers	Expected increase in Mkt Alignment	Outreach Plan
Cardiovascular/ Interventionist	[redacted]	1. 20% 2. 4.2% 3. 6.8 4. 35% 5. 0% 6. 0% 7. 0% 8. 0% 9. 0%	1. 10% 2. 10% 3. 10% 4. 10% 5. 10% 6. 10% 7. 10% 8. 10%	• Lunch and Learn with Cath Lab Director at Jefferson County Hospital, Davis County Hospital and Mahaska County Hospital • Cath Lab speaker at APP educational program Q2 • Cath Lab Lecture speaker at Area EMS
Orthopedic		1. 50.4% 2. 47.3 3. 17.8% 4. 6.5% 5. 6.5% 6. 33%	1. 10% 2. 10% 3. 10% 4. 10% 5. 10%	• New ortho provider lunch and learn at all 5 practices listed • Total joint ortho give talk on advancements in knee and hip replacement at APP educational program Q1 • Ortho Surgeon speaker at EMS educational event
Radiology MRI and Mammo's		1. 38% OON 2. 25% OON 3. 59% OON 4. 58.7%	1. 25% 2. 25% 3. 25% 4. 25% 5. 25%	• Find top reasons why employed providers send OON (MRI, Mammo, CT) • Roadshows with Director of Radiology and Director of Central Scheduling to focus providers listed.

3-year Recruitment Plan - Growth

Start Year	Specialty	FTE Needs	Commentary/Notes
2024	OB/GYN	1	• ORHC has no full-time OB/GYNs, we currently utilize 1099 contracted providers
2025	Internal Medicine	2	• PSA shows a need of 11.4 FTE's • ORHC has 4 Family medicine providers and currently no Internal Medicine providers
2025	Orthopedic APP	1	• Second Ortho begins late fall of 2024 • As ramp up continues, APP will be needed
2025	General Surgeon	1	• Continuing growth of service line.
2025	OB/GYN	1	• ORHC will have 1 full time OB/GYN by 2025 • Need 2 full-time physicians to maintain service line
2026	Internal Medicine	1	• Continuing growth of IM service line • Demand will continue to outpace access

3-year Recruitment Plan - Backfill

Provider Name	Specialty	FTE	Employed or Affiliate	Expected Departure Date / Year	Reason for Departure	Near-term Mitigation Plan (including other physicians)
[redacted]	Gen.Surg.	1	Employed	9/19/2024	Resignation	• Utilizing Locums while recruiting • Negotiating with Gen. Surg. regional practice for contract

Lifepoint Health

Market Share - Inpatient

Ottumwa

Data Recency | Inpatient | 2023Q4

Episode Visit Type
- [x] Select all
- [x] Inpatient
  - [x] IP Medical
  - [x] IP Surgical

Patient Origin
- [x] Select all
- [x] IP PSA
- [x] IP SSA

Where Care is Provided
- [x] Select all
- [x] IP Facility - in Near-Mar...
- [x] IP Facility - in Out of Re...
- [x] IP Facility - in PSA
- [x] IP Facility - in SSA

Service Indicator
All

Site of Care
- [ ] Select all
- [x] Inpatient
  - [x] Hospital IP
  - [ ] Outpatient
    - [x] HOPD

Service Line: All

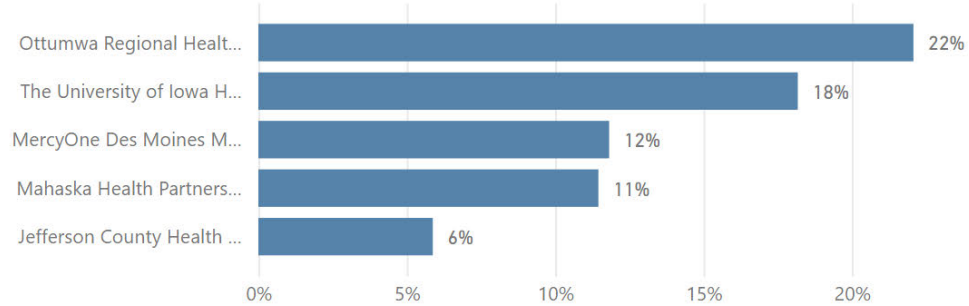
Sub-Service Line: All

DRG/Product Line: All

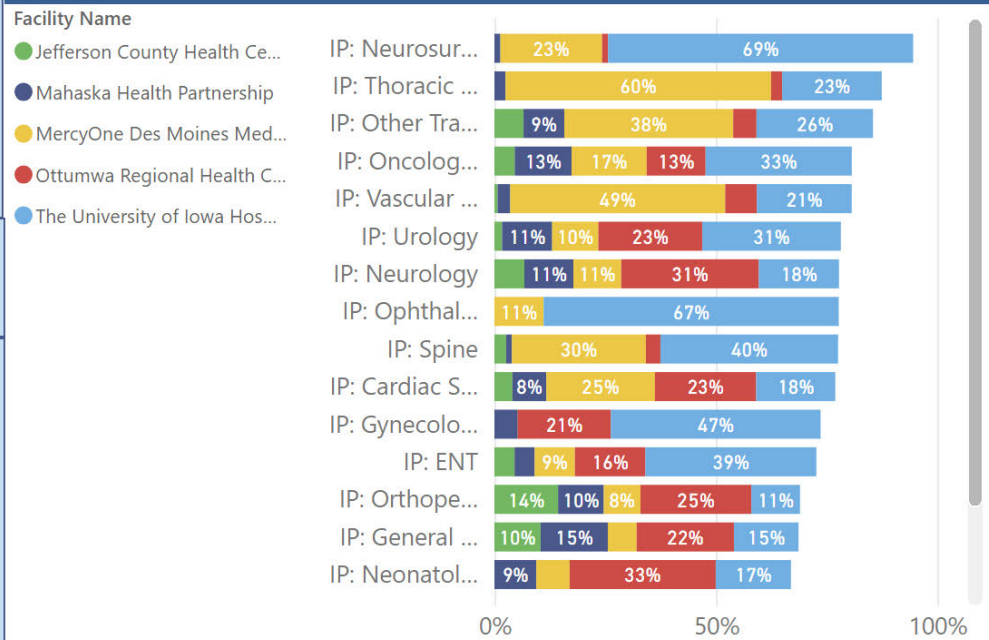
Top 5 Rendering Facilities

Facility Name	Facility Volume	Market Share %
Ottumwa Regional Health Center	1,705	22%
The University of Iowa Hospitals and Clinics	1,404	18%
MercyOne Des Moines Medical Center	913	12%
Mahaska Health Partnership	885	11%
Jefferson County Health Center	454	6%

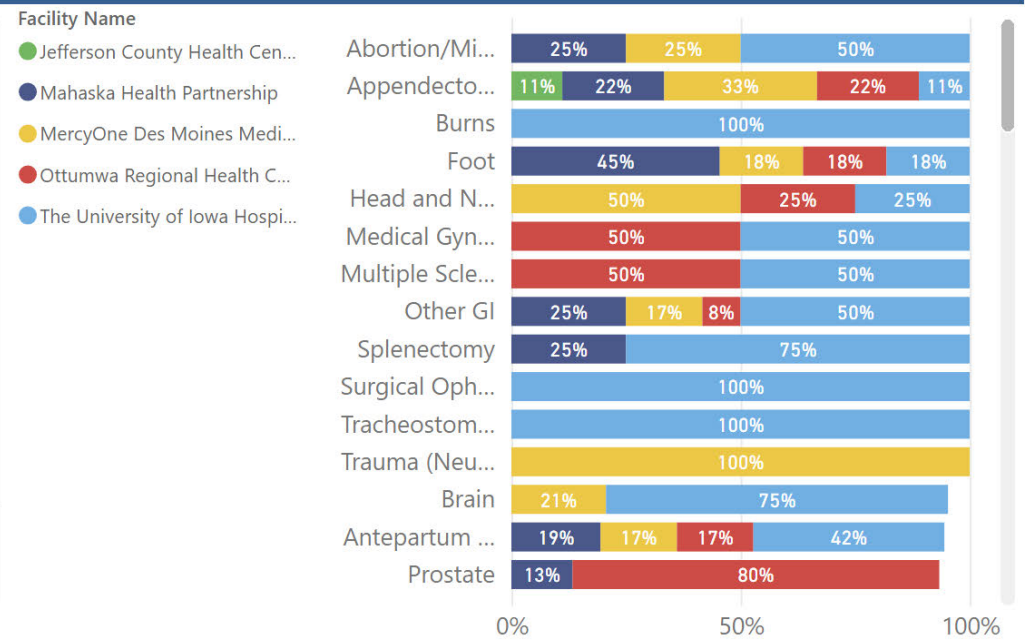
Market Share Composition



Market Share by Service Line (Top 5 Facilities)



Market Share by Sub-Service Line (Top 5 Facilities)



Market Share - Outpatient

Ottumwa

Data Recency | Outpatient | 2023Q4

Service Line: All

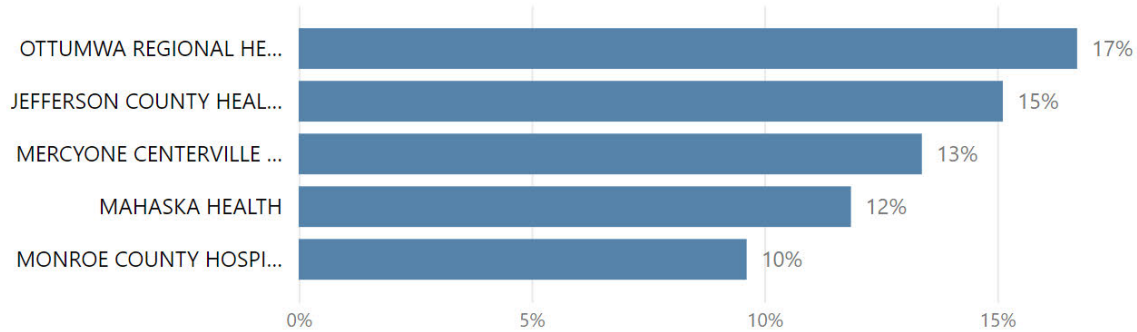
Sub-Service Line: All

Patient Origin: All

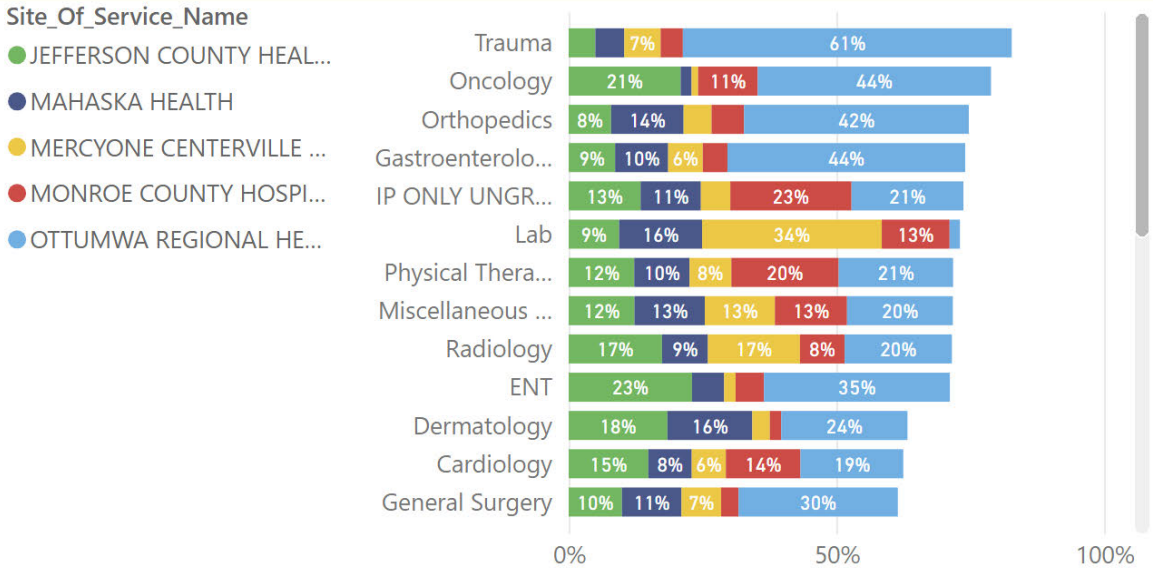
Top 5 Facilities

Site of Service	Facility Volume OP	Market Share % OP
OTTUMWA REGIONAL HEALTH CENTER	66,126	16.7%
JEFFERSON COUNTY HEALTH CENTER	59,821	15.1%
MERCYONE CENTERVILLE MEDICAL CENTER	52,939	13.4%
MAHASKA HEALTH	46,914	11.9%
MONROE COUNTY HOSPITAL AND CLINICS	38,054	9.6%

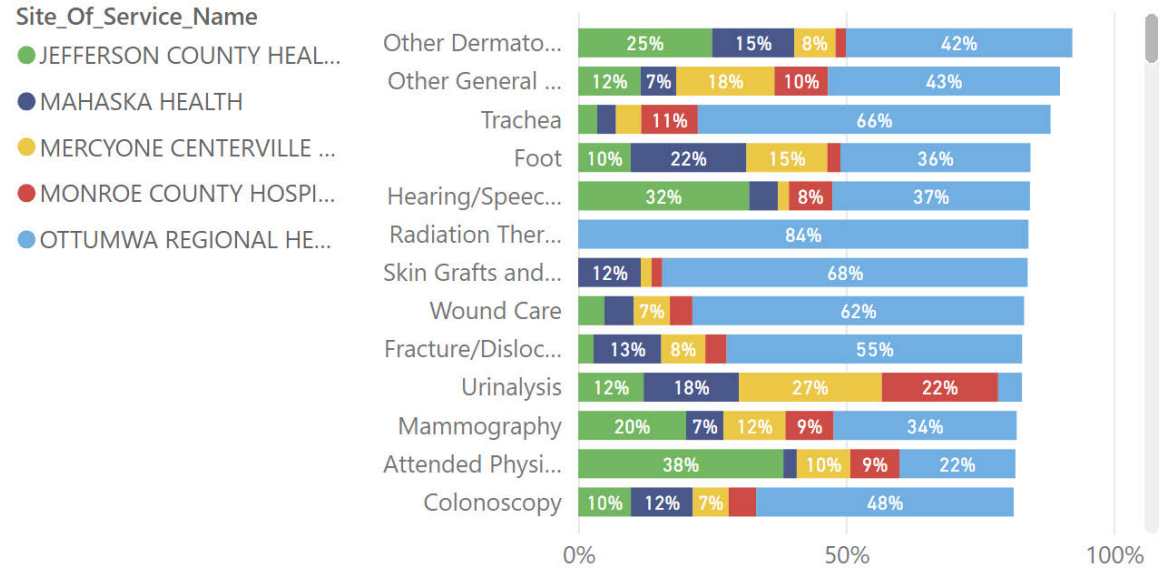
Market Share Composition



Market Share by Service Line (Top 5)*



Market Share by Sub-Service Line (Top 5)*



***The visuals** do not display all the data due to the limitations of PowerBI. Filter by the service line or sub-service line to view the accurate market share.

Employer Dynamics

Top Employers (# of Employees)	Insurance Provider/Broker	# Full Time Employees # Part Time Employees	Changes to insured base/insurer?	Potential increased alignment strategies?
JBS	BCBS	2,500 FT	n/a	[redacted]
Cargill Eddyville Corn Sweetener Plant	BCBS	953 FT	n/a	
Ottumwa Schools	BCBS	700	n/a	
John Deere Ottumwa Works	UH J.D.	650	n/a	
Indian Hills Community College	BCBS	420	n/a	
Dr. Pepper/Snapple Group	UH	275	n/a	
City of Ottumwa	BCBS	265	n/a	
Winger Contracting Company	BCBS	220	n/a	
Ajinomoto USA, Inc.	BCBS	215	n/a	

Lifepoint Health

Payer Dynamics

Payer	% of Market (volume)	% of Facility (internal)	Internal Profitability
Medicare	32%	25%	$0.6 million
Managed Medicare	13%	23%	$-2.5 million
Blue Cross	10%	13%	$6.1 million
Medicaid	30%	29%	$1.9 million
Other Commercial	7%	6%	$5.3 million
Uninsured	9%	4%	$-0.4 million

Payer Name	Payer Strategies Deployed	Opportunity / Risk	Plan to Maximize Benefit / Mitigate Risk
All Payers	• Payers are denying and requesting more and more information to process claim	• Risk- Delay until past timely filing, leaving no opportunity to rebill or appeal • Opportunity- Payers to be held accountable and contracts to have specifics to eliminate their tactics • Opportunity- ensure accurate insurance information upon admission/date of services • Appeal appropriately/timely/and accurately to fullest extent	**Risk mitigation** • Address tactics in payer contracts • Require payers to utilize CMS approved criteria for inpatient and OBS stays • Inaccurate insurance information delays filing, denials due to not notifying the correct insurance of admission within required timeline • Remove appeals from R1 or require R1's appeals team to be located within the US and have knowledge of our healthcare systems/processes/and payers

Government-Based Program	Description of Risk or Opportunity	Expected Impact Date	Impact to EBITDA	Strategies to manage or capture opportunities
Mgd Medicare/Medicaid	Opportunity – Requirements for prior authorization processing takes up to 2 weeks • Average should be 3-4 day • Delays testing for OBS, discharges to SNF	Upon Contract	Unknown- reduce LOS, OBS hours	Strategy- include in contracts as we renew • CMS does tag the managed care companies on untimely notifications but there is no penalty

Workforce Development Plan

Growth Strategy	# of Staff Needed (per Staff Type)	Skills/Skill Mix Targeted	# of Incremental Staff vs. Existing Staff	Education, Training and Development Plan to be Implemented
1 - Cardiac	• 3 • 2	• CV Tech • RN/Paramedic	• 3 Tech's vs. 1 • 2 RNs/Medics vs. 0	• Cath lab Comp.'s • New grad RN training at Mercy
2 - Ortho	• 1	• RN	• 1 vs. 0	• Dept. Orientation
3 – OB/GYN	• 1	• Medical Assistant	• 1 vs. 0	• Dept. Orientation
4 – Adolescent BHU	• 9 • 12 • 2 • 1	• RN • CNA/MHT • Social worker • Rec. Therapist	• 9 • 12 • 2 • 1	• Dept. Orientation

Lifepoint Health

Workforce Stabilization Plan

Nurses Available at Bedside by Month

Division / Facility	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
West								
Beginning Balance	55	52	52	51	53	54	50	50
Hires		1	2	2	1	2	1	1
Transfers In		2				1	3	
Terms	(2)		(2)			(4)	(2)	
Transfers Out	(1)	(3)	(1)			(3)	(2)	
Net Change	(3)	-	(1)	2	1	(4)	-	1
Ending Balance	52	52	51	53	54	50	50	51

Other Key Clinical/Support Staff Statistics

Staff Type:	Hospital RN	Surgical Techs	Xray/CT Techs	Ultrasound Tech			
Current v. Projected Need:	51 / 126	1/5	2/9	1/4			
Turnover:	19.2%	50%	60%	50%			

Recruiting Strategy Description	Impact / KPIs
Sign on Bonus Restructure – [redacted]	• No intended impact
Nurse Extern Program	• Interest from new grads
• Increased Sourcing • Paid Indeed Sponsored Ads – 10 RN • Job Fairs Onsite and at Offsite • Boosted Facebook Ads • Sense Messaging Implementation • Continued Designated Lifepoint Recruiter for • LPN/RN Recruitment • Establish relationships with new schools • Clinical Completion Breakfasts with students and faculty	• Increased visibility for critical positions • Increased presence locally and regionally • Drive brand, trust, and vision for future

Retention Strategy Description	Impact / KPIs
Referral Bonus Restructure	• No impact expected
Formalized Leadership Onboarding Leadership Development	• Leaders better prepared to create strong, cohesive teams in rewarding environments that foster collaboration, trust, and belonging
Competitive Comp & Shift Diff Referral Bonus Re-Implementation	• Competitive pay keeps employees happy & avoids high turnover • Referral bonuses add compensation opportunity which encourages morale.

Lifepoint Health

Growth Capital (>$0.5m)

Key Growth Strategy or Other	Expected Year of Deployment	Growth Capital	Volume Growth	EBTIDA Uplift	Projected Cost
1	2025	• ~$1.8M Renovation • ~$180K FFE	[redacted]		
2	2025	Remodel the inpatient Rehab Unit			
3	2026	[redacted]			

Lifepoint Health

Key Operational Excellence Initiatives

Initiative	Goals by end of 2024	Key milestones	Rationale for focus
• **Reduction in GLOS**	• Meet GLOS +/- 10%	• O's engaged in IDT improvement • Apogee/TH outcome reviews • Monitor social admission	• ED throughput • LOS improvement • High observation %
• **Transfer center utilization**	• Increase acceptance by 10% • Incr. transfer center referral by 10%	• Build ICU volume with reopening of ICU by 10% • Building "Yes" culture	• Volume growth • Imp. relationships w ref. facilities • Return to Ottumwa "Regional"
• **NQP Journey**	• Obtain 75% on qualitative NQP scorecard	• Train to just culture algorithm for frontline and medical staff • Patient experience action plans for each unit	• Complete alignment of goals • Engagement drives understanding, and outcomes
• **ED efficiency improvement**	• 25% reduction in DC LOS • 50% reduction in LWOT %	• Vertical ED process implementation • ED/BHU admission process	• Operational excellence drives pt. satisfaction, quality outcomes & volume
• **Patient Experience (HCAHPS)**	• 50th percentile in top 4 focus domains	• BSSR & Leader rounding • Hourly rounding mastery	• Patient experience drives CMS stars and Leapfrog
• **RN Recruitment and retention**	• Reduction in voluntary FT/PT/RN turnover rate by 25% • Functional vacancy rate reduction by 25%	• Implement CoSE action plans • Rollout recruitment toolkit • Need competitive compensation • Collaboration with local colleges	• Stabilized/engaged staff – foundation for quality outcomes & growth • Decreased CL expense
• **Billion Pill Pledge**	• Reduce opioid Rx from 60 to < 20 • Improve pt's pain and their involvement in their care • Reduce opioids in community	• ERAS protocol fully integrated • Opioid prescribed has dropped from 60 to 7 per surgical pt. - Mostly Ortho • Refills at 60 opioids down from avg. Of 3 to 1.2 refills with only 7 opioids	• ORHC from negative to positive in press and comm. • Make community healthier w less opioids • Lead comm. w positive program

Health Equity Strategic Plan (CMS Attestation)

Health Equity Goals for 2024	Action Steps	Specific Resources Dedicated	Community Stakeholder Engagement Strategies
• Reduce nulliparous C-Section rate in non-English speaking populations	• Utilize nurse navigator at local meat packing plant and local churches to increase utilization of prenatal care in this population. • Increase access to care at Women's Clinic by establishing Medicaid eligibility in uninsured populations	• Practice Management • Women's Clinic • OB Providers	• Work with local meat packing plant and churches
• Maintain >85% screening for social drivers of health	• Data collected and reviewed by the Health Equity Team • Identify action items to drive improvement • Data shared w/ Med. Staff, Med Exec, and Board	• Executive team • Clinical SMEs • Health Equity Team	• Info shared with board • CEO meets w/ community group, i.e. Rotary • Local and state legislative collaborations
• Training for collection of culturally-sensitive information	• Education at general hospital orientation/annually on collection of culturally-sensitive information, including scripting and use of translation services	• Human Resources • Clinical leadership • Education • Health Equity Team	• Clinic navigator with focus on at risk population engagement

Quality & Reputational Outcomes

Lifepoint Health

Leapfrog

Measure	Goals	Current Performance (Fall 2024 Survey Submission)	Action Plans & Tactics to Achieve or Sustain Goals	Milestones	Business Owner & Physician Champion
CPOE	≥ 60% CPOE Test ≥ 75% CPOE Compliance (obtain both scores from the Leapfrog survey site)	67% 91%	Monthly CPOE reports are run and monitored.	Achieving the goal.	[redacted]
BCMA	➢ 95% Compliance in all ICU, Med/Surg, L&D, pre-op, & PACU units Yes for 5/5 Decision support questions (section 2.C, question 17 a - e) Yes for 6/8 Processes & structures to prevent workarounds (section 2.C, question 18 a – h)	Avg. Compliance across all defined units: 97% 5 / 5 8/ 8	Monthly BCMA reports are run and monitored. Results are reported at PSQC. Department level recognition for staff with high BCMA rates.	Achieving the goal.	
Hand Hygiene	Yes to all questions (section 6.D, questions 1 – 7, 11-15, where applicable) Meets minimum monthly hand hygiene audits per unit based on Leapfrog-defined average daily census (section 6.D, questions 8-10)	Electronic Monitoring: 20 / 20 w/o Electronic Monitoring: N/A	Electronic hand hygiene monitoring program in place.	Achieving the goal.	
Safe Practice 1 Leadership Culture	Yes to all questions in awareness, accountability, ability, & action domains 13/13 questions (section 6.A, 1.1 to 1.4)	13 / 13	Maintain compliance with all required elements.	Achieving the goal.	
Safe Practice 2 Culture Measurement	Yes to all questions in awareness, accountability, ability, & action domains 12/12 questions (section 6.B, 2.1 to 2.4)	12 / 12	Maintain compliance with all required elements.	Achieving the goal.	

Patient Experience (HCAHPS)

Measure	Goals	Action Plans & Tactics	Milestones	Business Owner
Leader Rounding	80% of Inpatients	Scheduled time for nurse leaders to round daily on Med Surg unit. Enhanced use of iRound tool to monitor rounding compliance and follow-up.	• Achieve 80% rounding compliance in iround by end of August	[redacted]
Bed-Side Shift Report Audits or Press Ganey % patients reporting that BSSR occurred at shift change (not subject to self-reporting)	75% Top Box Goal 49.50% Jan-Jun '24	Use key phrases Include patient and family in BSSR Staff education through role play Traveler onboarding to include BSSR expectations Inclusion of BSSR question in leader rounding	• Achieve 75% of Always "Yes" for "Discussed care at bedside" by end of Q3.	

Lifepoint Health

NHSN Hospital-Acquired Infections (HAI)

Measure	Goals (Standardized Infection Ratio)	Action Plans & Tactics	Milestones	Business Owner & Physician Champion
CAUTI	SIR ≤ 0.400 Current SIR 0.00	Nurse-driven protocol Daily IP Audit Catheter "Bounty" Program Urine Testing Guide for Providers Daily leader accountability in leadership brief for all catheters in place.	Q3- Establish Catheter Free ED Last CAUTI 6/9/21	[redacted]
CDIFF	SIR ≤ 0.300 Current 0.38	Two-nurse verification Colored specimen bags to designate between ED & Inpatient Specimens run once daily, and IP called for any inpatient specimens Testing algorithm in place	Q3- Demonstrate consistent escalation to IP for all inpatient specimens.	
CLABSI	SIR ≤ 0.00 Current 0.00	Daily IP rounds. CHG bathing for all patients with lines. Daily leader accountability in leadership brief for all lines in place. Meditech flowsheet includes criteria for line to remain in place and tracker that monitors number of days.	Maintain SIR of 0.00 Last CLABSI 1/2/22	

Hospital-Defined Quality & Clinical Priorities

Priority Area	Goals	Action Plans & Tactics	Milestones	Business Owner & Physician Champion
HCAHPS Nurse Communication	Target 79.42 and/or 50th percentile Q2 76.39 – Percentile Rank: 25% YTD 66.67 – Percentile Rank: 2%	• Weekly executive leader rounding with BSSR audits • BSSR competency and sign off for onboarding traveler staff • 100% daily patient rounding completed by clinical leaders • CNO actively auditing BSSR	• Reach 50th percentile rank by January 2025 • Revamp patient communication folder by end of year	[redacted]
HCAHPS Medication Communication	Target 63.11 Q2 64.38 – Percentile Rank: 72% YTD 45.60 – Percentile Rank: 1%	• Med education cards launched Q2 • Adding education sheet to each patient folder with common side effects for new medications • Clinical pharmacist to round on patients	• Implement discharge phone call script with targeted medication questions by end of Q3 • Reach 50th percentile rank by January 2025	
HCAHPS Responsiveness of Staff	Target 65.52 Q2 50.98 – Percentile Rank: 6% YTD 46.53 – Percentile Rank: 2%	• Nurse leader rounds focusing on responsiveness • Nurse call system software utilization to run reports on response times and share with staff for improvement opportunities.	• Share individual call light response data with M/S staff • Post department level response times with shared goal • Reach 50th percentile rank by January 2025	

Lifepoint Health

Appendix

Lifepoint Health

Enterprise Risk Management

Lifepoint Health

Enterprise Risk Management Scorecard

ERM Pillar (People/ Quality)	Score	Key Metrics driving score down	Action Plan to improve risk metrics Projected Cost	Goals and Monitoring Plan	HSC Support Needed
Quality	*40*	• *LWOT %* • *AMA %* • *HCAHPS – ED*	• *Hired new ED director* • *Worked with HSC service-line team to process map identify inefficiencies in flow and develop action plans to remediate.*	• *LWOT – 5% by 3/31/25, 3.5% by 6/30/25* • *AMA – 3% by 3/31/25, 2.5% by 6/30/25* • *ED average wait time under 10 min by 6/30/2025*	• *Monthly visit from ED Service Line to discuss flow improvements* • *HSC support with Team Health for improved provider competency as well as facility medical director* • *Monthly on-site visits from Regional Team Health leaders* • *Additional NP for mid-shift 50% in ED*
People	*50*	• *RN Turnover* • *Contract Labor*	• *Develop and implement extern program* • *Working with People Services for recruiting*	• *Net gain of 10 RNs in 2025* • *Reduction in RN turnover <1 year to under 20% (rolling 12-month average) by 9/30/2025*	• *Assistance with development and rollout of extern program*

Lifepoint Health

Med Staff Development

Primary Care & Medicine Provider Employment

Adjustment Reasons:
- Demand too low, area can support additional physicians
- Demand too high, area has sufficient physicians
- Service patients outside of area
- Other (please provide notes)

Specialty	PSA Physician Supply	PSA Physician Demand	Demand Adjustment FTE	PSA Net Need	Adjustment Reason	Adjustment Notes
Family/General Practice	14.4	13.9		(0.5)		
Internal Medicine	4.6	15.9	2.0	11.2	Area can support additional physicians	
Pediatrics	4.9	6.8		2.0	Area needs mostly covered by local FQHC and independent providers	
Primary Care	**23.9**	**36.6**	**0.0**	**12.7**		
Allergy/Immunology	1.1	0.4		(0.6)		
Cardiology	5.2	2.3		(2.9)	Need additional cardiologists to meet area demand, [redacted]	
Dermatology	1.0	1.5		0.6		
Endocrinology	0.1	0.4		0.4		
Hematology/Oncology	1.5	1.3		(0.2)		
Infectious Disease	0.2	0.5		0.3		
Nephrology	1.5	0.6		(0.9)		
Neurology	1.8	1.8		0.0		
OB-GYN	4.4	5.5	2	1.0	Area can support additional physician	
Pulmonology	0.2	0.8		0.5		
Radiation Oncology	0.0	0.7		0.7		
Rheumatology	1.0	0.4		(0.6)		
Medicine	**17.9**	**16.3**	**0.0**	**(1.6)**		
Psychiatry	**3.5**	**3.1**	**0.0**	**(0.4)**	Utilizing contract service to fill needs	

Note that the Physician Supply and the Demand do not include APP's

Med Staff Development

Surgery

Provider Employment

Adjustment Reasons:
- Demand too low, area can support additional physicians
- Demand too high, area has sufficient physicians
- Service patients outside of area
- Other (please provide notes)

Specialty	PSA Physician Supply	PSA Physician Demand	Demand Adjustment FTE	PSA Net Need	Adjustment Reason	Adjustment Notes
ENT	0.3	1.8		1.5		
Gastroenterology	1.0	1.9		1.0		
General Surgery	3.0	4.1	1	1.0	Area can support additional physician	Needed support for increased ER Call support
Neurosurgery	0.0	0.6		0.6		
Ophthalmology	2.9	2.5		(0.4)		
Orthopedics	2.3	3.3		1.0	1 FT Ortho signed and will start 11/24	
Plastic Surgery	0.1	0.6		0.5		
Thoracic Surgery	0.4	0.4		0.0		
Urology	1.4	1.7		0.3	Demand met, new services being introduced to community and to state	
Vascular Surgery	0.6	0.7		0.1		
Surgical Total	**12.1**	**17.7**	**0.0**	**5.6**		

Note that the Physician Supply and the Demand do not include APP's

Lifepoint Health

Med Staff Development

Primary Care & Medicine
Affiliated Providers

Adjustment Reasons:
- Demand too low, area can support additional physicians
- Demand too high, area has sufficient physicians
- Service patients outside of area
- Other (please provide notes)

Specialty	PSA Physician Supply	PSA Physician Demand	Demand Adjustment FTE	PSA Net Need	Adjustment Reason	Adjustment Notes
Family/General Practice	13.7	13.0		(0.8)		
Internal Medicine	4.6	14.8		10.2		
Pediatrics	4.8	6.4		1.6		
Primary Care	**23.2**	**34.2**	**0.0**	**11.0**		
Allergy/Immunology	1.1	0.4		(0.6)		
Cardiology	5.2	2.2		(3.0)		
Dermatology	1.0	1.4		0.5		
Endocrinology	0.1	0.4		0.4		
Hematology/Oncology	1.5	1.2		(0.3)		
Infectious Disease	0.2	0.5		0.3		
Nephrology	1.4	0.6		(0.8)		
Neurology	1.8	1.7		(0.1)		
OB-GYN	4.4	5.1		0.7		
Pulmonology	0.2	0.7		0.5		
Radiation Oncology	0.0	0.6		0.6		
Rheumatology	1.0	0.4		(0.6)		
Medicine	**17.8**	**15.2**	**0.0**	**(2.6)**		
Psychiatry	**3.5**	**2.9**	**0.0**	**(0.6)**		

Note that the Physician Supply and the Demand do not include APP's

Lifepoint Health

Med Staff Development

Surgery

Affiliated Providers

Adjustment Reasons:
- Demand too low, area can support additional physicians
- Demand too high, area has sufficient physicians
- Service patients outside of area
- Other (please provide notes)

Specialty	PSA Physician Supply	PSA Physician Demand	Demand Adjustment FTE	PSA Net Need	Adjustment Reason	Adjustment Notes
ENT	0.3	1.6		1.4		
Gastroenterology	1.0	1.8		0.8		
General Surgery	3.0	3.8	1	0.8	Area can support additional physician	Needed support for increased ER Call support
Neurosurgery	0.0	0.6		0.6		
Ophthalmology	2.9	2.4		(0.5)		
Orthopedics	2.3	3.1		0.8		
Plastic Surgery	0.1	0.6		0.5		
Thoracic Surgery	0.4	0.4		(0.0)		
Urology	1.4	1.6		0.2		
Vascular Surgery	0.6	0.7		0.0		
Surgical Total	**12.0**	**16.5**	**0.0**	**4.5**		

Note that the Physician Supply and the Demand do not include APP's

Lifepoint Health

THE BOOK

LIFEPOINT
PROJECT QUARTERMASTER

CONEMAUGH MEMORIAL MEDICAL CENTER, CONEMAUGH MINERS MEDICAL CENTER, CONEMAUGH MEYERSDALE MEDICAL CENTER, CONEMAUGH NASON MEDICAL CENTER, OTTUMWA REGIONAL HEALTH CENTER, SOUTHWESTERN MEDICAL CENTER, PALESTINE REGIONAL MEDICAL CENTER, SAGEWEST HEATH CARE – RIVERTON, SAGEWEST HEALTH CARE – LANDER, WESTERN PLAINS MEDICAL COMPLEX

CONFIDENTIAL

Medical Properties Trust

** "ADD CHECK BOXES" BUTTON- FOR USE BY MANAGERS AND UP ONLY

Remove Task

Due Diligence Checklist

Project Name: Project Quartermaster - LifePoint/Quorum
Location(s): Multiple
Date: 1/21/2021

Sign Off

	A. Project Overview		Status - Drop Down	FALSE	Sign Off (Use Button for automatic sign offs)	Additional Notes
A1	Project Summary	Confidential Information Memorandum (CIM), Offering Memorandum, or some other form of project overview.	Approved	☐		
A2	Market Information	Market Study including description of the area in which the project resides and details on competition for the project.	Approved	☐		Includes a strategic overview for each facility or a similar analysis including high level market information. Substitute facilities also provided.
A3	Organizational Chart	Organizational Chart of Lessee(s), Parent Company, & any Affiliates (including Guarantors), dated within the last 6 months.	Approved	☐		
A4	List of Entities	Schedule of entities included in Organizational Chart, including a detailed description of each entity, its members and its purpose.	Approved	☐		Complete.
A5	Sources & Uses	A pro forma of the sources and uses of net transaction proceeds, including all debt that will be paid off as part of the transaction. Additionally, please provide a schedule of all debt instruments that will survive the transaction.	Waived	☐		
A6	Bios	Bios on the Lessee(s) Management Team and Parent Company Management Team.	Waived	☐		
B. Financial Information						
B1	Historical Financials	One year of audited financial statements on the Lessee(s), the parent company, and all entities that consolidate into LifePoint and Quorum (including Guarantors), including audit reports and monthly financials for the prior year and current year-to-date.	Approved	☐		
B2	Statistical Information	Monthly utilization statistics for the prior year for each facility and all entities that consolidate into LifePoint and Quorum including but not limited to Office Visits, Admissions, Discharges, Patient Days, Surgical Volumes, ER Visits, ER Admissions, Adjusted Admissions, Adjusted Discharges, Adjusted Patient Days, Average Length of Stay and Case Mix Index.	Approved	☐		See B1
B3	Pro Forma	A detailed three year operating pro forma (IS, BS, CF) and free cash flow analysis for the project, including all volume, operational, and financial assumptions used in making pro forma. In addition, please provide all qualitative strategic initiatives.	Approved	☐		Qoll from PWC also saved in Financial Information folder.
B4	Historical Cash Collections	Comparison of monthly Historical Cash Collection to Net Revenue for all business segments for the last year.	Approved	☐		
B5	Guarantor Debt (Pro Forma Post Transaction)	Schedule of all Guarantor debt (including any debt guaranteed by the Parent Company).	Approved	☐		LifePoint Health quarterly/annual filings
B6	Debt Agreements for Post Transaction Debt	Copies of agreements for any debt instruments of the Lessee(s), Parent Company, and any Affiliates (including Guarantors) that would survive transaction.	Approved	☐		
B7	Material Defaults	Schedule of any material defaults by Lessee(s) and/or its affiliates (including Guarantors) to any leases or debt instruments.	Approved	☐		N/A
B8	Net Revenue by Payor	Net Revenue by Payor and by operating segment and region for current year.	Approved	☐		Schedule for 2018-2019 YTD
B9	Aging Net A/R	Aging Net Accounts Receivable balances by payor for current year by operating segment and region.	Approved	☐		AR 2017-2019YTD
B10	Aging AP	Aging Accounts Payable balances by vendor for current year.	Approved	☐		
B11	Cost Reports	Schedule of all open cost report years, including outstanding amounts and current status. In addition, NPR's for any settled cost reports for the last five years. MPT may request copies of Cost Reports.	Approved	☐		
B12	Cash Flow Forecasts	Any management dashboards or reports used for tracking weekly or monthly cash flow projections.	Waived	☐		
C. Real Estate						
C1	List of Real Estate	Schedule of all owned and leased real estate by Parcel ID, including Address, Parcel/Tax ID, Lot Size, and Description of Real Estate (Exhibit A).	Approved	☐		
C2	Property Taxes	Current property tax statements.	Approved	☐		Summary provided for Conemaugh. Tax bills provided for other facilities.
C3	Capital Expenditures	Detailed schedule of next three years of budgeted capital expenditures by operating segment and region.	Approved	☐		
C4	Environmental Reports	Copies of any existing Phase I Reports, inclusive of wetlands report and permit (if applicable), pest report, and any Phase II Reports.	Approved	☐		
C5	Property Condition Reports	Copies of any existing Property Condition Reports, inclusive of ADA compliance review.	Approved	☐		
C6	Maps	Hospital campus maps including legend with building names and whether owned or leased.	Not Applicable	☐		
C7	Pictures	If available, high resolution images of facilities used for marketing purposes. If these photos include any patients, please ensure MPT has coverage under all patient releases.	Waived	☐		
C8	Plans & Specs	As-built building plans and specifications. If unavailable, please provide floor plans that include gross square footage. Electronic documents preferred.	Approved	☐		Received floor plans for all facilities.
C9	Warranties	Any building related warranties still in effect.	Approved	☐		

A. Project Overview:			Status - Drop Down	FALSE	Sign Off (Use Button for automatic sign offs)	Additional Notes
D. Contracts & Agreements:						
D1	Physician Contracts & Medical Directorship Agreements	Schedule of all physician contracts and medical directorship agreements including Physician or Group Name, Specialty, Compensation, Start Date, and End Date (Exhibit B). In addition, MPT may request copies of physician contracts and medical directorship agreements.	Approved	12	[redacted]	Contract/ Agreement summary and physician agreements provided.
D2	Payor Agreements	Schedule of all payor agreements including Payor Name, Start Date, End Date, and Termination Clauses (Exhibit C). In addition, MPT may request copies of payor agreements.	Approved	9		See B9
D3	Union Contracts	Schedule of all union contracts including Union Name, Major Terms, Expiration Date, and Termination Clauses (Exhibit D). In addition, MPT may request copies of union contracts.	Approved	12		Union contracts provided for Conemaugh.
D4	Lease Agreements as Lessee	Schedule of all leases in which the seller is a lessee including Lessor, Address, Parcel ID, Rental Rate, and Facility Use (Exhibit E). In addition, MPT may request copies of subleases.	Approved	11		Lease Agreements as Lessee summary, lease agreements, and substitute facilites schedule provided.
D5	Lease Agreements as Lessor	Schedule of all leases in which the seller is a lessor including Lessee, Address, Parcel ID, Rental Rate, and Facility Use (Exhibit F). In addition, MPT may request copies of sublessor agreements.	Approved	6		Rent Rolls and Rent Aging Reports provided.
D6	Joint Venture Agreements	Schedule of all joint venture agreements including Joint Venture Party, Ownership Percentages, and Description of the Agreement (Exhibit G). In addition, MPT may request copies of joint venture agreements.	Approved	9		Joint Venture agreements provided.
D7	Hospital Management Agreement	If applicable, copy of hospital management agreement(s).	Approved	12		N/A for Ottumwa and Southwestern. Others saved in folder.
D8	Management Agreements	Schedule of all management agreements held by the Parent Company including Managed Facility, Compensation, Start Date, and End Date (Exhibit H).	Approved	12		
D9	Other Material Contracts	Schedule of all other material contracts of Lessee, including maintenance contracts, service contracts, equipment leases, IT agreements, and any other material contracts. Schedule should include Name of Contracted Party, Description of Agreement, Compensation, Start Date, and End Date (Exhibit I). In addition, MPT may request copies of material contracts.	Approved	6		
E. Operations; Items						
E1	Accreditations	Certificates from any hospital accreditation bodies including TJC, DNV, HFAP, and any others.	Approved	12		MPT confirmed internally.
E2	Compliance Plans	Copies of all regulatory compliance plans in accordance with applicable accreditation and licensing requirements.	Waived	6		
E3	Billing & Reimbursement	Overview of revenue cycle including all billing and reimbursement practices.	Waived	6		
E4	Medical Staff Peer Reviews	Summary of pending peer review or utilization review committee actions or investigations involving active members of the medical staff.	Waived	12		
E5	Employee Handbook	Copy of currently effective employee handbook/guidelines.	Waived	12		
F. Regulatory						
F1	Licenses	Schedule of all licenses and governmental authorizations required in connection with the operation of each property. Please provide a copy of the most recent state Hospital License and include Statements of Deficiencies and Plans of Corrections, if applicable.	Approved	12		
F2	CON	If applicable, Certificate of Need application and approval.	Approved	12		N/A for all except Ottumwa.
F3	Material Litigation	Description of any material Lessee and/or Guarantor litigation or other legal or regulatory proceedings.	Approved	12		Litigation Matters summary provided.
F4	Government Approvals	Any approvals or documentation, which were sent to or received from any governmental agencies, as required in connection with the operation of the hospital.	Approved	12		None.
F5	Government Correspondence	Any correspondence, including letters, subpoenas, notices or any other form of communication including conversations, from or with any government agency including the Center for Medicare and Medicaid Services, the U.S. Attorney's Office, the Department of Justice, federal, state, intermediary or carrier fraud units, the Office of Inspector General, peer review organizations and/or state licensure and certification agencies.	Approved	6		

Medical Properties Trust

August 2, 2019

[redacted]

Via email: [redacted]

Dear [redacted]

MPT is pleased to submit this non-binding proposal to accompany our markup of the Term Sheet outlining the general terms of a possible transaction between affiliates of MPT Operating Partnership, L.P. ("MPT") and affiliates of LifePoint Health, Inc. ("LifePoint") with regard to the acquisition and leaseback of LifePoint's 20 existing hospitals listed in Schedule B-1 of the term sheet (the "Lima Property Portfolio", "Lima" or the "Hospitals").

Subject to our discretionary diligence, MPT Board approval, and completion of definitive legal documentation, MPT expects to acquire from and lease back to Prospect all of the real estate interests (including land and all improvements located thereon, collectively, the "Real Estate") in the Hospitals on terms described in Schedule B-1 of the Term Sheet. Our proposal reflects the following assumptions:

- Initial purchase price of [$750,000,000]
- Lima Pro Forma Adjusted EBITDAR of $150,000,000
- Initial annual rent of $56,250,000, based on an initial lease rate of 7.50%
- Annual rent escalations based on CPI, with a floor of [2.0]% and a ceiling of [4.0]%
- Lease and fixed charge covenants to be determined
- Minimum 20-year initial lease term with four, five-year renewal options

We understand that as a part of our preliminary, non-binding proposal, you have requested certain information about MPT and our process that we have provided below.

Description of Acquirer: MPT is a publicly-traded (NYSE: MPW), self-advised real estate investment trust formed to acquire and develop net-leased hospital facilities. With assets of more than $12 billion [and an equity market capitalization of $7.9 billion], MPT is the world's premier capital provider to hospitals. Our portfolio is comprised of over 320 hospitals throughout the United States, Germany, Italy, Spain, Switzerland, the United Kingdom, and Australia. Our management team consists of people with hospital experience who have worked in virtually all parts of hospital operations, finance, development, and ownership. MPT is confident that our unique experience in the hospital business will minimize the delays and disruption that might otherwise result from a prospective buyer's investigations of LifePoint, Quorum and the Hospitals. Recent acquisitions include:

- $1.55 billion acquisition of 16 Prospect Hospitals

Medical Properties Trust, Inc.
1000 Urban Center Drive, Suite 501, Birmingham, Alabama 35242
205.969.3755, Fax 205.969.3756, www.medicalpropertiestrust.com

- **$145 million acquisition of 7 Saint Luke's Community Hospitals**
- $282.5 million investment in Infracore SA, a Swiss healthcare real estate company
- $45 million acquisition of BMI Harbour Hospital in Poole, England
- $906 million acquisition of 11 Healthscope Hospitals in Australia

Financing: At present, MPT has more than [$1.0 billion of cash on hand in addition to $1.3 billion of immediately available cash under our revolving credit facility, and a substantial history of being able to access capital markets for multiple $1.0 billion-plus transactions.] **There will be no financing condition or contingency related to any offer that MPT makes.**

Conditions / Approvals: Entering into a binding transaction will be conditioned upon completion of satisfactory and customary due diligence detailed below and the negotiation and execution of all necessary definitive documentation for the transaction on terms satisfactory to MPT, in its sole discretion. Prior to the signing of definitive legal documents, the transaction would require the approval of MPT's board of directors, the final internal and only other approval necessary. We are not aware of any other external approvals or filings that would be required by us to consummate a transaction. However, national, state and/or local governmental agencies or regulators may have requirements related to the transaction including but not limited to the need for notification of the purchase of the Portfolio. We would work with LifePoint's management team to facilitate the meeting of these requirements. Given our experience in acquiring assets and portfolios of assets, we do not foresee any difficulties in this process. The timeframe necessary for obtaining board approval would be simultaneous the timetable described below.

Due Diligence: As the global leaders in hospital real estate finance, our underwriting team does not need to be educated about the business of operating hospitals. Our diligence requirements will generally consist of the following:

- Meeting Apollo, LifePoint and Quorum's senior management team in New York and Tennessee; our people will be well prepared to discuss Lima's strategies, operations and future plans and forecasts
- Site visits to major facilities, including tours and access to local hospital management and physicians
- In-depth review of individual facility and parent level historical and projected financials (along with review of KPIs, volume trends, etc.)
- Analysis of future capex requirements
- Individual market reviews, including local competition and bed need analyses
- Technical real estate due diligence (property condition reports, phase 1 environmental, title and survey)
- Legal review of material contracts
- Other confirmatory real estate and legal items

Timing: The majority of our team comes from a healthcare operating background, which makes us much more efficient than less-experienced purchasers when it comes to hospital due diligence and underwriting. This translates to a shorter due diligence timeframe, a faster and more certain closing, and fewer distractions for management. We have unmatched expertise regarding the economic, tax, legal, governance and regulatory challenges that may affect the execution of a large hospital real

estate transaction. We have closed similarly sized portfolio transactions in the recent past with comprehensive diligence processes in less than 45 days. We foresee no impediment to achieving the same outcome with the Lima Property Portfolio.

Based on more than 15 years of experience in underwriting and closing more than 300 hospital transactions, we believe that absent unforeseen and unusual circumstances, we would meet the following timetable:

1. Completion of diligence and affirmative confirmation to LifePoint of any impact on MPT's valuation or willingness to complete the transaction…[15] days from LifePoint's instruction to commence.

2. Site visits, facility and parent financial review and market reviews…[45] days from LifePoint's instruction to commence and provision of materials; can be performed concurrently with item 1 above.

3. Technical real estate reviews…as soon as possible after ordering from consultants. MPT will accept updated reports if reasonably recent prior reports are available from LifePoint. Estimate [30] days from LifePoint's instruction to commence and provision of materials; can be performed concurrently with items 1 and 2 above.

4. Legal review and other…[45] days from LifePoint's instruction to commence and provision of materials; can be performed concurrently with items 1, 2 and 3 above.

5. Completion of fully negotiated definitive documentation (primarily Purchase and Sale Agreement, Master Lease Agreement, and other related transaction documents)… [45] days from LifePoint's instruction to commence and provision of materials; can be performed concurrently all other diligence processes.

Advisors: *See Attachment I – **MPT Working Group**.* At this point we have not engaged any third party advisors and do not expect to need to do so for this transaction. The majority of our diligence will be completed utilizing in-house resources and our outside counsel, Baker Donelson, who has advised us on almost every U.S. hospital acquisition we have completed. We would utilize our outside corporate counsel Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C. for legal services as part of our proposed transaction. However, rest assured your primary contact throughout this transaction will be MPT personnel including our CEO, Ed Aldag, CFO, Steve Hamner, and our COO, Emmett McLean. Primary points of contact will be Justin Bass and Harrison Hyde.

Other Factors: We believe that this indication of interest provides all the information necessary for LifePoint to evaluate our proposal. However, we would welcome the opportunity to present our proposal in person or to answer any questions that may arise.

If the provisions described in this letter are satisfactory to you, we would begin our diligence procedures immediately, along with simultaneously drafting definitive agreements. Accordingly, we believe this transaction can be closed within [60] days.

Although this non-binding proposal sets forth some of the principal terms of our proposal for Prospect, it does not include all of the representations, warranties, defaults, definitions, covenants (affirmative and negative) and other terms which will be contained in the definitive documents for the transaction. Moreover, this non-binding proposal creates no obligation or right of any party with respect to any other party.

Please do not hesitate to contact me with any questions.

Regards,

R. Steven Hamner
Executive Vice President & CFO

CC: Edward K. Aldag, Jr.
Emmett E. McLean

Medical Properties Trust, Inc.
1000 Urban Center Drive, Suite 501, Birmingham, Alabama 35242
205.969.3755, Fax 205.969.3756, www.medicalpropertiestrust.com

Attachment I – MPT Working Group
Project Quartermaster
August 2, 2019

Role	First Name	Last Name	Title	Telephone	Email
Executive	Steve	Hamner	EVP & CFO	[redacted]	[redacted]

Medical Properties Trust, Inc.
1000 Urban Center Drive, Suite 501, Birmingham, Alabama 35242
205.969.3755, Fax 205.969.3756, www.medicalpropertiestrust.com

MPT UW Site Visit Summaries

Conemaugh Health System (4 facilities) - Johnstown, Pennsylvania (2019E Adj. EBITDARM: $55M)

- Site Visit Date: 8/28/2019
- [redacted]
- 4 hospital health system in Johnstown, PA (population approx. 58,000) that is a member of Duke LifePoint Healthcare.
- The 537-bed Conemaugh Memorial Medical Center flagship campus' main structure was built in 1924. Multiple additions over time have created inefficiencies and a lack of cohesiveness between units and buildings.
    - Planned 2020 construction of an $82M "D Building" in the center of existing structures is expected to create a more patient friendly experience at the hospital as well as improve hospital operational efficiency. We are confirming whether or not this CapEx is included in their cash projections.
- 3 remaining hospitals serve as rural access points to the system in the primary service area of the main hospital. While they are a benefit and referral source to the main campus, they are essentially breakeven.
    - Meyersdale campus is currently designated a Critical Access Hospital and Conemaugh is awaiting a decision regarding CAH designation for the Minors campus.
- Conemaugh continues to evaluate needs and growth opportunities in their service area. Currently, they are building two large outpatient service clinics.
- Both major payors own and operate the main competitors of the Conemaugh system.
    - UPMC: Nearest hospital to Conemaugh Memorial located in Somerset, PA joined UPMC in February 2019.
    - Allegheny Health System: Purchased by Highmark (Blue Cross) in 2013.

Palestine Regional Medical Center in Palestine, TX (2019B Adj. EBITDARM $16M)

- Site Visit Date: 9/23/2019
- [redacted]
- In 2000 two hospitals that were both built in the late 1980s merged creating Palestine Regional. As such, there are two campuses located approximately one mile from one another.
    - Main Campus: General Acute Care
    - Secondary Campus: Behavioral Health Hospital
- Main competitors (CHRISTUS Mother Frances and UT Health East which is partially owned by Ardent) are located one hour northeast in Tyler, TX. There are several Critical Access Hospitals to the East and South of the hospital.
- In 2017 CHRISTUS Mother Frances purchased the city's large, independent primary care practice (20+ providers). This caused a major issue for Palestine

Regional as they had to build their primary care network from scratch. CHRISTUS also built a nice and large Urgent Care almost directly across from the hospital.

- Management is working to build their specialty network in order to capture market share that has declined over time due to the primary care purchase mentioned above coupled with an 18 month interim-CEO. (2015 IP Market Share of 48% to 38% in 2018)
- Palestine contracts with five nearby prisons that house 15,000 prisoners. As such, Palestine has a significant number of prisoners who visit their ER. The 14 bay ER sees 32,000 visits per year and is very busy. Each prisoner patient requires at least two guards which likely contributes to a public image challenge as there is not a segregated area for this population.
- Currently, the Behavioral Health Campus has 20 beds that are part of the state's Forensic Unit. The Forensic Unit is used to treat patients so that they can stand trial and the ALOS is 120 days. The hospital is reimbursed $550/bed/day regardless of utilization. They are in the final approval stages for a new two year contract for 24 additional beds. This will require a $4.2M renovation and take approximately 8 to 9 months to complete, but is expected to generate an additional $2.0M to $2.5M in EBITDA for the hospital.

SageWest Healthcare - 2 facilities in Lander and Riverton, WY (2019B Adj. EBITDARM $15M)

- Site Visit Date: 9/17/2019
- [redacted]
- Facilities are located approximately 30 minutes from one another and share many resources including administration, medical staff, and nurses.
- While Riverton is a full-service General Acute hospital, much of the higher acuity volume and surgeries go to Lander. Generally, Riverton ADC is 5 and Lander is 15.
- The Hospital/Community relationship has become strained over the years. This has been driven by the following:
    - Community perception is that the hospital is closing services: OB and ENT services were consolidated from Riverton to Lander and Adult Psych Unit was closed due to changes in reimbursement and investment to comply with anti-ligature requirements.
    - Hospital often transfers patients out and is on track for nearly 1,000 transfers in FY2019. Budgeted admissions for 2019 are approximately 2,500.
    - SageWest is one of the largest employers in the area and had a 40% turnover rate in 2018.
- As a result, a group of community members has come together to explore the feasibility of building a new not-for-profit hospital in Riverton. The feasibility study has not yet been released, but LifePoint believes it is not economically feasible.

- The county is home to two large Indian Nations (Eastern Shoshone and Northern Arapaho) and a large portion of the county's population is a member of these tribes. There are two Outpatient clinics located on the shared reservation, but no separate hospital.
- Wyoming is not a medicaid expansion state and the economy is driven by coal, oil and gas which have shown signs of slow down recently. Unemployment in the PSA is 9.8% which is much higher than the state or national average.
- The hospital has recently hired a Cardiologist and is in the process of getting approvals to put in a mobile, but attached Cath Lab. They expect to be opened by the end of 2019 and are projecting 150+ cases the first year.

Western Plains Medical Complex - Dodge City, KS (2019E Adj. EBITDARM: $10M)

- Site Visit Date: 8/29/2019
- [redacted]
- Rural farming and meat processing community. Two major meat processors employ 8,900 people which provides for a relatively strong commercial payor mix and potential for direct contracting.
- Earlier in August 2019, the local Tyson plant which employs over 3,500 burned down. Although they have announced that they will rebuild, it is not clear how long that could take.
- Leadership long neglected recruiting needs, but efforts have recently ramped up due to a CEO change who has had some success.
- CEO believes that they can recruit physicians and likely maintain the status quo. However, he is focused on an affiliation or partnership with Kansas University and believes this would greatly benefit the community and hospital's bottom line. CEO is in the very early beginnings of discussions with KU, this could take some time, and benefits are not yet known.
- Overall, UW would expect this facility to maintain the status quo, but unless a rich affiliation with KU is established we do not expect significant growth.

Ottumwa Regional Health Center - Ottumwa, Iowa (2019E Adj. EBITDARM: $8M)

- Site Visit Date: 8/29/2019
- [redacted]
- 120-bed hospital located in Wapello County, which includes approximately 33% more Medicaid eligible lives than the remainder of Iowa.
    - Facility is the only for-profit hospital in Iowa.
    - An aging local population remains stable and below the poverty line. The hospital is the 3rd largest employer in the community.
- Ottumwa Regional lacks any negotiating power with commercial contracts due to the size of the Iowa market as a whole.
- Overall, UW would expect this facility to maintain the status quo.

MEDICAL PROPERTIES TRUST

Project Quartermaster Underwriting Report

April 2, 2020

Table of Contents

Executive Summary

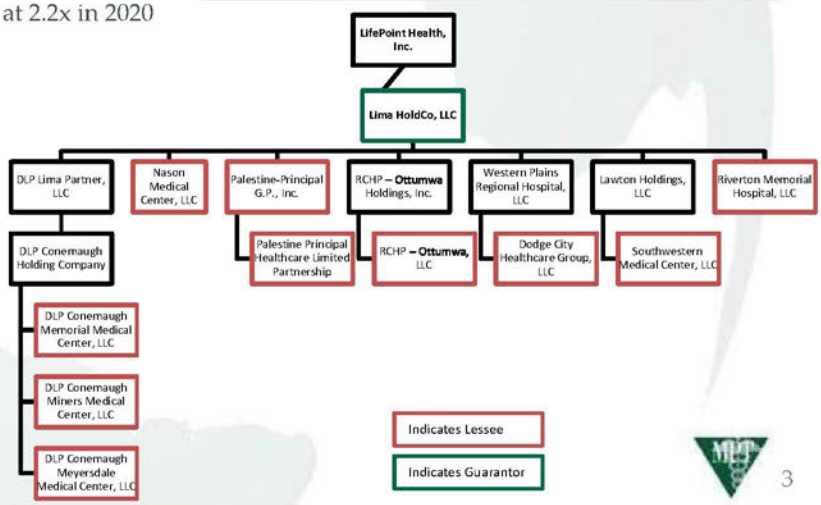
Project Overview

- Transaction includes the sale-leaseback of ten existing, high quality LifePoint Facilities.
    - Six geographically diverse markets across six states including Iowa which is new to the MPT Portfolio.
    - Hospitals are needed in the community; often the largest employer and economic driver.
    - Each system has a #1 or #2 market share.
- LifePoint will continue to operate the facilities post transaction.
- Projected Adj. EBITDARM portfolio coverage is strong at 2.2x in 2020 and 2021.

Total Investment	$700M
Beds	1,449
Square Feet	3,753,200
States	Six (one new to MPT)
Initial Annual Rent	$50.75M
Cap Rate	7.25%
Annual Escalator	CPI (2% floor, 4% cap)
Lease Term	20 Years
Lease Extensions	Two-five year options.
LOC	$8.5M
Guarantor	Lima HoldCo, LLC

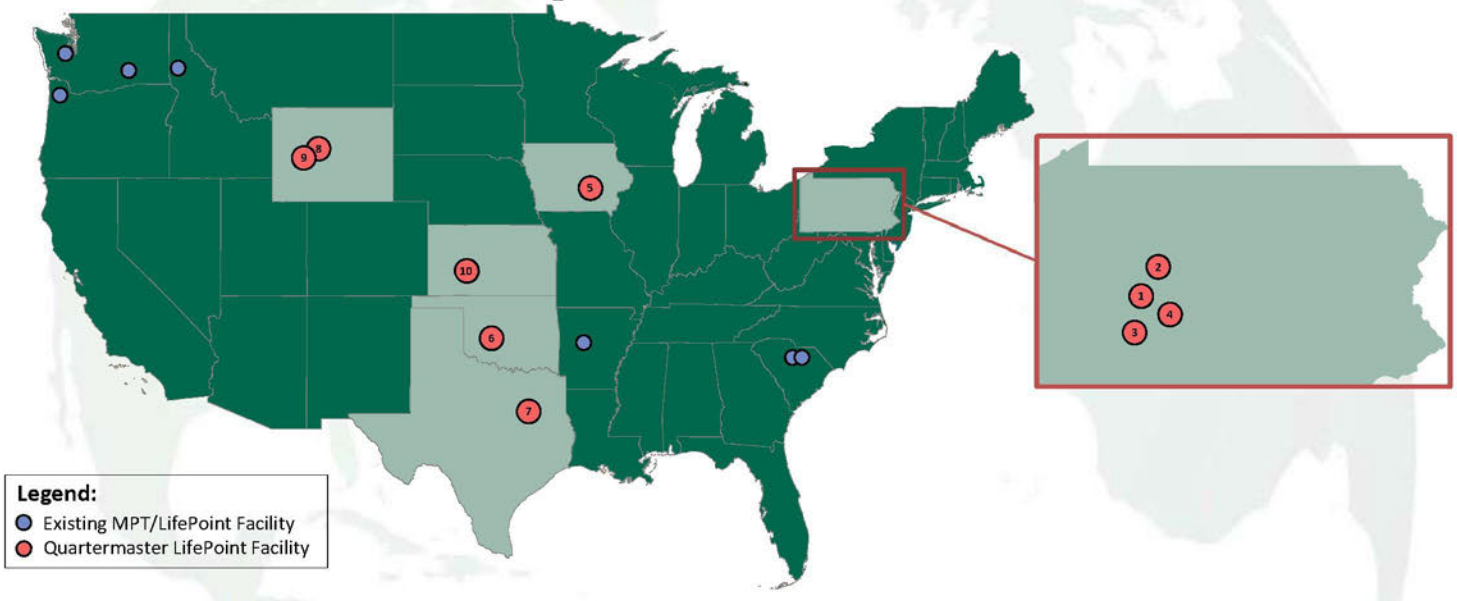
Lima HoldCo as Guarantor

- As noted in the chart to the right, Lima HoldCo, LLC is the guarantor entity for the Project Quartermaster Master Lease
- Lima HoldCo, LLC is a direct subsidiary of LifePoint Health, Inc.



Project Quartermaster Hospitals Overview

Portfolio Overview – 10 Hospitals in 6 States



Facility	Location	Beds	Investment (M)	Brief Overview
1 Conemaugh Memorial Medical Center	Johnstown, PA	537	$295.0	Four hospital health system anchored by the main campus (Conemaugh Memorial Medical Center) and supported by three hospital access points as well as multiple outpatient centers in the surrounding communities. The main campus includes a Level I trauma center and is affiliated with the Duke LifePoint system. The system is the market leader in Central Pennsylvania.
2 Conemaugh Miners Medical Center	Hastings, PA	30	$10.7	
3 Conemaugh Meyersdale Medical Center	Meyersdale, PA	20	$5.3	
4 Conemaugh Nason Medical Center	Roaring Spring, PA	45	$12.7	
5 Ottumwa Regional Health Center	Ottumwa, IA	217	$57.0	Rural hospital focused on partnering with and serving the local agricultural industry.
6 Southwestern Medical Center	Lawton, OK	199	$73.2	Hospital with acute and behavioral campuses focused on meeting the needs of US Army Post Fort Sill.
7 Palestine Regional Medical Center	Palestine, TX	156	$106.1	Two campus hospital providing acute care and behavioral services to the community and nearby prisons.
8 SageWest Health Care – **Riverton**	**Riverton,** WY	70	$33.8	Rural hospital system with two campuses approximately 30 minutes apart. Higher acuity volume and surgeries are performed at Lander. Local economy defined by coal, oil, gas, and two Indian Nations.
9 SageWest Health Care – **Lander**	**Lander,** WY	76	$47.6	
10 Western Plains Medical Complex	Dodge City, KS	99	$58.6	Rural hospital driven by the meat processing industry.
Total Portfolio		**1,449**	**$700M**	

LifePoint Overview

LifePoint History

- RegionalCare and Capella merged in 2016, forming RCCH Healthcare. In late 2018, a merger between RCCH Healthcare and LifePoint Health was completed.
    - To fund the merger, Apollo Funds and certain other co-investors indirectly contributed $1.0B of newly invested capital.
- Post merger, LifePoint now operates 89 hospital campuses (12,000+ beds) in 30 states and is one of the largest for-profit acute care hospital providers in the U.S.
    - LifePoint is the sole community healthcare provider in the majority of communities it serves.
    - Through strong clinical partnerships with leading academic institutions, LifePoint operates facilities that consistently provide quality healthcare.

Leadership Team

David M. Dill
President & CEO

Mr. Dill joined LifePoint in 2007 as executive vice president and CFO before assuming his current role in 2009. During Mr. **Dill's** time as CEO, LifePoint has grown to a $6B revenue company with 89 hospital campuses.

Michael S. Coggin
Executive VP & CFO

Mr. Coggin joined LifePoint in 2008 and has previously served as senior vice president and chief accounting officer. Mr. Coggin is responsible for the **company's** external financial reporting, corporate accounting and consolidation functions.

Victor E. Giovanetti
Executive VP, Hospital Operations

Mr. Giovanetti provides operational oversight for **LifePoint's** four hospital divisions, as well as quality and clinic operations. Mr. Giovanetti joined LifePoint in 2013 as COO for the Eastern Group, before becoming Western Group president in 2015.

Rob Jay
Executive VP, Integrated Operations

Mr. Jay oversees integration, physician services, post-acute service and managed care and payor transformation for LifePoint. Mr. Jay served as executive VP and COO for RCCH prior to joining LifePoint.

Quartermaster Hospital Portfolio Analysis

Financial Performance

Quartermaster Consolidated	2017	2018	2019E	2020E	2021E
in Millions					
Net Revenue	$911	$893	$936	$957	$979
Total Operating Expenses	816	784	810	825	844
Adj. EBITDARM	**$95**	**$109**	**$125**	**$131**	**$134**
Adj. EBITDAR(1)	**$77**	**$92**	**$107**	**$112**	**$115**
Rent(2)	51	51	51	51	52
CapEx	65	79	44	51	51
Free Cash Flow	**($39)**	**($38)**	**$12**	**$11**	**$12**

(1) Management Fee equal to 2% of Net Revenue
(2) MPT Year 1 rent used for 2017-2020

- Historical Adjusted EBITDAR growth driven by consistent rate growth and margin uplift
- Near-term EBITDAR is projected to grow through 2020 driven by a few discreet factors:
  - Maturation of recent in-market investments
  - Ramp of recently hired physicians
  - Opening of new specialty service lines
- Capital Expenditures are forecasted to decline after 2021, driven by the contractual step-down in the annual capital commitment at Conemaugh

Adjusted Admissions

Quartermaster Consolidated	2017	2018	2019E	2020E	2021E
in Thousands					
Conemaugh	57.6	56.5	55.1	54.2	54.4
Palestine Regional	8.3	8.4	8.1	8.5	8.6
Sage West	7.3	6.7	6.9	7.0	7.1
Southwestern	10.7	11.4	12.3	12.6	12.8
Western Plains	4.7	4.8	5.0	5.1	5.1
Ottumwa Regional	11.8	11.2	10.6	10.6	10.6
Total	100.4	99.0	98.1	97.9	98.5

LifePoint Financial Analysis

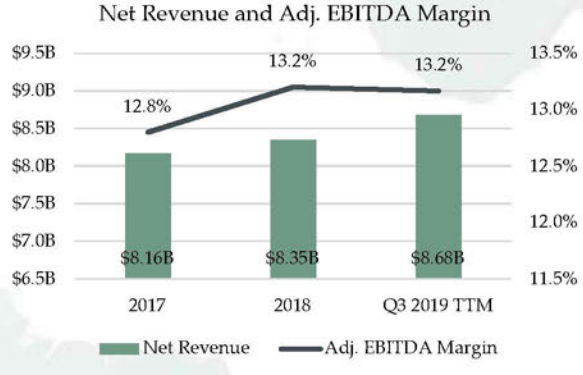
Credit Stats	Q3 2019 (1)	Q2 2019 (1)
T12 Net Rev. ($M)	8,679.5	8,577.7
T12 Adj EBITDA ($M)	1,142.9	1,136.2
EBITDA Margin	13.2%	13.2%
Liquidity ($M)(2)	145.3	42.8
Current Ratio	1.58x	1.59x
Total Assets ($M)	8,985.2	8,930.3
Total Debt ($M)	6,457.9	6,488.8
Debt to Capitalization	0.85x	0.85x

(1) Period includes prorated legacy RCCH Healthcare and legacy LifePoint data.
(2) Liquidity defined as Cash and Cash Equivalents

Debt Analysis ($M)	Q3 2019	Q2 2019
Secured Notes	$800.0	$800.0
Unsecured Notes	1,775.0	1775.0
Financing Leases & Capital Leases	554.8	557.8
Unamortized Debt	(198.5)	(214.3)
ABL Facility	0.0	35.0
Other	3,526.6	3,535.3
Total Debt ($M)	**$6,457.9**	**$6,488.8**

Background Information

- RegionalCare and Capella merged on 4/29/16, forming RCCH Healthcare
  - MPT sold its equity position in Capella as a result of merger
  - As of 9/30/2018, RCCH operated 18 Acute Care Hospitals (2,787 beds) in 12 states
- RCCH merged into LifePoint on 11/16/2018
  - To fund the merger, Apollo Funds and certain other co-investors indirectly contributed $1.0B of newly invested capital
- Post merger, LifePoint now operates 89 hospital campuses (12,000+ beds) in 30 states



Risk Factors

Concentration of EBITDA at Conemaugh

- The Conemaugh Health System accounted for $57M (52.3%) of the $109M Total Portfolio adjusted EBITDARM in 2018. A decline in performance at Conemaugh would have a significant impact on rent coverage for the entire portfolio.

Aging Facilities

- The newest facility, Palestine Regional Medical Center, was built in 1988 and the oldest and largest facility, Conemaugh Memorial, was first constructed in 1924. The expense of upkeep and significant renovations could put a strain on free cash flow.
- Patients in rural areas have shown a willingness to travel for healthcare. Aging LifePoint facilities may lose market share to competitors with newer facilities, even though the LifePoint facilities are more convenient.

PSA Population Decline

- Four of the six markets are projecting little to no population growth or even population decline in the next few years.
- Most of the competing facilities are located outside of the Quartermaster **facilities'** PSAs. However, the **competition's** market share will increase as the population moves out of these rural communities into either neighboring communities or larger population centers where competitors are located.
- Physician and staff recruitment may pose a challenge in these shrinking communities.

Decline in Rural Hospitals

- Rural hospitals across the country have been struggling recently, with many turning to critical access status to remain open. Strategic growth initiatives at the Quartermaster facilities will be vital to the long term viability of these facilities.

Third Party Report Summary

Phase I Reports

Per MPT Executive direction, no additional Phase I reports were commissioned. Existing report notes are outlined below:

- **Conemaugh Memorial Medical Center**
  - Multiple Phase I Reports were conducted on site from 6/12/ 2014 – **7/30/2014.**
- **Palestine Regional**
  - No environmental reports available.
- **Sage West**
  - No environmental reports available.
- **Southwestern Medical Center**
  - Multiple Phase I Reports were conducted on 9/29/2005.
- **Western Plains Medical Complex**
  - No environmental reports available.
- **Ottumwa Regional**
  - No environmental reports available.

Property Condition Reports (PCRs)

Per MPT Executive direction, no PCRs were commissioned. Kemp Management was retained to perform site assessments for all locations except Southwestern Medical Center, which MPT previously owned. Kemp Management noted that their recommended repairs were included within **LifePoint's** CapEx plans as summarized below.

(in 000s)	2019	2020	2021	2022	2023	Total
Conemaugh	$4,699.3	$2,965.1	$679.4	$686.0	$8.5	**$9,038.3**
Palestine	1,065.9	717.5	546.0	96.0	96.0	**$2,521.4**
SageWest	3,026.6	2,439.3	668.0	75.0	22.5	**$6,231.4**
Western Plains	812.4	155.0	134.0	170.0	125.0	**$1,396.4**
Ottumwa	1,119.3	879.7	125.0	-	-	**$2,124.0**
Total	**$10,723.5**	**$7,156.6**	**$2,152.4**	**$1,027.0**	**$252.0**	**$21,311.5**

Exhibit 1: Facility Summaries

Conemaugh Health System

Overview

- Conemaugh Health System is a four hospital health system in Johnstown, Pennsylvania that is affiliated with the Duke LifePoint system and is a member of the Duke LifePoint joint venture.
- The 537-**bed Conemaugh Memorial Medical Center flagship campus'** main structure was built in 1924. Multiple additions over time have created inefficiencies and a lack of cohesiveness between units and buildings.
- Three remaining hospitals (Nason, Meyersdale and Miners) and multiple outpatient centers serve as rural access points for the system in the primary service area of the main hospital.

Key Stats

2018 Admissions	18,701
2018 ED Visits	53,527

Conemaugh Memorial Medical Center – **Main** Campus

Conemaugh Memorial Medical Center – **Lee** Campus

Market Leader in Central Pennsylvania

- The Conemaugh system maintains 67% of the market share due to the geographic isolation of Johnstown. The flagship hospital is a Level I trauma center and has a variety of specialties which are referred from an extensive employed physician group.
- Both major payors own and operate the main competitors of the Conemaugh system.
  - The nearest hospital to Conemaugh Memorial is located in Somerset, PA and joined the UPMC network in February 2019. Conemaugh has plans for an additional outpatient center in Somerset to avoid losing market share.
  - The Allegheny Health System was purchased by Highmark (Blue Cross) in 2013.

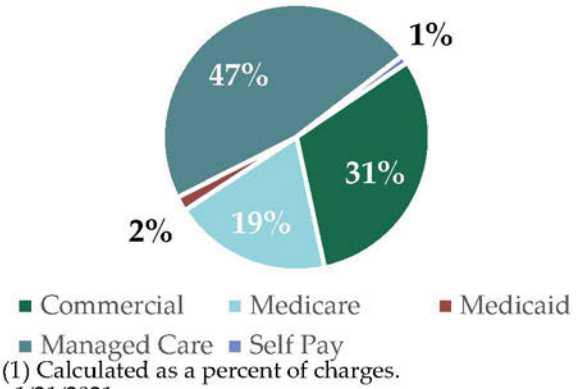
Strategic Growth through Access Points

- Projected growth of the system expected to be driven by:
  - Trauma designations at Meyersdale, Miners, Nason and improved cardiology volume at Nason from the recently renovated cath lab.
  - The existing East Hills outpatient center and the planned Somerset outpatient center and Ebensburg outpatient center (expected opening December 2019) to serve as additional access points throughout the market.

Building D Construction to Improve Efficiency

- Due to the multiple additions throughout its life, Conemaugh Memorial is inefficient and segmented. The proposed solution to the segmented hospital is an addition at the center of campus.
- The $82M Building D project is expected to break ground in 2020.

2018 Payor Mix(1)



(1) Calculated as a percent of charges.
1/21/2021

Financial Summary

in Millions	2017	2018	2019E	2020E	2021E
Net Revenue	$550	$538	$565	$571	$584
Adj. EBITDARM	$41	$57	$64	$66	$68
Adj. EBITDAR(1)	$30	$46	$53	$55	$56
Rent(2)	$23	$23	$23	$23	$24
CapEx	$56	$70	$38	$41	$44
Free Cash Flow	($50)	($48)	($9)	($9)	($11)

(1) Management fee equal to 2% of Net Revenues.
(2) MPT Year 1 rent used for 2017-2020.

Conemaugh (4 facilities)

Overview

Conemaugh Health System includes 4 hospitals and 4 outpatient clinics in and around Johnstown, PA. All hospitals are members of Duke LifePoint Healthcare.

1 Conemaugh Memorial

- *Flagship hospital*
- The most technically sophisticated hospital between Pittsburgh and Hershey and home to the highest level of care designations for Neonatal (Level III) and Trauma (Level I).
- Two campuses in Johnstown, PA (Main and Lee)

2 Conemaugh Meyersdale Medical Center

- 20-bed facility for inpatient and outpatient care
- Designated critical access hospital in Meyersdale, PA, approximately 45 miles from Johnstown.

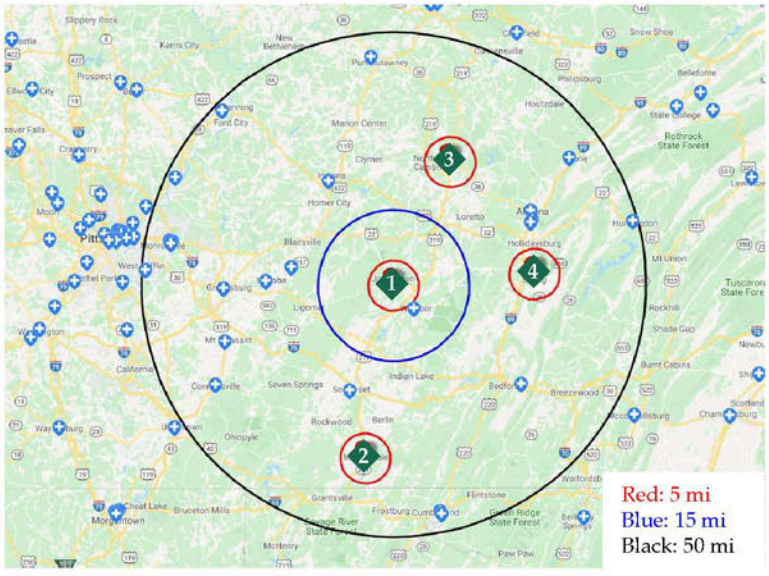
3 Conemaugh Miners Medical Center

- 30-bed facility for inpatient medical, surgical and intensive care services
- Located in Hastings, PA, approximately 37 miles from Johnstown.
- Awaiting critical access designation

4 Conemaugh Nason Medical Center

- 45-bed facility with a recently renovated cath lab expected to drive cardiology volume for the system.
- Located in Roaring Spring, PA, approximately 37 miles from Johnstown.

	Licensed Beds	Square Feet
1 Conemaugh Memorial	537	1,657,962
2 Meyersdale	20	39,651
3 Miners	30	66,660
4 Nason	45	110,222



Conemaugh Memorial Medical Center

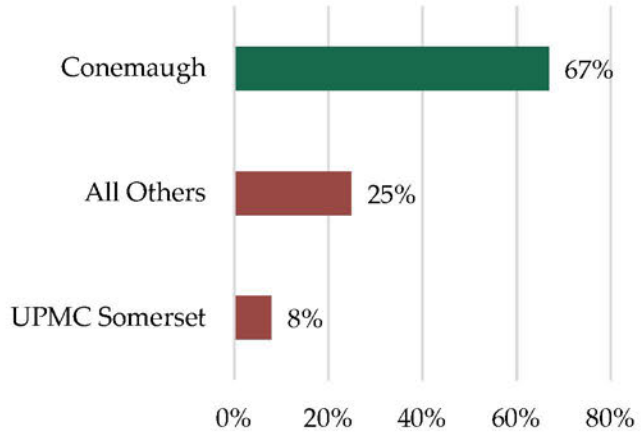
Conemaugh Meyersdale Medical Center

Conemaugh Miners Medical Center

Conemaugh Nason Medical Center

Conemaugh Health System

2018 IP PSA Mkt Share



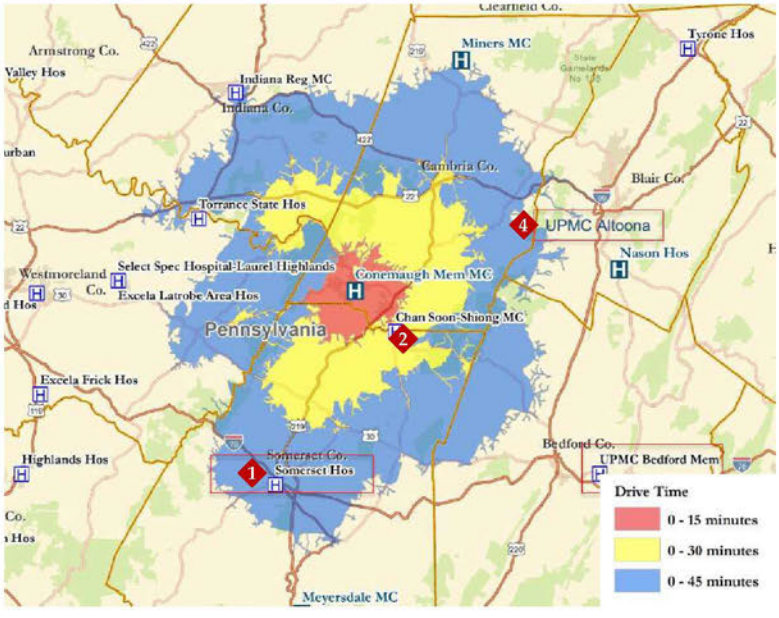
Market Demographics

Modest population growth projected

	5 mile radius	15 mile radius	50 mile radius
2018 Population	60,359	127,694	1,278,179
0-18	18.3%	18.0%	18.2%
19-64	57.9%	58.8%	60.5%
65+	23.8%	23.2%	21.3%
2023 Projection	60,704	128,101	1,282,380
% growth	*0.6%*	*0.3%*	*0.3%*
Median HH Income	$39,453	$43,439	$89,971
At or Below Poverty Level	18%	15%	13%

Competition

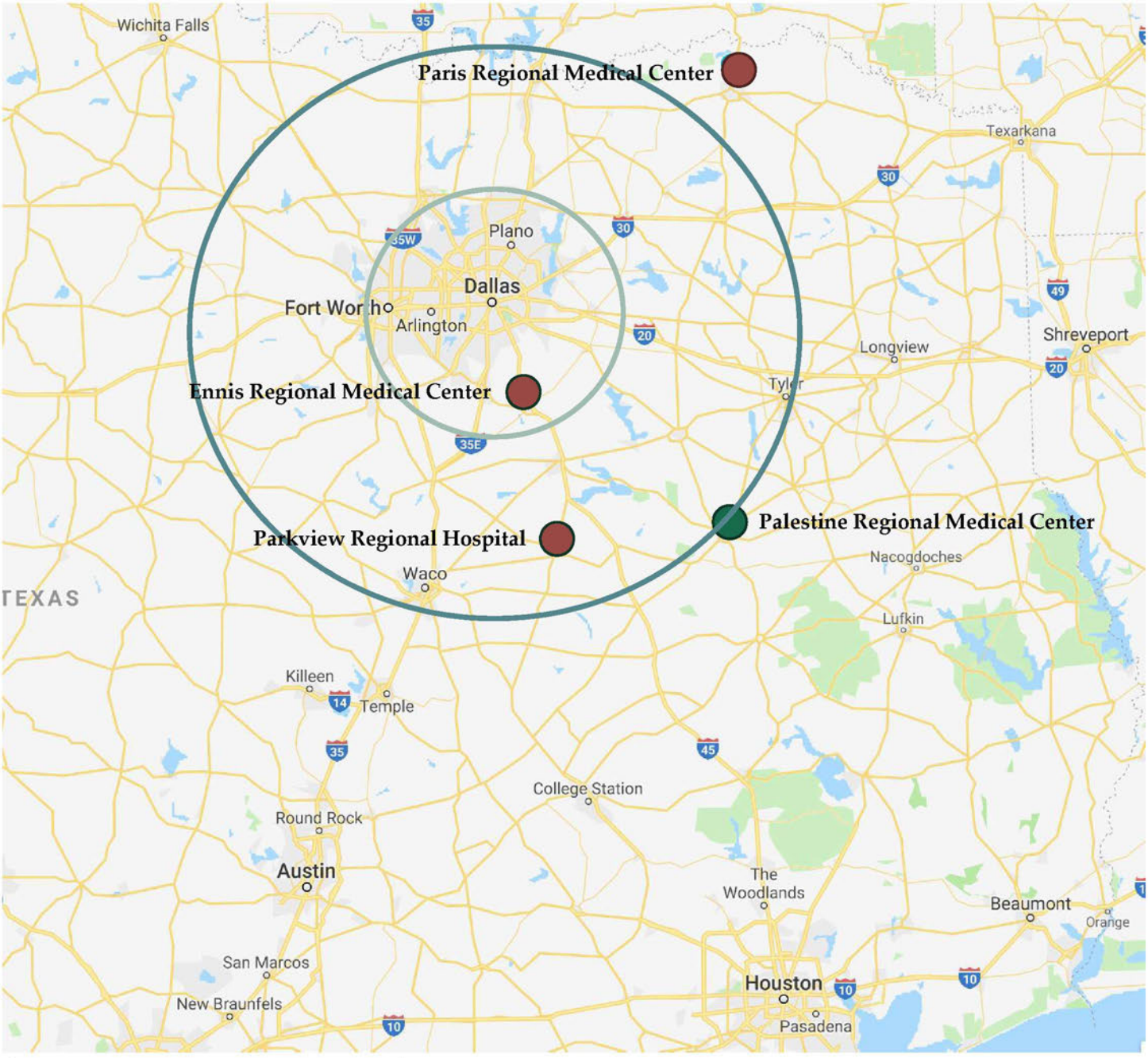
1. UPMC Somerset (UPMC)
   - 118-bed acute care facility located in Somerset, PA
2. Windber Hospital (Chan Soon-Shiong Institute)
   - 50-bed acute care facility located in Windber, PA (65 mile East)
3. UPMC Shadyside (UPMC) (Not listed on map)
   - 520-bed tertiary care hospital located in Pittsburgh, PA
4. UPMC Altoona (UPMC)
   - 380-bed acute care hospital with a surgery and trauma center located in Altoona, PA



UPMC Somerset

Windber Hospital

Texas



Legend:

- NewCo Hospitals
- LifePoint Hospitals (Remaining)
- 50 Miles
- 100 Miles

Palestine Regional Medical Center

Medical Properties Trust

Overview

- In 2000, two hospitals built in the late 1980s merged creating Palestine Regional. As such, there are two hospital campuses located approximately one mile from one another:
  - Main Campus: General Acute Hospital
  - Secondary Campus: Behavioral Health Hospital

Palestine, TX	
Licensed Beds	156
Square Feet	196,950
Year Built	1988
Market Share	#1 in PSA

Key Stats	
2018 Admissions	3,677
2018 ED Visits	30,605

Prison Contracts Help Keep ER Busy

- Palestine contracts with five nearby prisons that house 15,000 prisoners. Therefore, Palestine has a significant number of prisoners who visit their ER. The 14-bay ER sees 32,000 visits per year and is very busy. Each prisoner patient requires at least two guards which contributes to a public image challenge as there is not a segregated area for this population.

Hospital Meeting Behavioral Health Need

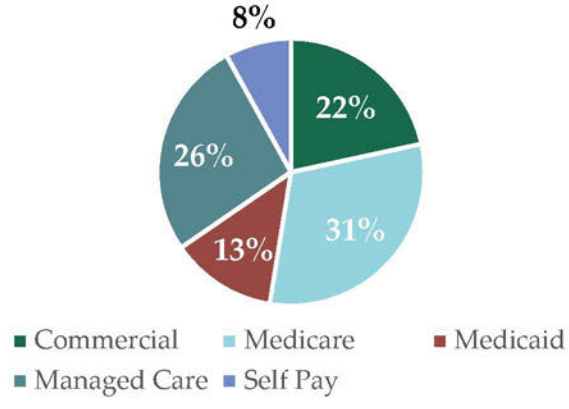
- Currently, the Behavioral Health Hospital has 20 beds that are part of **the state's Forensic Unit. This unit is used to treat patients so that** they can prepare to stand trial. ALOS for the unit is 120 days and the hospital is reimbursed $550/bed/day regardless of utilization.
- Management is in the final approval stages for a two year contract for 24 additional beds. This will require a $4.2M renovation and take approximately 8 to 9 months to complete, but is expected to generate an additional $2.0M to $2.5M in EBITDA for the hospital each year.

Palestine Regional Medical Center

Competition Encroaching from Tyler, Texas

- Main competitors (CHRISTUS Mother Frances and UT Health East which is partially owned by Ardent) are located one hour northeast in Tyler, TX.
- **In 2017 CHRISTUS Mother Frances purchased Palestine's large,** independent primary care practice (20+ providers). This caused a significant challenge for Palestine Regional as they had to rebuild their primary care network from scratch. CHRISTUS also built large, new Urgent Care Center almost directly across from the hospital.
- Management is working to build their specialty network in order to capture market share that has declined over time. This decline has been driven by the primary care purchase mentioned above coupled with an 18 month interim-CEO (2015 IP Market Share of 48% to 38% in 2018).

2018 Payor Mix[1]



(1) Calculated as a percent of charges.

Financial Summary

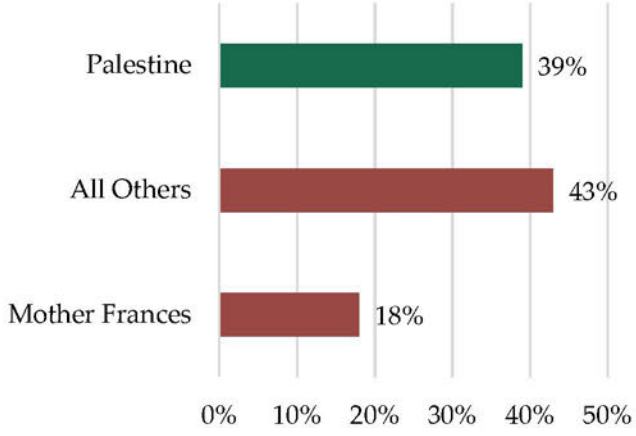
in Millions	2017	2018	2019E	2020E	2021E
Net Revenue	$70	$73	$73	$79	$82
Adj. EBITDARM	$12	$12	$16	$17	$17
Adj. EBITDAR[1]	$10	$11	$14	$15	$16
Rent[2]	$8	$8	$8	$8	$8
CapEx	$2	$1	$1	$6	$2
Free Cash Flow	$1	$2	$5	$2	$6

(1) Management fee equal to 2% of Net Revenues.
(2) MPT Year 1 rent used for 2017-2020.

1/21/2021

Palestine Regional Medical Center

2018 IP PSA Mkt Share



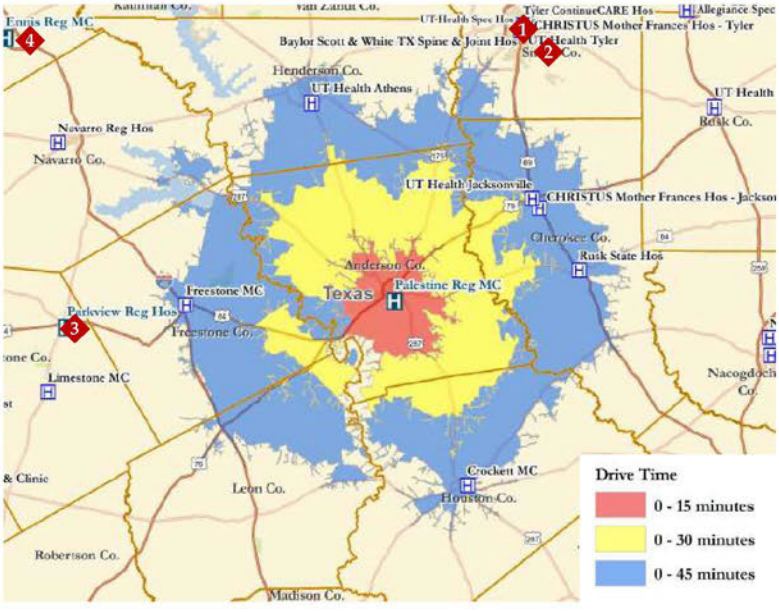
Market Demographics

Modest population growth projected

	5 mile radius	15 mile radius	50 mile radius	75 mile radius
2018 Population	22,161	43,969	450,036	1,150,829
0-18	26.7%	21.5%	23.2%	23.1%
19-64	57.4%	62.9%	59.0%	59.7%
65+	15.9%	15.7%	17.9%	17.2%
2023 Projection	22,521	44,893	466,920	1,194,337
% growth	*1.6%*	*2.1%*	*3.8%*	*3.8%*
Median HH Income	$39,613	$42,448	$47,696	$46,686
At or Below Poverty %	18%	16%	16%	17%

Competition

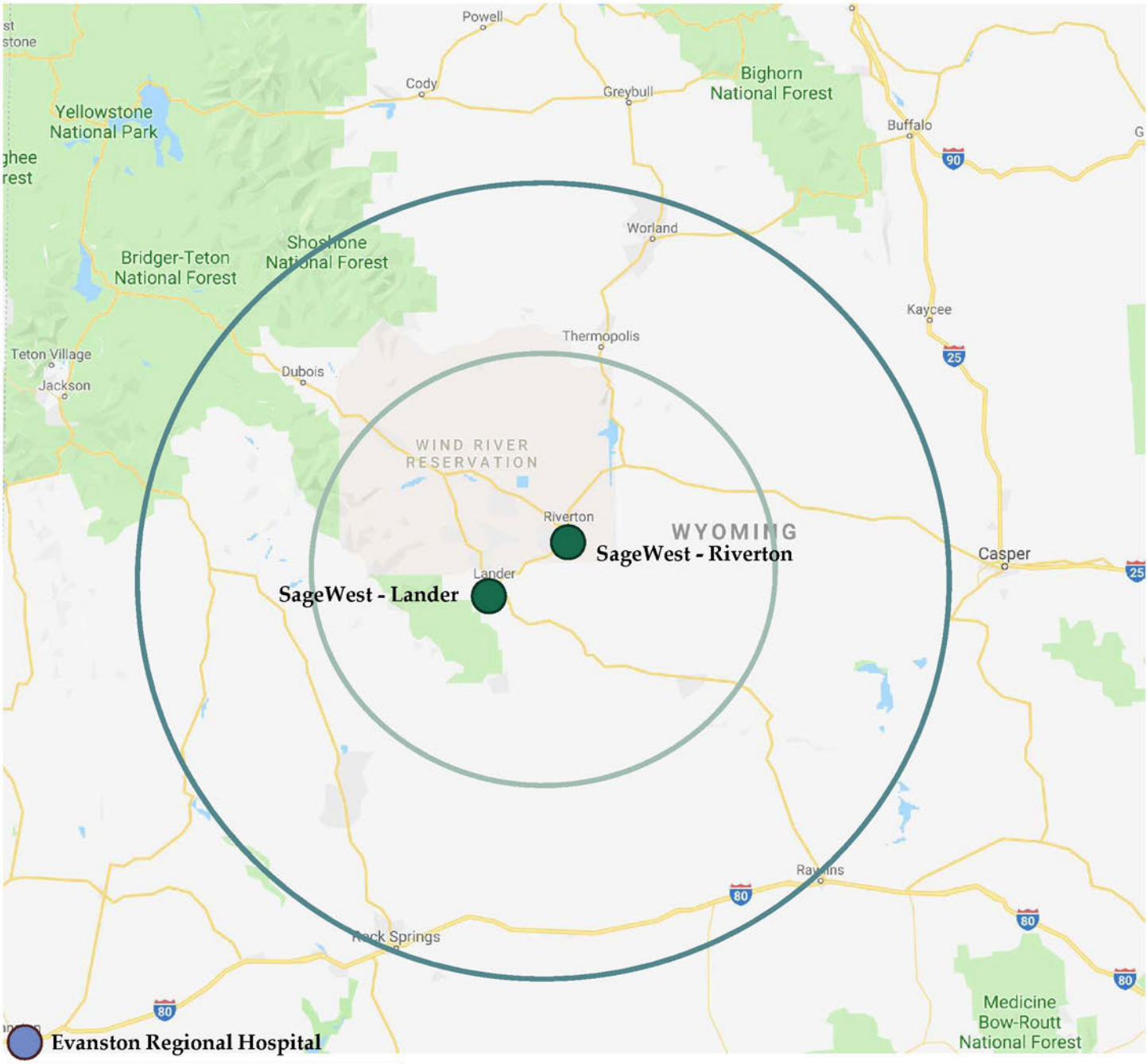
1. **CHRISTUS Mother Frances – Tyler**
   - 457-bed acute care hospital
2. **UT Health East Texas – Tyler (Ardent)**
   - 399-bed acute care hospital
3. Parkview Regional Hospital (LifePoint)
   - 58-bed acute care hospital
4. Ennis Regional Medical Center (LifePoint)
   - 60-bed acute care hospital



CHRISTUS Mother Frances - Tyler

UT Health East Texas - Tyler

Wyoming



Legend:

- NewCo Hospitals
- LifePoint Hospitals (Remaining)
- Quorum Hospital
- 50 Miles
- 100 Miles

SageWest Health Care

Overview

- SageWest Health Care includes two campuses: Riverton and Lander which are approximately 30 minutes from one another.
- While Riverton is a full-service hospital, much of the higher acuity volume and surgeries go to Lander.
- Both locations operate under the same hospital license.

Rural Economy Driven by Coal, Oil, and Gas

- Wyoming is not a Medicaid expansion state and the economy is driven by coal, oil and gas which have shown signs of slow down recently. Unemployment in the PSA is 9.8% which is much higher than the state or national average.
- County is home to two large Indian Nations (Eastern Shoshone and Northern Arapaho) and a large portion of the county's population is a member of these tribes. There are two outpatient clinics located on the shared reservation, but no separate hospital.

Strained Relationship with Community

- Hospital/Community relationship has become strained over the years driven by the following:
  - Community perception that the hospital is closing services: OB and ENT consolidated to Lander. Adult Psych Unit closed due to changes in reimbursement and investment required for anti-ligature.
  - Hospital often transfers patients out and is on track to transfer nearly 1,000 patients as compared to 2,500 budgeted admissions.
  - SageWest is one of the largest employers in the area and had a 40% turnover rate in 2018.
- As a result, a group of community members has come together to explore the feasibility of building a new not-for-profit hospital in Riverton. The feasibility study has not yet been released, but LifePoint believes it is not economically feasible.

Adding Cath Lab to Keep and Grow Volume

- Hospital recently hired a Cardiologist and is in the process of getting approvals to put in a mobile, but attached Cath Lab. They expect to be opened by the end of 2019 and are projecting 150+ cases the first year.

Riverton and Lander, Wyoming

Licensed Beds	146
Square Feet	199,353
Year Built	1983
Market Share	#1 in PSA

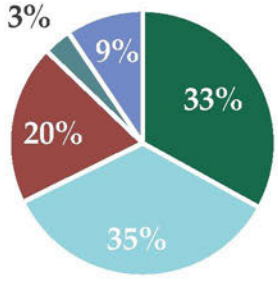
Key Stats

2018 Admissions	2,520
2018 ED Visits	21,384

SageWest - Lander

SageWest - Riverton

2018 Payor Mix(1)



■ Commercial ■ Medicare ■ Medicaid
■ Managed Care ■ Self Pay

(1) Calculated as a percent of charges.

Financial Summary

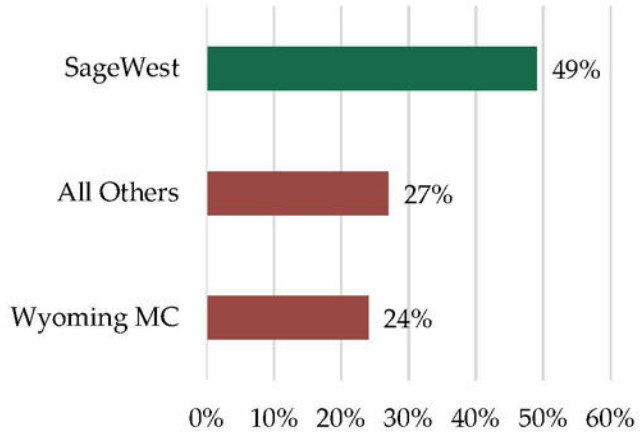
in Millions	2017	2018	2019E	2020E	2021E
Net Revenue	$70	$64	$63	$65	$67
Adj. EBITDARM	$16	$15	$15	$15	$16
Adj. EBITDAR(1)	$15	$14	$14	$14	$14
Rent(2)	$6	$6	$6	$6	$6
CapEx	$2	$2	$1	$1	$1
Free Cash Flow	$7	$5	$7	$7	$7

(1) Management fee equal to 2% of Net Revenues.
(2) MPT Year 1 rent used for 2017-2020.

1/21/2021

SageWest Health Care

2017 IP PSA Mkt Share



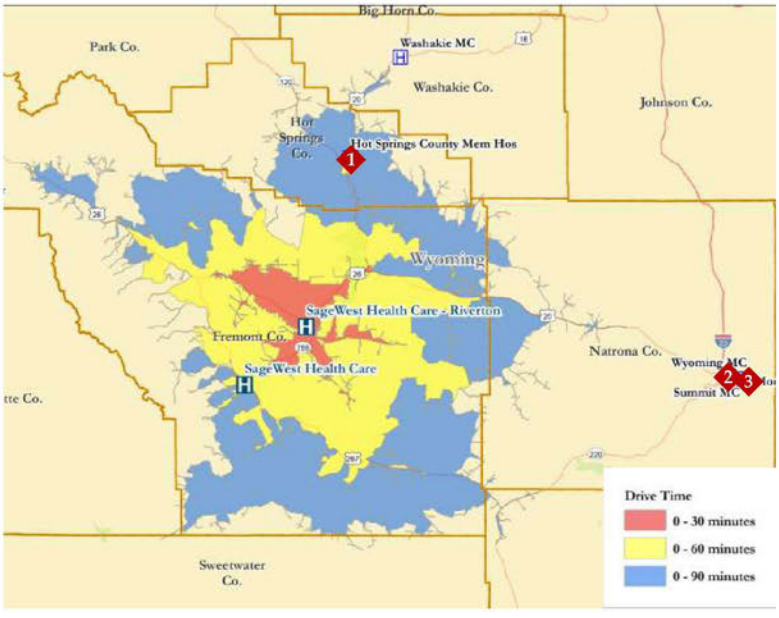
Market Demographics

Modest population growth projected

	5 mile radius	15 mile radius	50 mile radius	75 mile radius
2018 Population	15,964	20,852	42,180	56,977
0-18	24.9%	24.7%	23.6%	23.2%
19-64	58.2%	58.3%	57.7%	57.7%
65+	16.9%	17.0%	18.7%	19.1%
2023 Projection	16,615	21,645	43,488	59,254
% growth	*4.1%*	*3.8%*	*3.1%*	*4.0%*
Median HH Income	$51,617	$53,926	$54,052	$54,641
At or Below Poverty %	14%	13%	12%	11%

Competition

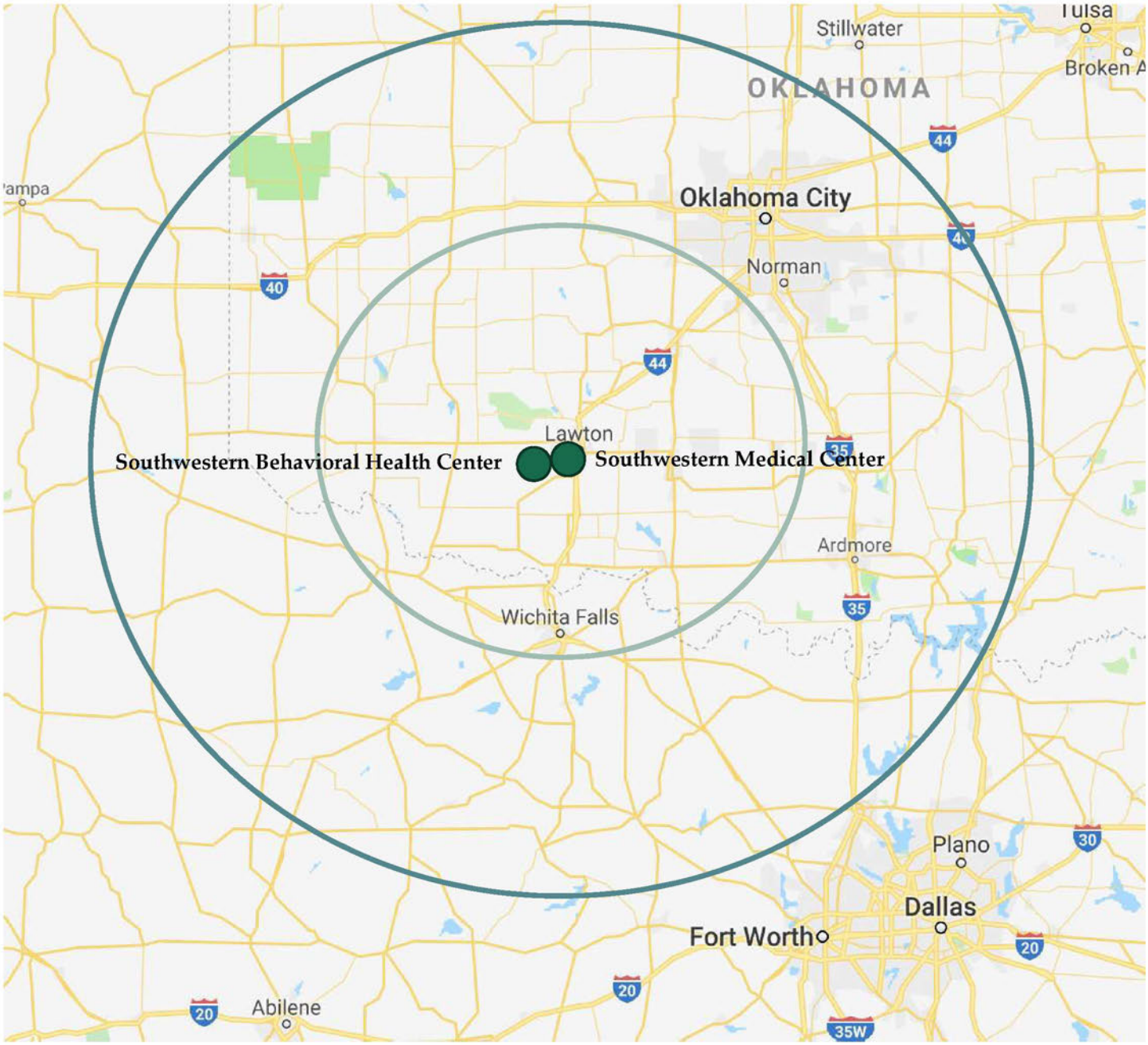
1. Hot Springs County Memorial Hospital
   - 25-bed acute care hospital
2. Wyoming Medical Center
   - 163-bed acute care hospital
3. **Wyoming Medical Center – East Campus**
   - 86-bed acute care hospital
   - Formerly Mountain View Regional Hospital
   - Flys doctors to Riverton for certain clinics each week
   - SageWest would like to partner with this hospital, but is in very early discussions.



Wyoming Medical Center

Hot Springs County Memorial Hospital

Oklahoma



Legend:

- NewCo Hospitals
- LifePoint Hospitals (Remaining)
- 50 Miles
- 100 Miles

Southwestern Medical Center

Overview

- Southwestern Medical Center includes the Main Hospital as well as a Behavioral Health campus and is located in Lawton, OK. The Main Hospital campus also has an on-site Ambulatory Surgery Center **("ASC") that opened in August** 2014. The ASC includes two Operating Rooms and is reimbursed as an HOPD.
- Lawton is located approximately 90 minutes southwest of Oklahoma City.

Population Fluctuation Driven by Army Post

- **Directly north of Lawton is Fort Sill, a US Army post. Fort Sill's** recruitment and civilian contracts have a heavy influence on **Lawton's population.**
- **Hospital's growth initiatives include targeting services that are** needed by the Fort Sill community including certain Cardiology and Behavioral Health.

#2 Player Behind Local Not For Profit

- **Southwestern's primary competitor, Comanche County Memorial Hospital ("CCMH"), is located approximately 3 miles away. CCMH** is an independent, not-for-**profit, and has 51% of the PSA's inpatient** market share.
- Comanche County has a large employed physician base, strong brand awareness, and a dedicated ambulance service.

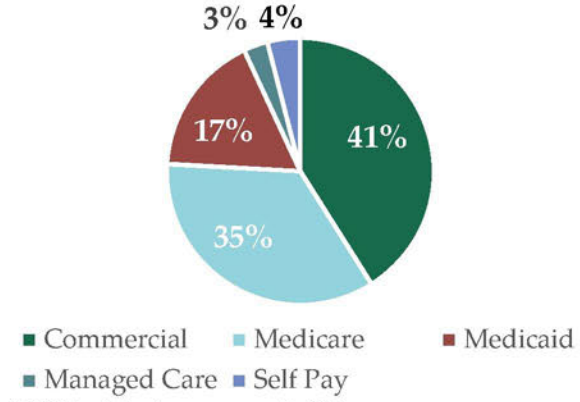
Behavioral Health Meets Community Need

- **Southwestern Medical Center's behavioral health facility which** provides care for children, adolescents, and adults, is the only one in southwest Oklahoma.

Lawton, OK	
Licensed Beds	199
Square Feet	128,411
Year Built	1985
Market Share	#2 in PSA
Key Stats	
2018 Admissions	4,744
2018 ED Visits	21,328

Southwestern Medical Center

2018 Payor Mix(1)



(1) Calculated as a percent of charges.

Financial Summary

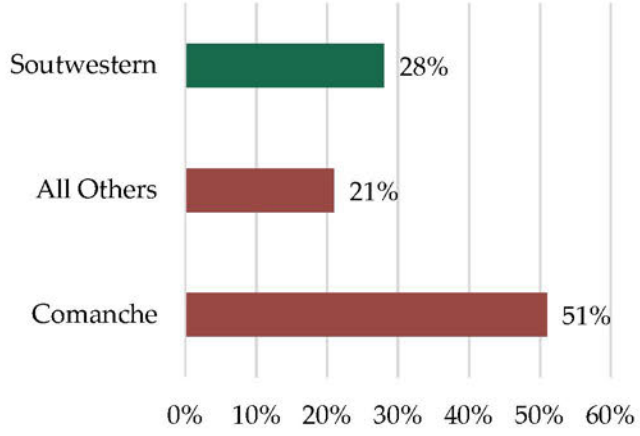
in Millions	2017	2018	2019E	2020E	2021E
Net Revenue	$89	$79	$94	$97	$99
Adj. EBITDARM	$10	$8	$11	$12	$12
Adj. EBITDAR(1)	$8	$6	$9	$10	$10
Rent(2)	$5	$5	$5	$5	$5
CapEx	$2	$2	$2	$1	$1
Free Cash Flow	$1	($2)	$2	$3	$3

(1) Management fee equal to 2% of Net Revenues.
(2) MPT Year 1 rent used for 2017-2020.

1/21/2021

Southwestern Medical Center

2016 IP PSA Mkt Share



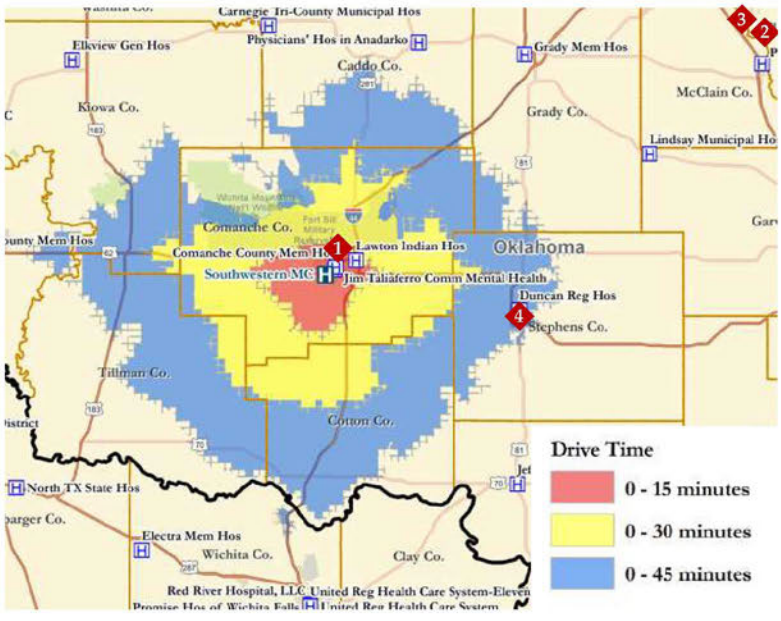
Market Demographics

Modest population growth projected

	5 mile radius	15 mile radius	50 mile radius	75 mile radius
2018 Population	69,546	112,268	356,386	904,954
0-18	26.8%	24.4%	23.5%	23.7%
19-64	58.4%	64.1%	61.3%	61.5%
65+	14.8%	11.5%	15.2%	14.8%
2023 Projection	69,144	112,301	360,273	938,585
% growth	*-0.58%*	*0.03%*	*1.09%*	*3.72%*
Median HH Income	$42,411	$47,717	$45,515	$52,686
At or Below Poverty %	19%	17%	17%	14%

Competition

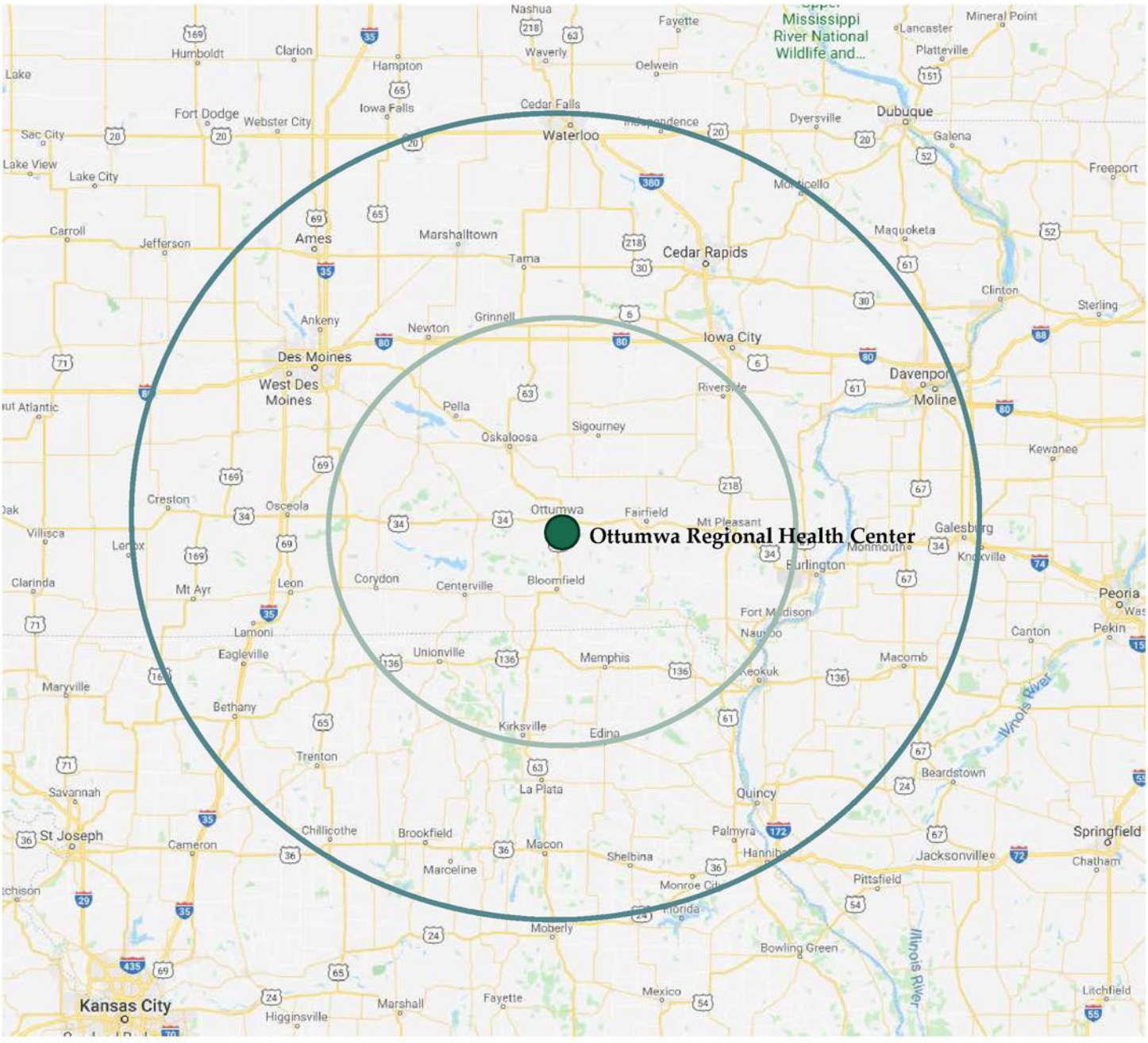
1. Comanche County Memorial Hospital
   - 283-bed acute care hospital
2. OU Medical Center
   - 680-bed acute care hospital (95 miles NE)
3. INTEGRIS Baptist Medical Center
   - 500-bed acute care hospital
4. Duncan Regional Hospital
   - 138-bed acute care hospital



Comanche County Memorial Hospital

OU Medical Center

Iowa



Legend:

- NewCo Hospitals
- LifePoint Hospitals (Remaining)
- 50 Miles
- 100 Miles

Ottumwa Regional Health Center

Overview

- 217-bed hospital located in Wapello County, which includes approximately 33% more Medicaid eligible lives than the remainder of Iowa.
- ORHC is the only for-profit hospital in Iowa but maintains a positive relationship with the state hospital association.
- The local economy is driven by a pork processing plant, JBS, located approximately three miles from the facility. The hospital has entered into agreements to provide health services to the plant employees and is currently covering 3,500 lives. There is potential to expand this offering to other local plants and businesses.

Focus on Physician Recruitment

- In 2018 one surgeon and one ophthalmologist were terminated causing a disruption to surgical volume and impacting financial performance. A new general surgeon was hired in Q4 2018 and is expected to bring back lost surgical volume.
- The current focus is to recruit an orthopedic physician and a cardiologist. One of the major competitors, Mercy Health, has a strong cardiology program and the hospital hopes to recapture some of that volume.
- Management plans to focus on recruitment of primary care physicians. Currently, there is one employed primary care physician and two nurse practitioners. The goal is to increase coverage to three primary care physicians and additional nurse practitioners by 2020.

Hospital Benefits from Rural Location

- The hospital serves an eight county service area and the primary competition within the 60 mile radius are critical access hospitals. It is a 90 minute drive to Iowa City to the NE and Des Moines to the NW.
- Five of the eight surrounding critical access hospitals have stopped OB service and management expects this will create opportunities for the existing OB program. Strategic initiatives include recruiting additional OB physicians and maintaining the Level II nursery status.
- The hospital has the only cath lab in southern Iowa. This results in an annual EBITDA increase of approximately $1.2M.

Ottumwa, IA

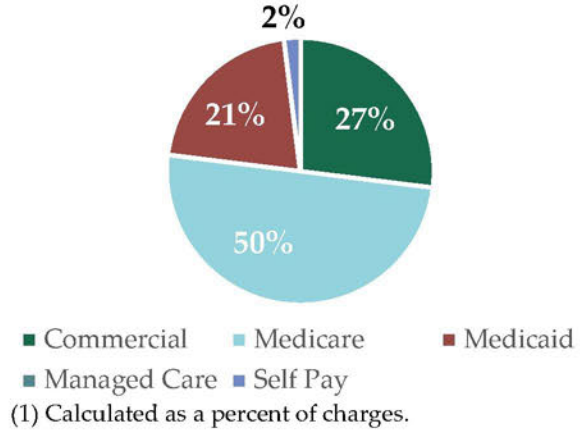
Licensed Beds	217
Square Feet	268,820
Year Built	1950
Market Share	#1 in PSA

Key Stats

2018 Admissions	3,098
2018 ED Visits	19,469

Ottumwa Regional Health Center

2018 Payor Mix(1)



(1) Calculated as a percent of charges.

Financial Summary

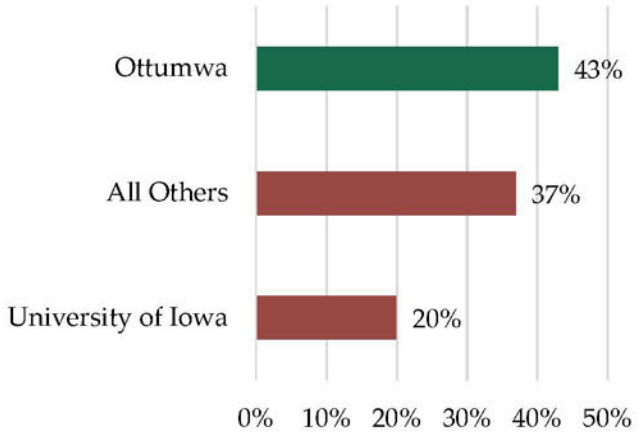
in Millions	2017	2018	2019E	2020E	2021E
Net Revenue	$89	$92	$93	$94	$96
Adj. EBITDARM	$9	$8	$8	$9	$9
Adj. EBITDAR(1)	$8	$6	$7	$7	$7
Rent(2)	$4	$4	$4	$4	$4
CapEx	$2	$2	$1	$2	$2
Free Cash Flow	$2	($0)	$1	$1	$1

(1) Management fee equal to 2% of Net Revenues.
(2) MPT Year 1 rent used for 2017-2020.

1/21/2021

Ottumwa Regional Health Center

2018 IP PSA Mkt Share



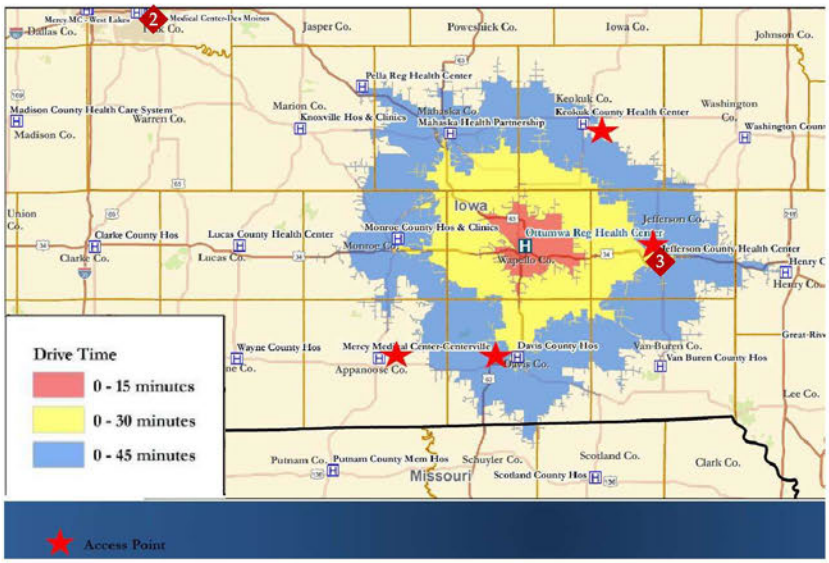
Market Demographics

Modest population growth projected

	5 mile radius	15 mile radius	50 mile radius	75 mile radius
2018 Population	28,101	39,304	231,692	954,615
0-18	22.1%	21.5%	20.9%	22.0%
19-64	59.5%	59.2%	59.0%	61.0%
65+	18.4%	19.3%	20.1%	17.0%
2023 Projection	27,701	38,857	232,340	982,993
% growth	*- 1.4%*	*- 1.1%*	*- 0.3%*	*3.0%*
Median HH Income	$39,916	$43,475	$49,276	$53,041
At or Below Poverty %	19%	17%	13%	14%

Competition

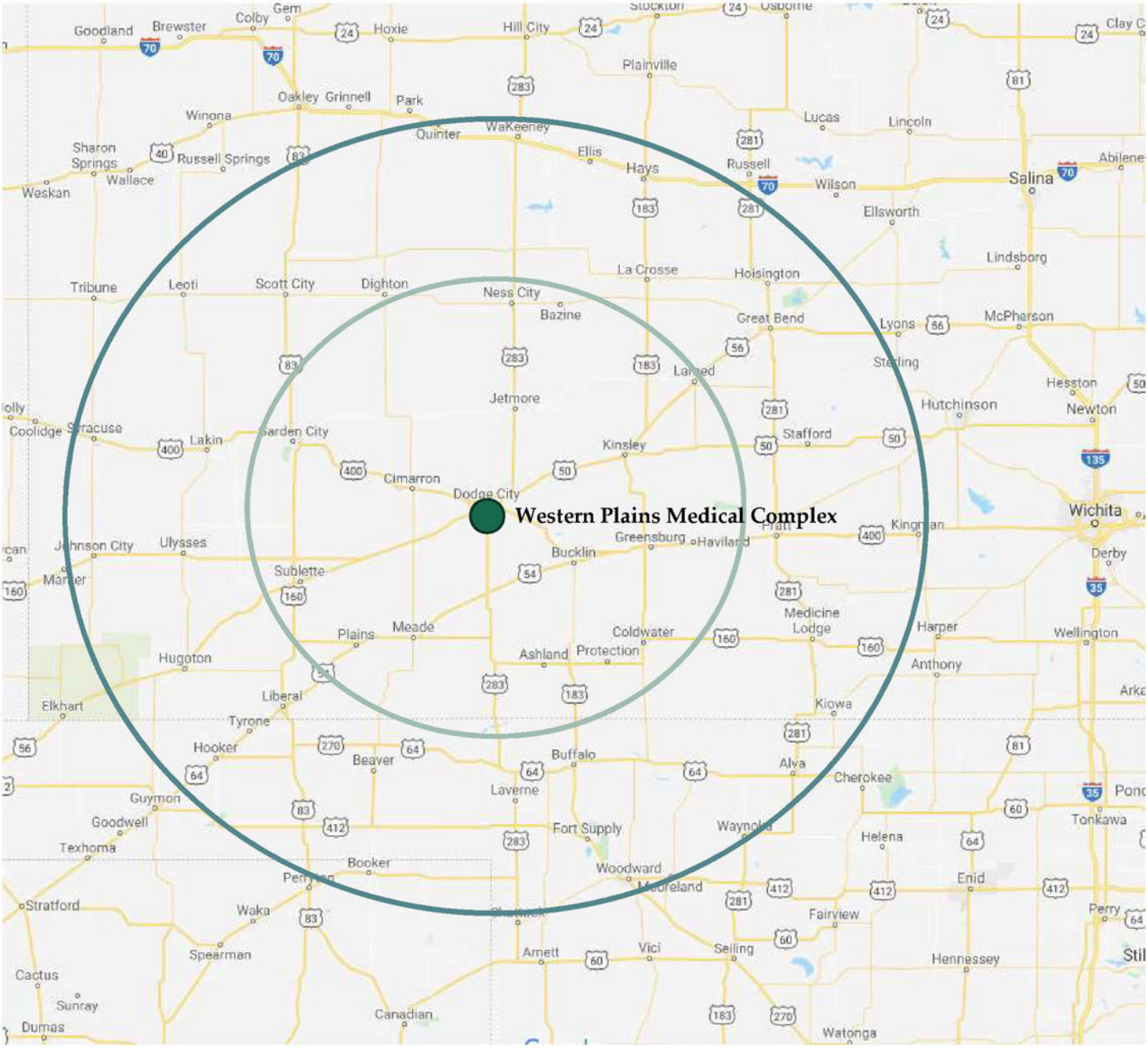
1. University of Iowa Health Care (Not listed on Map)
   - Academic medical center (80 miles NE in Iowa City)
2. Mercy Health Network (Common Spirit)
   - Four hospital NFP system with 875 beds in Des Moines (90 miles NE)
   - Affiliated with 14 community hospitals in Iowa
3. Jefferson County Health Center (county owned)
   - 25 bed CAH built in 2009 (25 mi East)



University of Iowa Health Care

MercyOne Des Moines

Kansas



Legend:

- **NewCo Hospitals**
- **LifePoint Hospitals (Remaining)**
- **50 Miles**
- **100 Miles**

Western Plains Medical Complex

Overview

- Western Plains Medical Complex is located in Dodge City, Kansas. Dodge City is in southwestern Kansas and is approximately 2.5 hours west of Wichita.

Rural Economy Driven by Agriculture

- Dodge City's economy is primarily driven by agriculture and more specifically, meat manufacturing. The top two employers include Cargill (~5,000 employees) and National Beef (~3,900 employees).
- Management sees local manufacturers as a potential for direct contracting and is focused on developing a relationship with them. This relationship will begin with the hospital providing occupational and preventative health services.

Hospital Faces Competition Despite Isolation

- **Due to the rural location, the hospital's primary competitors are located** more than 50 miles away:
  - **Centura's St. Catherine's in Dodge City, KS (1 hour drive)**
  - **Kansas University's ("KU") Pratt Regional in Pratt, KS (1.5 hour drive)**
  - Hays Medical Center in Hays, KS (2 hour drive)
- Management explained that the local residents are accustomed to **driving long distances for healthcare services. St. Catherine's and Pratt** Regional have embedded primary care and specialty physicians in Dodge City in order to direct volume.

Previous Administration Neglected Recruitment

- **Hospital's previous administration did not focus on recruiting** physicians to Western Plains. The current CEO has made this his top priority since arriving and while he has had some success, he continues to focus on additional growth. Primary recruiting needs include Primary Care and specifically, Family Practice/Internal Medicine and OB/GYN.
- The current medical staff is divided between KU alum and J-1 visa physicians. Management is also focused on uniting the medical staff to build a stronger hospital.

Management Desires KU Affiliation

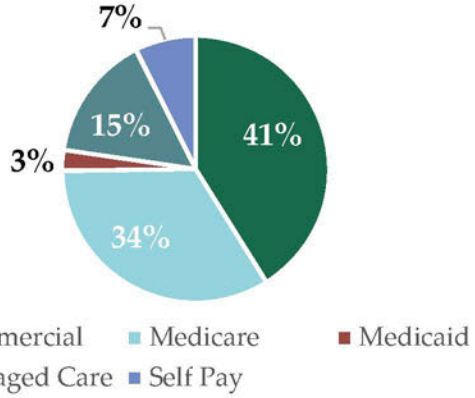
- Management believes one way to ensure the future success of Western Plains is through an affiliation or partnership with KU. The CEO is in the early stages of discussions with KU, which is expected take time and the benefits are not yet known.

Dodge City, KS	
Licensed Beds	99
Square Feet	73,258
Year Built	1976
Market Share	#1 in PSA

Key Stats	
2018 Admissions	1,756
2018 ED Visits	11,321

Western Plains Medical Complex

2018 Payor Mix(1)



(1) Calculated as a percent of charges.

Financial Summary

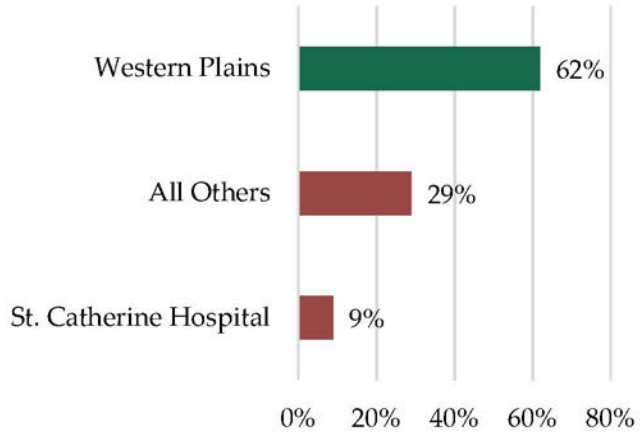
in Millions	2017	2018	2019E	2020E	2021E
Net Revenue	$43	$47	$48	$51	$52
Adj. EBITDARM	$7	$11	$10	$12	$12
Adj. EBITDAR(1)	$6	$10	$10	$11	$11
Rent(2)	$4	$4	$4	$4	$4
CapEx	$1	$1	$1	$1	$1
Free Cash Flow	$1	$4	$4	$6	$6

(1) Management fee equal to 2% of Net Revenues.
(2) MPT Year 1 rent used for 2017-2020.

1/21/2021

Western Plains Medical Complex

2018 IP PSA Mkt Share



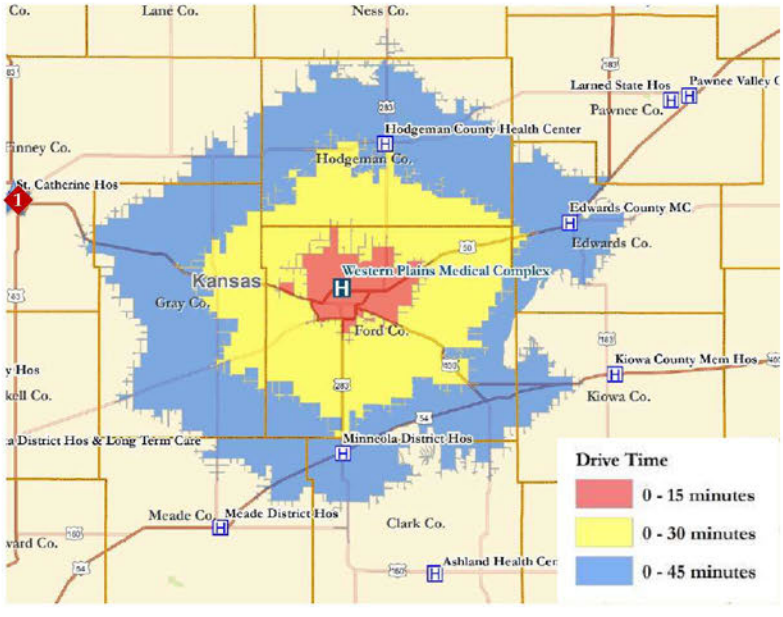
Market Demographics

Modest population growth projected

	5 mile radius	10 mile radius	50 mile radius
2018 Population	29,784	32,962	90,836
0-18	28.3%	27.9%	26.3%
19-64	60.5%	60.5%	60.0%
65+	11.2%	11.6%	13.7%
2023 Projection	29,794	32,945	90,108
% growth	*0.0%*	*0.0%*	*-0.8%*
Median HH Income	$48,472	$49,704	$50,911
At or Below Poverty %	15.0%	14.3%	12.6%

Competition

1. St. Catherine Hospital (Centura Health)
   - 102 bed hospital in Garden City, KS (50 mi East)
2. Wesley Medical Center (HCA) (Not listed on map)
   - Large, Level 1 trauma center in Wichita (160 mi East)
3. Via Christi Hospital St. Francis (Ascension) (Not listed on map)
   - 491 bed facility in Wichita (160 mi East)



Wesley Medical Center

St. Catherine Hospital

Medical Properties Trust

Final Underwriting Report Approval Form

Those signing below have read the Final Underwriting Report and give their final approval to close this transaction.

Final Underwriting Report Approval Signatures:

[redacted]

2/8/2021
Date

Date

1/25/21
Date

1/21/21
Date

1/21/21
Date

1/21/2021
Date

1/21/21
Date

1/21/21
Date

Medical Properties Trust

Closing Approval Form

The following give their final approvals to close this transaction.

EXECUTIVE COMMITTEE
All members required

Chairman, President & CEO - Edward K. Aldag, Jr. — Date

Emmett McLean — 3-12-21
EVP & COO - Emmett E. McLean — Date

6.28.21
EVP & CFO - R. Steven Hamner — Date